STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

BEVERLY HEALTHCARE EVANS, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 02-0699

RECOMMENDED ORDER

Notice was provided, and on May 22, 2002, a formal hearing was held in this case. The hearing location was Fort Myers, Florida. The authority for conducting the hearing is set forth in Sections 120.569 and 120.57(1), Florida Statutes. The hearing was conducted by Fred L. Buckine, Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: R. Davis Thomas, Jr.
Qualified Representative
Broad and Cassel
215 South Monroe Street, Suite 400
Post Office Drawer 11300
Tallahassee, Florida 32302

For Respondent: Dennis L. Godfrey, Esquire
Agency for Health Care Administration
525 Mirror Lake Drive, North
Room 310L
St. Petersburg, Florida 33701

STATEMENT OF THE ISSUES

Should Respondent, Agency for Health Care Administration, rate Petitioner's, Beverly Healthcare Evans, nursing home facility license "Conditional" for the 60-day period of January 8 through March 5, 2001, pursuant to Section 400.23(7), Florida Statutes? In particular, did Petitioner commit the acts or omissions alleged in Tags F281, F326, and F426 as determined in Respondent's periodic survey concluded on November 15, 2000? Are Tags F281, F326, and F426 "Class III" deficiencies as defined in Section 400.23(8)(b), Florida Statutes (2000)? Did the results of Respondent's survey concluded on January 8, 2001, reveal "Class III" deficiencies that were uncorrected on or before February 8, 2001, the time specified by Respondent? If so, was Petitioner's "Conditional" rating for the 60-day period of January 8 through March 5, 2001, appropriate?

PRELIMINARY STATEMENT

Respondent (hereinafter AHCA) alleged that Petitioner (hereinafter Evans) violated various provisions of the Florida Statutes and the Florida Administrative Code, and provided notice that Evans' licensure rating was changed from Standard to Conditional for the 60-day period of January 8 through March 5, 2001. Evans contested assignment of a "Conditional" license for that period by requesting a formal hearing to be conducted, pursuant to Sections 120.569 and 120.57(1), Florida Statutes.

On February 2, 2002, the Division of Administrative Hearings was notified that Evans desired a formal hearing. Evans requested assignment of an Administrative Law Judge to conduct proceedings leading to a recommended order resolving the fact disputes and recommending the legal outcome. The case was assigned, and the hearing ensued.

By stipulation, the parties agreed that AHCA bore the burden of proof in this proceeding to show that there was a basis for imposing the "Conditional" rating on Evans' license. In support of that proof, AHCA presented the following witnesses: Mary Maloney, Lori Riddle, Jim Marrione, Maria Donohue, Christine Grushchke, and by agreement of the parties, the deposition testimony of Norbert G. Smith. AHCA's 29 Exhibits were admitted. Evans presented the testimony of one witness and submitted two Exhibits into evidence without objection.

Official notice was taken of Rules 59A-4.128(3)(b) and 59A-4.1288, Florida Administrative Code; Sections 400.022, 400.141, and 400.23, Florida Statutes; and 42 Code of Federal Regulations (C.F.R.) Sections 483.20(k)(3)(i), 483.25(i)(2), and 483.60(a). The identity of the witnesses, Exhibits, and any attendant rulings are set forth in the two-volume Transcript of the hearing filed on June 13, 2002.

The parties filed a joint pre-hearing stipulation that has been utilized in preparing this Recommended Order. Proposed recommended orders were scheduled to be filed not later than 20 days after the filing of the Transcript. Requests made for additional time to file proposed recommended orders were granted, extending the time for filing proposed recommended orders. By these arrangements, the parties have waived the requirement that the Recommended Order be entered within 30 days of receipt of the hearing Transcript. Rule 28-106.216, Florida Administrative Code. Proposed Recommended Orders were filed on July 19 and 22, 2002, by AHCA and Evans, respectively, and have been considered in rendering this Recommended Order.

FINDINGS OF FACT

1. Evans is a nursing home located at 5405 Babcock Street, Northeast, Fort Myers, Florida, which is duly-licensed under Chapter 400, Part II, Florida Statutes.

2. AHCA is the state agency responsible for evaluating nursing homes in Florida pursuant to Section 400.23(7), Florida Statutes. As such, it is required to evaluate nursing homes in Florida in accordance with Section 400.23(8), Florida Statutes. AHCA evaluates all Florida nursing homes at least every 15 months and assigns a rating of standard or conditional to each licensee. In addition to its regulatory duties under Florida law, AHCA is the state "survey agency," which, on behalf

of the federal government, monitors nursing homes that receive Medicaid or Medicare funds. This standard is made applicable to nursing homes in Florida pursuant to Rule 59A-4.1288, Florida Administrative Code, which provides:

> Nursing homes that participate in Title XVIII or XIX must follow certification rules and regulations found in 42 C.F.R. 483, Requirements for Long Term Care Facilities, September 26, 1991, which is incorporated by reference. Non-certified facilities must follow the contents of this rule and the standards contained in the Conditions of Participation found in 42 C.F.R. 483, Requirements for Long Term Care Facilities, September 26, 1991, which is incorporated by reference with respect to social services, dental services, infection control, dietary and the therapies.

