STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case Nos. 02-0669
	)	02-1638
WESTMINSTER CARE OF ORLANDO,	)	
Respondent.	)	

RECOMMENDED ORDER

Administrative Law Judge (ALJ) Daniel Manry conducted the administrative hearing of these consolidated cases on June 25, 2002, in Orlando, Florida, on behalf of the Division of Administrative Hearings (DOAH).

APPEARANCES

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For Respondent: Karen L. Goldsmith, Esquire
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STATEMENT OF THE ISSUE

The issue in these cases is whether Respondent failed to provide appropriate emergency care for a nursing home resident in respiratory distress in violation of 42 Code of Federal Regulation (CFR) Section 483.25 and Florida Administrative Code Rule 59A-4.1288. (All references to rules are to rules promulgated in the Florida Administrative Code in effect as of the date of this Recommended Order.)

PRELIMINARY STATEMENT

By letter dated November 30, 2001, Petitioner alleges that Respondent violated 42 C.F.R. Section 483.25, which has been adopted as a state requirement by Rule 59A-4.1288, for an alleged "failure to provide appropriate emergency care for a resident in respiratory distress and failure." The letter identified the alleged violation as Tag F309 (F309) and cited a scope and severity of "G" and Class II. In Case No. 02-0669, Petitioner filed a notice of intent to assign a conditional license for the period from September 14, 2001, until substantial compliance is achieved. Petitioner changed Respondent's license rating to a conditional license effective September 14, 2001.

On December 20, 2001, Petitioner filed an Administrative Complaint and, on May 1, 2002, Petitioner filed an Amended Administrative Complaint without objection by Respondent. The

Amended Administrative Complaint in Case No. 02-1638, seeks to impose an administrative fine of $2,500.00. The proposed change in license status in Case No. 02-0669 and the proposed administrative fine in Case No. 02-1638 are based on the same allegations.

At the administrative hearing, Petitioner withdrew paragraphs 9B and 9D of the Amended Administrative Complaint. The remaining allegations in this consolidated proceeding are that Respondent violated Rules 59A-4.106, 59A-4.1288, which adopts 42 C.F.R. Section 483.25, and Section 400.022, Florida Statutes (2001). (All chapter and section references are to Florida Statutes (2001) unless otherwise stated.) Respondent timely requested an administrative hearing.

Petitioner presented the testimony of one witness and submitted five exhibits for admission in evidence. Respondent presented the testimony of one witness, and submitted eight exhibits for admission in evidence. The identity of the witnesses and exhibits and any attendant rulings are set forth in the Transcript of the hearing filed on July 16, 2002.

On June 25, 2002, the ALJ ordered the parties to file their Proposed Recommended Orders (PROs) no later than 10 days after the date that the Transcript was filed. On July 22, 2002, the ALJ granted the parties' request for an extension of time to

file their PROs on August 6, 2002. The parties timely filed their respective PROs on August 6, 2002.

FINDINGS OF FACT

1. Petitioner is the state agency responsible for licensing and regulating nursing homes inside the State of Florida. Respondent operates a licensed nursing home at 830 West 29th Street, Orlando, Florida (the facility).

2. Petitioner conducted a complaint survey of the facility on September 14, 2001. The survey cited the facility for a deficiency described in F309, and rated the deficiency with a scope and severity of "G" and Class II, respectively.

3. The deficiency classifications authorized in Subsection 400.23(8) range from Class I through Class IV. Class I deficiencies are not relevant to this case. The statute defines the remaining classifications as follows:

> (a) A Class II deficiency is a deficiency that the agency determines has compromised the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. . . .
>
> (b) A Class III deficiency is a deficiency that the agency determines will result in no more than minimal physical, mental or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable physical, mental, or psychosocial well-being as defined. . . .

> (c) A Class IV deficiency is a deficiency that the agency determines has the potential for causing no more than a minor negative impact on the resident. . . .

4. Rule 59A-4.1288 requires nursing home facilities licensed by the state of Florida to adhere to federal regulations found in Section 483 of the Code of Federal Regulations (CFR). In relevant part, Rule 59A-4.1288 provides:

> Nursing homes that participate in Title XVIII or XIX must follow certification rules and regulations found in 42 CFR 483, Requirements for Long Term Care Facilities, September 26, 1991, which is incorporated by reference.