3. AHCA conducted an annual survey of Evans on November 15, 2000, and alleged that there were three deficiencies. These deficiencies were organized and described in a survey report by "Tags," numbered F281, F326, and F426. The results of the survey were noted on an AHCA form entitled "Statement of Deficiencies and Plan of Correction." The parties refer to this form as the HCFA 2567-L or the "2567." AHCA conducted a follow-up survey of Evans, which was completed on January 8, 2001.

4. The 2567 is the document used to charge nursing homes with deficiencies that violate applicable law. The 2567

identified each alleged deficiency by reference to a Tag number. Each Tag on the 2567 includes a narrative description of the allegations against Evans and cites a provision of the relevant rule or rules in the Florida Administrative Code violated by the alleged deficiency. To protect the privacy of nursing home residents, the 2567 and this Recommended Order refer to each resident by a number (Resident 1, etc.) rather than by the name of the resident.

5. AHCA must assign a class rating of I, II or III to any deficiency that it identifies during a survey. The ratings reflect the severity of the identified deficiency, with Class I being the most severe and Class III being the least severe deficiency. There are three Tags (F281, F326, and F426) at issue in the case at bar, and, as a result of the November 15, 2000, survey, AHCA assigned each Tag a Class III deficiency rating.

6. Tag F281 generally alleged that Evans failed to meet professional standards of quality, evidenced by examples of three residents, in violation of 42 C.F.R. Section 483.20(k)(3)(i), which provides:

> Comprehensive Care Plans
>
> (3) The services provided or arranged by the facility must---
>
> (i) Meet professional standards of quality.

7. Tag F326 generally alleged that Evans failed to ensure that a resident received a therapeutic diet, when there was a nutritional problem, in violation of 42 C.F.R. Section 483.25(i)(2), which provides, in pertinent part:

> (i) Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident--.
>
> (2) Receives a therapeutic diet when there is a nutritional problem.

8. Tag F426 generally alleged that Evans failed to provide pharmaceutical services to meet the needs of the residents, evidenced by examples of three residents, in violation of 42 C.F.R. Section 483.60(a), which provides:

> (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

9. The November 15, 2000, survey cites three Class III deficiencies. AHCA's January 8, 2001, survey cites repeated (or failure to correct the three) Class III tag violations cited in the November 15, 2000, survey.

10. Effective January 8, 2001, AHCA changed the rating of Evans' license from Standard to Conditional.

Tag F281 - NOVEMBER 15, 2000 - SURVEY

11. Tag F281, a Class III deficiency, generally alleged that Evans failed to meet professional standards of quality of

care regarding three residents in violation of 42 C.F.R. Section 483.20(k)(3)(i).

12. Glenn T. Boyles, a surveyor/pharmacist for AHCA and qualified as an expert pharmacist, testified that a nurse for Evans, on November 15, 2000, was observed not to have followed the professional standards and quality in preparing and administering medications for three residents.

13. Boyles observed the nurse preparing the drug Colace for administration by removing the medications from the manufacturer's bottle and placing the medications into her hand before placing these medications into a soufflé cup.

14. Boyles also observed the same nurse pre-pour two doses of Colace liquid for administration to two other residents. Medications are not to be pre-poured or touched with the fingers except when opening a capsule to empty the medication into a cup, which is not the case here. The correct number of tablets or capsules are to be poured directly into the medication cup. In a discussion with the Director of Nurses for Evans about the above observations, the Director of Nurses substantially acknowledged that the nurse's actions were an inappropriate standard of practice.

15. Boyles opined that there was an increased risk of contamination; there was a potential for subsequent infectious conditions that would affect the resident; pre-pouring the

medication increased the opportunity for the dosages to be contaminated by organisms of an infectious nature which could, in turn, be transferred to the resident; and there was an increased risk of administering the medications to the wrong residents.

16. Evans' contention that hand washing by the nurse prior to administering medications and the length of time the Colace capsule was in contact with the nurse's hands resulted in minimizing the chance of actual contamination misses the mark of no hands on the actual medication to be administered and no pre-pouring as was the case here.

17. Based upon Findings of Fact 11 through 16 hereinabove, AHCA has proved that Evans failed to follow policy and to meet the professional standards of quality in preparing and administering medications regarding the three residents who were subjects of Tag F281 as to the November 15, 2000, survey.

TAG F281 - JANUARY 8, 2001 - SURVEY

18. Tag F281, a Class III deficiency, generally alleges that Evans failed to meet professional standards of quality of care regarding Resident 2 and Resident 7.

Resident 2

19. Lori Riddle, AHCA's surveyor, during the January 8, 2001, follow-up survey of the November 15, 2000, survey, conducted a survey involving Resident 2.

20. A review of Resident 2's medical records revealed multiple diagnoses, one of which was convulsions, for which the anti-convulsant medication Dilantin was prescribed to be taken four times a day. The importance of taking the anti-convulsant medication Dilantin as prescribed is to maintain a therapeutic level of the drug in the body to prevent convulsions.

21. Resident 2's medical administration record (MAR) reflected that the resident refused medication, by spitting out the Dilantin, on seven different occasions in December 2000 and on five different occasions in January 2001. Resident 2 was not taking the medication as prescribed, and there was no documentation by Evans' staff that the physician had been alerted to the fact that Resident 2 was not taking the prescribed medication.

22. It was the responsibility of Evans' nursing staff to inform the physician that Resident 2 was not taking the prescribed medication, for whatever reason. Evans had no documentation or facility staff testimony evidencing the fact that a nurse contacted the physician concerning Resident 2 spitting out the prescribed medication, Dilantin.

23. Dr. Dosani, resident physician, after completion of the January 8, 2001, survey, informed the surveyor that the doctor had been notified that Resident 2 was spitting out the prescribed medication, Dalantin.

24. Jim Marrione, expert in nursing practices and procedures, opined that Evans failed to provide services that met professional standards of quality as to Resident 2 under the facts and circumstances presented at the time.

25. Evans does not contest and, in fact, agreed that its staff did not document Resident 2's repeated spitting out of the Dalantin and, thus, was not in compliance of assuring the accurate dosage of prescribed medication. Failure to document Resident 2 spitting out the medication at the time it occurred, when coupled with the failure to document advising the resident's physician of the situation, resulted in Resident 2 not receiving medication four times a day.

26. AHCA has proved the allegations regarding Resident 2, Tag F281 of the January 8, 2001, survey, regarding the failure to properly medicate the resident with anti-convulsant medication, Dilantin, four times a day.

Resident 7

27. Jim Marrione, a surveyor and an expert in nursing practices and procedures, conducted a survey of Resident 7 during the survey of January 8, 2001. According to Marrione, Resident 7 suffered pneumonia and chronic airway obstruction and hypoxemia. In his opinion, Evans was out of compliance with standards of practice for the following reasons: (i) failure to document daily record of oxygen saturation rates

as ordered by the physician on October 23, 2000; (ii) failure to document the monitoring of daily oxygen saturation on December 25 and 26, 2000; and (iii) failure to document the monitoring of daily oxygen saturation on January 3, 4, 5, and 6, 2001.

28. Daily monitoring of the oxygen saturation rate indicated that the doctor wanted to make sure that the resident's saturation rate was maintained at an acceptable level. The potential harm that results from the failure to document the saturation rate is respiratory failure of the resident. This failure to document the daily oxygen saturation rate was beneath the professional standards of quality and in violation of the Nursing Practice Act.

29. Evans' contention that other manifested physical symptoms would be more observable indicators of respiratory failure begs the question of quality care that is intended to avoid and prevent, when possible, respiratory failure in residents. The standard of care does not permit substitution of more observable indicators of potential respiratory failure.

30. AHCA has proven Evans' failure to document the daily record of oxygen saturation rates; failure to document the monitoring of daily oxygen saturation on December 25 and 26, 2000; and failure to document the monitoring of daily oxygen saturation on January 3, 4, 5, and 6, 2001.

TAG F326 - NOVEMBER 15, 2000 - SURVEY

31. Tag F326, a Class III deficiency, generally alleges that Evans failed to ensure that Resident 6 received a therapeutic diet,[1] when there was a nutritional problem, in violation of 42 C.F.R. Section 483.25(i)(2).

Resident 6

32. Mary Maloney, an expert in nutrition, surveyed Resident 6 who had multiple diagnoses, including being severely underweight, chronic renal failure, diabetes, dysphagia (difficulty in swallowing), and other conditions that caused him to be much debilitated, bed bound and, therefore, requiring a specialized tube feeding formula for diabetes and a gastrostomy tube for the dysphagia.

33. According to Maloney, Resident 6's ideal body weight (IBW) was 136 pounds; therefore, the care plan goal for this resident was weight increase. Evans' nutritional assessment for Resident 6 dated September 19, 2000, revealed that the resident weighed 122 pounds on September 9, 2000, and his caloric needs were 1,706 per day. The nutritional assessment dated September 25, 2000, assessed Resident 6's caloric needs at 1,6ll calories; however, the resident was only receiving 1,380 calories. Evans' dietician recommended increasing the tube feeding from 60ccs to 65ccs over a 23-hour period, providing 1,495 calories over a 24-hour period. The caloric increase

recommended by Evans' dietician, in Maloney's expert opinion, did not meet Resident 6's caloric needs.