5. The "G" rating adopted by Petitioner for the scope and severity rating of the deficiency alleged in F309 is a rating authorized in relevant federal regulations. A "G" rating means that the alleged deficiency was isolated.

6. Applicable state law authorizes Petitioner to change a facility's licensure rating from standard to conditional whenever Petitioner alleges that a Class II deficiency exists. Petitioner alleged in the survey report that a Class II deficiency existed at the facility and assigned a conditional rating to the facility's license. The conditional rating was effective September 14, 2001, and continued until substantial compliance was achieved.

7. When Petitioner proves that a Class II deficiency exists, applicable law authorizes Petitioner to impose a civil money penalty. Petitioner filed an Administrative Complaint against Respondent seeking to impose a fine of $2,500.00 and subsequently filed an Amended Administrative Complaint.

8. The allegations on which both the change in license status to a conditional license and the proposed fine are based are set forth in F309. The deficiency alleged in F309 is set forth on CMS Form 2567, entitled "Statement of Deficiencies and Plan of Correction" (the 2567).

9. The 2567 that Petitioner used to charge Respondent with the deficiency described in F309 involved only one resident. In order to protect this resident's privacy, the 2567, F309, the Transcript, and all pleadings refer to the resident as Resident 1.

10. F309 alleges that the facility failed to satisfy the requirement of 42 C.F.R. Section 483.25. In relevant part, the federal regulation provides:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, or psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by 483.25(a)-(m).

11. F309 alleges that the facility failed to satisfy the requirement of 42 CFR Section 483.25 because:

> Based on interview and record review the facility neglected to provide appropriate emergency care for [Resident 1] in respiratory distress and failure.

12. Petitioner promulgates an officially stated policy in written guidelines entitled the State Operations Manual (the Manual). The Manual states agency policy regarding the interpretation and application of the regulatory standards surveyors must enforce.

13. The facility admitted Resident 1 to the pediatric long-term care unit on November 20, 2000. The admitting diagnosis was cerebral palsy, pneumonia and convulsions, a tracheostomy, and a gastrostomy.

14. Resident 1 could breathe on her own and was being weaned from the trach. She could breathe through her nose at times. She was not on a ventilator but could breathe room air. At all times, Resident 1 was making respiratory effort. Resident 1 was on an apnea monitor.

15. Resident 1 had three stomas. Stomas are the openings for the tracheostomy tube. Her throat structures were very frail. She had received numerous throat reconstructions. She had significant scar tissue and a granuloma at her stoma sites. A granuloma is a tumor-like growth. The granuloma was vascular,

and the blood vessels were easily broken. Resident 1 was spastic as a result of her cerebral palsy.

16. On September 7, 2001, at 2:50 a.m., Resident 1's apnea monitor alarm sounded. Staff immediately responded to find that Resident 1 had pulled out her tracheostomy tube and was bleeding profusely. Facility staff called 911 and notified the treating physician and the parents.

17. An ambulance was dispatched to the facility at 2:51 a.m. on September 7, 2001. While awaiting the ambulance, the Registered Nurse on duty (RN) could not detect an apical or radial pulse.

18. The RN did not administer CPR. Rather, the RN established an airway by successfully replacing the tracheostomy tube.

19. Securing a patent airway was the first thing that the RN should have done for Resident 1 under the circumstances. No oxygen can be given without a patent airway. It was difficult for the RN to visualize the trach opening because of the profuse bleeding. The RN was able to tactilely reinsert the tube.

20. Vital signs taken by the RN showed that Resident 1 was alive when EMT personnel arrived on the scene. CPR is not appropriate when vital signs are present.

21. The ambulance and EMT personnel arrived shortly after the RN reinserted the trach tube. At 2:56 a.m., EMT personnel took over the care of Resident 1.

22. EMT personnel worked on Resident 1 for 23 minutes before transporting her to the hospital. Resident 1 died at the hospital at 3:35 a.m., 38 minutes after the EMTs took responsibility for her care.