34. Maloney opined that the initial assessment documented Resident 6 as underweight and did not include sufficient additional calories to promote weight gain (the target weight of 136 pounds). Even with the additional tube feeding increase to provide 1,495 calories, there was a deficit of 116 calories from the initial assessment of 1,611 calories.

35. Inquiry was made of an Evans' dietician, Andrea, as to why Resident 6 was not receiving the calorie amount assessed (1,495 calories), to which she replied that Resident 6 had hemoptysis (spitting up blood). Review of Resident 6's medical records revealed only periodically excessive sputum and no documented episodes specifically related to hemoptysis.

36. In the opinion of Maloney, not receiving enough calories for this resident, who was underweight and suffering with pressure sores, may have delayed healing of the pressure sores and resulted in a continued weight loss. Further, holistic consideration of Resident 6's debilitated condition, with the addition of a failure to receive sufficient calories, over time would not assist but would rather delay or defeat Resident 6's efforts to reach the resident's highest practicable condition.

37. AHCA has proven, by a preponderance of the evidence, the allegations of failure of Evans to provide therapeutic diet for the nutritional problems suffered by Resident 6, Tag F326 of the November 15, 2000, survey.

TAG F326 - JANUARY 8, 2001 - SURVEY

Resident 7

38. AHCA surveyor, Jim Marrione, testified concerning Resident 7. Evans stipulated to the factual allegations contained in paragraph 2 of Tag F326 of the survey report of January 8, 2001, to wit: Based on the record review, observations and interview with the Dietician and staff nurse two (Resident 7 and Resident 10) of 13 active residents of the facility were sampled.

39. Resident 7 was admitted to the facility with multiple diagnoses, including dysphagia (difficulty in swallowing). The medical orders on October 23, 2000, revealed that Resident 7 was to receive thickened liquids, nectar consistency, that the resident was capable of swallowing. The nectar-thickened liquids were a mechanically altered and therapeutic diet plan. Evans was to protect the resident from receiving any thin liquids that could cause him difficulty in swallowing. The potential for harm to this resident could have been choking if given non-thickened juices or water.

40. On January 7, 2001, the surveyor observed Resident 7 being given non-thickened orange juice, and on January 8, 2001, again observed Resident 7 being given non-thickened water.

Resident 10

41. Surveyor Norbert Smith's deposition testimony was admitted in lieu of his personal appearance. Evans objected to Smith's deposition testimony that was not related to and/or specifically contained in the 2567 survey report dated January 8, 2001.

42. Resident 10 was admitted to the facility on May 24, 2000, whose diagnoses included dysphagia (difficulty in swallowing). The physician's order of September 23, 2000, required a "pureed" NCS (No Concentrated Sweets) diet, and the order of October 24, 2000, gives instruction to thicken all liquids to honey consistency for all meals, med passes, and activities.

43. Smith observed Resident 10 on January 7, 2001, in the dining room, and at 12:40 p.m., observed the resident being served prune juice thickened by Evans' Quality Assurance Director (QAD) to the consistency of Jell-O and served soup that did not appear to be of honey consistency. The surveyor opined that the Mighty Shake (milk shake) being served Resident 10 did not appear to be honey-thickened. When Smith queried Evans'

nurse about the Mighty Shake's thickness, she replied, "This is as close to honey thickened as they get."

44. Smith inquired of Evans' QAD if the Mighty Shake and soup were honey thickened, and the QAD acknowledged she did not know. Evans' dietician became involved in this issue and confirmed that the soup served to Resident 10 was nectar-thickened and the Mighty Shake had to be further thickened to be considered honey-thickened.

45. In the afternoon of January 7, 2001, Smith entered Resident 10's room and asked the staff nurse in the room at that time to check if the water on Resident 10's bedside stand was honey-thickened. Upon examination by the staff nurse, she determined that the water was not honey-thickened.

46. Smith defined "dysphagia" as a condition where one's windpipe does not cover when swallowing, as it should. Therefore, when people suffering with dysphagia drink a liquid, unless thickened, that person could choke or aspirate and possibly die.

47. Evans' two contentions: (1) AHCA's November allegation concerned "adequate diet to maintain acceptable nutritional status," was purportedly corrected; and (2) AHCA's January allegations of non-thickened liquids is different from the November allegation or at best is de minimus, are inadequate.

48. AHCA has proven by a preponderance of evidence the allegation that Evans failed to thicken all liquids to honey consistency for all meals, med passes, and activities with regard to Resident 10 and, therefore, did not ensure that the resident received a therapeutic diet as ordered by the physician.

TAG F426 - NOVEMBER 15, 2000 - SURVEY

49. Tag F426, a Class III deficiency, generally alleges that Evans failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of the residents, in violation of 42 C.F.R. Section 483.60(a).

50. Glenn T. Boyles, AHCA's surveyor/pharmacist, gave testimony regarding allegations of paragraph 1 of Tag F426 of the November 15, 2000, survey report. According to Boyles, based upon his observations, record review and interviews with staff, he determined that Evans did not provide pharmaceutical services to meet the needs of three residents.

51. Boyles testified that in his opinion a nurse failed to wait the federally prescribed amount of time (five minutes) between administering eye drops, and did not properly measure the prescribed amount of Abuterol solution (eye drops) for administration.

52. The above-observed deficiencies created the potential for harm to the resident that would be more than minimal because the physician had ordered the resident to receive the medication's effect of two eye drops. The improper administration caused the resident to receive the medication's effect of only one eye drop. The improper administration also created the potential for harm because the physician had ordered a prescribed amount of solution to be used, and the nurse, when preparing the medication, did not properly measure the amount prescribed by the physician.

53. In paragraph 2 of Tag F426 of the survey report, Boyles found two instances of non-compliance by Evans. First, Evans stocked an expired tube of ointment and allowed the expired medication to remain in the medication room. In doing so, Evans did not take steps to limit the possibility that the resident may receive a less than full potency antibiotic ointment. An outdated and expired antibiotic would not be as strong in combating the infection for which it was prescribed. Second, Evans failed to return medications prescribed for a resident who left the facility two months before the survey. The failure to return medication violated Evans' policy that states a medication form must be completed within 15 days of discharge (of a resident), and the policy sets out the procedure to be taken (return or destroy) with medications based on the

class of the medication. In Boyles' opinion, the potential for harm is that Evans did not preclude the diversion to a resident or staff for whom the medications were not intended.

54. Evans did not dispute the above Findings of Fact numbered 49 through 53, contending that the SOM guidelines contained no directive to surveyors to cite medication administration error as violations of the Tag, but rather directed surveyors to determine whether Evans' system provides that Evans' pharmaceutical services result in medication being available to residents. The requirement is clear that Evans must provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

55. AHCA has proved by a preponderance of the evidence that Evans failed to provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of the residents hereinabove cited.

56. In paragraph 3 of Tag F426 of the survey report of November 15, 2000, Boyles reported (subsection A) that Evans failed to administer medications from September 20, 2000, to October 28, 2000, to a resident on dialysis. In the opinion of Boyles, this omission resulted from the failure of Evans' staff

to comply with the physician's instructions that they "may" omit the resident's medications on days the resident underwent dialysis treatment, i.e. Tuesday, Thursday, and Saturday.

57. Boyles further opined that Evans was to "hold" (not administer) these medications three days a week before the dialysis treatments. Boyles opined that Evans' nurses disregarded the physician's "hold" medication instructions and gave the medication before dialysis treatment on the above days. In Boyles' opinion, the medication and its effect was subsequently removed by the dialysis treatment. Further, Evan's staff did not re-administer the medication after each dialysis treatment, and thereby, did not ensure the accurate administration of medication as called for by 42 C.F.R. Section 483.60(a).

58. Regarding paragraph 3 of Tag F426 of the survey report (subsection B) of November 15, 2000, Boyles reported that Evans was non-compliant for its failure to ensure accurate administration of drugs to Resident 4. This resident's physician prescribed the drugs Vasotec (for hypertension) and Diflucan. Both drugs, after being administered, were removed by the resident's dialysis treatment on Tuesdays, Thursdays, and Saturdays. Boyles opined that Evans, knowing the drugs were removed by dialysis, should have given Resident 4 supplemental doses of the prescribed drugs on Tuesdays, Thursdays, and

Saturdays, after dialysis treatment. Boyles opined that the potential harm would be the negative effect that the absence of the anti-hypertension medication would have on the resident's ability to excrete urine, an added complication to the resident's dialysis treatment.

59. As to paragraph 3 of Tag F426 (subsection A) Evans contends that the physician's order stated "may" withhold medications on dialysis days and that Boyles' opinion that Evans should have withheld medication until after dialysis treatment (or administered medication after dialysis treatment) would be in violation of the physician's order. Evans points to the fact that on October 28, 2000, the physician clarified the order to indicate that Evans should "not" (with) hold administration of medications on dialysis days.

60. Evans' position hereinabove does not address the failure to ensure "accurate" administration of drugs to Resident 4. Should Evans' nursing staff doubt, question or be confused regarding the intent and meaning of the physician's instructions or content of the order, they were under professional obligation to seek clarification from the physician so as to maintain the required standard to ensure accurate administration of drugs on dialysis days.