23. EMT personnel generated EKG strips indicating that Resident 1's heart was beating at some point after they took over. Two sets of x-rays subsequently taken at the hospital substantiate that Resident 1 was alive when EMT personnel took over her care.

24. EMT personnel removed the trach the nurse had inserted and replaced it with an endotracheal tube. Removing the trach eliminated the airway that the RN had established for Resident 1 before EMT personnel arrived.

25. The endotracheal tube was 22 centimeters long and significantly longer and larger than the regular trach tube used for Resident 1. The physician's order for Resident 1 stated that nothing should go past 6 centimeters into Resident 1's trach. It took the EMTs three attempts to get the endotracheal tube placed.

26. The EMTs should have hyperventilated Resident 1 before placing the endotracheal tube. They did not do so. The x-ray

taken at 3:42 a.m. in the hospital, shows that the endotracheal tube was improperly positioned in Resident 1's lung.

27. All steps taken by the RN were appropriate for Resident 1 under the circumstances. Petitioner failed to show a nexus between any act or omission by the facility and the harm to Resident 1.

28. The care plan for Resident 1 called for suctioning of her tracheal tube. Care plans are to be followed under normal circumstances. Emergency procedures take precedence in critical situations.

29. Suctioning for Resident 1 was appropriate under normal circumstances when she had a patent airway. If Resident 1 did not have an airway, the first priority is to establish an airway. The RN first established a patent airway for Resident 1.

30. It would have been inappropriate for the RN to suction Resident 1 before establishing an airway because it would have sucked out the air remaining in Resident 1's lungs. Suctioning also could have caused a vasovagal response that could stop the heart and could have caused tissue damage.

31. After the RN opened an airway for Resident 1, the next priority would have been for the RN to check for vital signs. The RN checked Resident 1's vital signs after opening an airway,

and the vital signs showed that Resident 1 was alive when EMT personnel arrived on the scene.

32. The presence of vital signs made it inappropriate for either the RN or EMT personnel to administer CPR. CPR is appropriate only in the absence of vital signs.

33. When EMT personnel arrived, they continued the same procedure that the RN had followed. EMT first established an airway by removing the trach tube used by the RN and replaced it with an endotracheal tube. The resident had vital signs after placement of the trach and CPR was inappropriate.

34. F282 relates to failure to implement a care plan. Respondent was not cited under F282. Petitioner stipulated in the Prehearing Stipulation that both the conditional license and fine were based on F309 alone.

CONCLUSIONS OF LAW

35. DOAH has jurisdiction over the parties and subject matter in this proceeding. Sections 120.569 and 120.57(1). The parties received adequate notice of the administrative hearing.

36. Petitioner must show by a preponderance of the evidence that Respondent committed an act or omission for which the imposition of a conditional license is appropriate. Beverly Enterprises-Florida v. Agency for Health Care Administration, 745 So. 2d 1133 (Fla. 1st DCA 1999); Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 349 (Fla. 1st

DCA 1977). Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977). See also Agency for Health Care Administration v. Beverly Savana Cay Manor, Inc., et al., DOAH Case No. 00-3356, 2001 WL 246776; and Capital Health Care Center v. Agency for Health Care Administration, DOAH Case No. 00-1996.2000 WL 1867290. Petitioner must show by clear and convincing evidence that Respondent committed the acts or omissions alleged in the Administrative Complaint and the reasonableness of the proposed fine. Department of Banking and Finance v. Osborne Stern and Co., 670 So. 2d 932.935 (Fla. 1996).

37. Petitioner failed to satisfy either burden of proof. All steps taken by the facility were appropriate for Resident 1 under the facts and circumstances.

RECOMMENDATION

Based on the forgoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that Petitioner enter a Final Order finding Respondent not guilty of the allegations in F309 and the Administrative Complaint, dismissing the Administrative Complaint, and changing Respondent's conditional license to a standard license effective September 4, 2001.

DONE AND ENTERED this 6th day of September, 2002, in Tallahassee, Leon County, Florida.

DANIEL MANRY
Administrative Law Judge
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Filed with the Clerk of the
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this 6th day of September, 2002.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.