61. Accordingly, AHCA has proven by a preponderance of evidence that Evans failed to provide pharmaceutical services

(including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of the residents in paragraphs 1, 2, and 3 of Tag F426.

TAG F426 - JANUARY 8, 2001 - SURVEY

62. In the January 8, 2001, survey report, Tag F426, ACHA determined that Evans failed to provide pharmaceutical services to meet the needs of the residents, in violation of 42 C.F.R. Section 483.60(a).

63. It was alleged by AHCA that Evans failed to comply with the regulations because Evans did not ensure accurate dispensing and administrating of drugs to meet the needs of each resident. The surveyor observed expired drugs in the A Wing and B Wing refrigerators. AHCA further alleged that Evans did not ensure that residents received their medications within one hour before and after the scheduled medication time.

64. Lori Riddle, surveyor, testified that Evans' nurse was still passing out medications to residents at 12:00 noon. Evans does not dispute that morning medication for the A Wing were to be administered at 9:00 a.m. Mariana Yingling informed Riddle that she was an "Evans" nurse, paid by Evans. She admitted that even though the medications were not timely administered, she signed off as having given the medications at 9:00 a.m. Nurse Yingling acknowledged that as an Evans' nurse, she believed she

was to be held to the same standards of nursing as a regular full-time employee responsible for ensuring compliance with Evans' policy: to wit, medications are to be administered within one hour before and one hour after the scheduled time, which was 9:00 a.m. for the A Wing and the B Wing.

65. In Riddle's opinion, the potential for harm to residents if the drugs were not timely administered would be that the effectiveness of the drugs would be affected. If drugs were administered too close in time, there would exist a potential for toxicity and other related side effects.

66. It is undisputed that four residents did not receive their medication in a timely fashion in violation of Evans' own policy. AHCA has proven by a preponderance of the evidence that Evans failed to provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of the residents as alleged under Tag F426. Evans does not dispute the above facts in Tag F426.

67. On January 8, 2001, Jim Marrione, a registered nurse surveyor, saw medication in the medication room of the A Wing that expired "after 12/21/00." Marrione was informed by an Evans' nurse that the drug belonged to a resident who had died "last week," confirming that the drug should have been discarded as required by Evan's policy.

68. On the above date, Marrione looked in the refrigerator of the B Wing medication room and found that two bottles of Ri Max, an over-the-counter antacid, were stored in the refrigerator and had expired on "12/00."

69. Marrione opined that the potential for harm existed with the expired medications because of their lost of potency, which deprived the residents of the intended full benefits of the medications. Evans did not dispute the allegations regarding the expired medications in the refrigerators located in the A Wing and in the B Wing of the facility.

70. Accordingly, AHCA proved, by a preponderance of the evidence, that Evans failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident by Findings of Fact 62 through 69 hereinabove.

CONCLUSIONS OF LAW

71. The Division of Administrative Hearings has jurisdiction over the subject matter and the parties pursuant to Sections 120.569 and 120.57(1), Florida Statutes.

72. Respondent licenses nursing homes in Florida in accordance with Chapter 400, Part II, Florida Statutes. Petitioner is a nursing home licensed under that part.

73. Respondent evaluates nursing home facilities at least every 15 months to determine the degree of compliance by the

licensee with regulatory rules adopted under Chapter 400, Florida Statutes, as a means to assign a license status to the nursing home facility. Section 400.23(7), Florida Statutes.

74. The license status assigned to the nursing home following the periodic evaluation is either a standard license or a conditional license.

75. Standard licensure status and conditional licensure status are defined in Sections 400.23(7)(a) and (b), Florida Statutes (2000), as:

> (a) A standard licensure status means that a facility has no class I or class II deficiencies, has corrected all class III deficiencies within the time established by the agency, and is in substantial compliance at the time of the survey with criteria established under this part, with rules adopted by the agency . . . .
>
> * * *
>
> (b) A conditional licensure status means that a facility, due to the presence of one or more class I or class II deficiencies, or class III deficiencies not corrected within the time established by the agency, is not in substantial compliance at the time of the survey with criteria established under this part, with rules adopted by the agency, ...

76. If deficiencies are found during the periodic evaluation, they are classified in accordance with the definitions at Sections 400.23(8)(a) through (c), Florida Statutes (2000), which state as follows:

> (a) Class I deficiencies are those which the agency determines present an imminent danger to the residents or guests of the nursing home facility or a substantial probability that death or serious physical harm would result therefrom. . . .
>
> (b) Class II deficiencies are those which the agency determines have a direct or immediate relationship to the health, safety, or security of the nursing home facility residents, other than class I deficiencies. . . .
>
> (c) Class III deficiencies are those which the agency determines to have an indirect or potential relationship to the health, safety, or security of the nursing home facility residents, other than class I or class II deficiencies. . . .

77. Respondent has authority to adopt rules to classify deficiencies. Sections 400.23(2) and (8), Florida Statutes. Rule 59A-4.1288, Florida Administrative Code, refers to nursing homes participating in Title XVIII or XIX and the need to follow certification rules and regulations found at 42 C.F.R. Chapter 483. Petitioner must comply with 42 C.F.R. Chapter 483.

78. The parties assert, and it is accepted, that Petitioner is substantially affected by the issuance of the Conditional license for the period in question. See Daytona Manor Nursing Home v. AHCA, 21 FALR 119 (AHCA 1998). Thus, Petitioner has standing to oppose Respondent's intent to rate Petitioner's nursing home license as Conditional for the period of January 8, 2001 through March 5, 2001. In this context,

Respondent bears the burden of proof of alleged deficiencies and consequences for the deficiencies. Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981); and Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977). Findings of facts in association with that burden are based upon a preponderance of the evidence, failing a contrary instruction set forth in Chapter 400, Part II, Florida Statutes. Section 120.57(1)(j), Florida Statutes.

79. A nursing home licensed in this state is given a quality rating on the basis of its substantial compliance with two independent bodies of law: state law and federal law. The quality rating of nursing homes is unique to the State of Florida. The pertinent state law is found in Sections 400.23(8)(a) through (c), Florida Statutes (2000). Under state law by the terms of Section 400.23(8)(c), Florida Statutes (2000), a nursing home is rated as conditional if it has a "class I," a "class II," or an uncorrected "class III" deficiency. Further, by the terms of Section 400.23(8)(b), Florida Statutes (2000), a nursing home is rated as conditional if it is not in substantial compliance with applicable federal regulations. While federal law deficiencies, for purposes of sanctions, may fall under any of the regulations in 42 C.F.R. Part 483 (Requirements for States and Long-Term Care

Facilities), Rule 59A-4.128, Florida Administrative Code, effective October 13, 1996 through May 5, 2002, for rating purposes, limits the consideration of federal deficiencies to those federal deficiencies constituting "substandard quality of care." "Substandard quality of care" is a federal law term of art, and refers only to a certain level of non-compliance with three particular sections of 42 C.F.R. Part 483: to wit, 483.13, 483.15, and 483.25. Florida Administrative Code Rule 59A-4.128's use of "substandard quality of care" was added by the amendment to the rule of October 13, 1996, and was recognized in rule challenge proceedings as an appropriate reference to federal law in Florida Health Care Association v. Agency for Health Care Administration, 18 F.A.L.R. 3458, 3471 (DOAH 7/16/96).

80. The state "Class I," "Class II," and "Class III" scheme of deficiencies is simply more broad than the federal "substandard quality of care" scheme. See Sections 400.23(8)(a) through (c), Florida Statutes (2000), for the definition of the three classes of deficiencies. There is no indication in Chapter 400, Part II, Florida Statutes, that the legislature intended for the statutory definitions to be limited by federal law. Thus, under Rule 59A-4.128(4), Florida Administrative Code, effective October 13, 1996 through May 5, 2002, a nursing home is rated as conditional if one of the state "class"

deficiencies is found, or if one of the federal "substandard quality of care" deficiencies is found. In summary, a separate inquiry into substantial compliance with (1) state law and (2) federal law is required to ascertain the proper quality rating of a nursing home.

81. The purpose of the follow-up inspection is to determine whether a deficient practice has been corrected. However, if the alleged practice in question has been corrected as to the residents sampled on the initial visit, but is deficient as to other residents on the follow-up visit, then the deficiency which was initially cited remains outstanding. It is for this reason, and for an accurate determination of the facility's quality of care, that a new sample of residents is drawn upon on the follow-up visit. Absolutely no prejudice results from this practice to a licensee whose facility meets the prevailing standards of quality of care.

82. Under Tag F281 both the November 2000 and the January 2001 survey reports revealed similar problems evidencing Petitioner's failure to meet professional standards of quality care by its failure to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. During the November survey, Petitioner's nurses poured medication from a capsule into her hand then into a soufflé cup before administering the medication

to the residents. During the resurvey in January 2001, Petitioner's staff failed to document and record that a resident refused to take prescribed medication and spat out prescribed medication. During the January resurvey, it was also noted that Petitioner failed to properly adjust and document the daily oxygen saturation level for another resident.

83. As revealed in the January 2001 survey, Petitioner's employees did not document that staff notify the assigned physician that Resident 2 had refused to take and had spat out the anticonvulsant medication as ordered by the physician. As the result of the November 2000 survey report, Petitioner established a correction policy, requiring the physician to be notified by nurses of all residents refusing medications and to review and update each such resident's MAR. Petitioner's own policy was not followed as reflected in the January 2001 survey report. This deficiency has a direct and immediate relationship to the resident's medical, nursing, and mental needs that are identified in the comprehensive assessment plan of Resident 2.

84. Under Tag F326, both the November 2000 and the January 2001 survey reports revealed similar problems evidencing Petitioner's failure to ensure that the resident received a therapeutic diet when there was a nutritional problem based upon the resident's comprehensive assessment. During the November survey, it was observed that Resident 6 was to receive continuous

tube feeding of Glucerna at 65ccs per hour. The resident developed a Stage II pressure area. Additionally, Petitioner's nurse reported that the resident's history of hemoptysis was the reason for no increase in his protein intake. However, the review of the resident's most recent hospitalization medical records does not document episodes of hemoptysis. Petitioner had no plan or recommendation to ensure that Resident 6's caloric needs were met.

85. During the January 2001 resurvey, it was observed that Resident 10's liquids were not thickened to honey consistency for all meals, medical passes, and activities. The resident was given non-thickened orange juice, non-thickened water, and a non-thickened milk shake.

86. Under Tag F426, both the November 2000 and the January 2001 survey reports revealed similar problems evidencing Petitioner's failure to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. During the November survey, Petitioner's nurse was observed instilling two eye drops of Artificial Tears in the resident's left eye and two eye drops in the resident's right eye. The nurse did not wait three to five minutes between administering the first and second drops of solution in the resident's eyes as is required. Additionally, during the November survey it was found that a

resident on dialysis treatment three days per week was prescribed several medications to be administered daily. The medications were administered on dialysis days of Tuesdays, Thursdays, and Saturdays before the resident underwent dialysis treatment. However, Petitioner's employees did not readminister medications after the dialysis treatment to replace the medications removed by the dialysis treatment. This failure to readminister the medications denied the resident the full benefit of the medication prescribed by the physician.

87. During the January resurvey, two separate incidents reflected Petitioner's failure to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. During the resurvey on January 8, 2001, Petitioner's registered nurse was observed passing out medications in the A Wing of the facility between the hours of 11:30 a.m. and 12:00 p.m. When the surveyor made inquiry, the nurse admitted she began passing out her "morning" medications at 7:40 a.m. but having to medicate 26 different residents caused some to receive their medications after 10:00 a.m. Petitioner's nurse admitted she signed off all medications as having been passed out and given to residents at 9:00 a.m. Petitioner's policy and procedures on medication administration require "medications to be administered within one hour before and one hour after the scheduled time, except

for orders relating to before, after, and during meal orders, which are administered as ordered."

88. It was during the January 2001 resurvey that the surveyor observed medication, in the medication room of the A Wing, labeled "discard after 12/21/00." Inquiry of staff revealed that the resident for whom the medication was prescribed expired "last week" (i.e. during the period of December 26, 2000 through January 1, 2001). Likewise, in the B Wing the surveyor observed two bottles of medication that expired in December 2000.

89. The deficiencies practiced by Petitioner and cited under Tags F281, F326, and F426 were properly classified as Class III deficiencies in that they represented an indirect or potential relationship to the health, safety, or security of the nursing home facility residents. In the case at bar, it is not just a matter of failing to correct those initial deficiencies cited under each tag hereinabove, it was the discovery of those initial deficiencies as to other residents upon resurvey. Not the former, but the latter reflects the failure of Petitioner to ensure adequate and appropriate healthcare standards of the facility's residents.

90. The discovery of specific acts, omissions, or deficiencies cited under Tags F281, F326, and F426 during the survey conducted on November 15, 2000, coupled with discovery of

similar acts, omissions, or deficiencies cited during resurvey on January 8, 2001, are "uncorrected Class III deficiencies" and are "substandard quality of care deficiencies," and therefore, constitute reason to assign Petitioner's facility a Conditional licensure status for the period of January 8, 2001 through March 5, 2001.

RECOMMENDATION

Upon consideration of the Findings of Fact and Conclusions of Law reached, it is

RECOMMENDED:

That a final order be entered in which Respondent assigns Petitioner a Conditional license for the period of January 8, 2001 through March 5, 2001.

DONE AND ENTERED this 8th day of October, 2002, in Tallahassee, Leon County, Florida.

FRED L. BUCKINE
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 8th day of October, 2002.

ENDNOTE

1/ Therapeutic diet, under SOM guidelines, is defined as a "diet ordered by a physician as part of treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet or to increase certain substances in the diet or to provide food the resident is able to eat [mechanically altered diet]."

COPIES FURNISHED:

Dennis L. Godfrey, Esquire
Agency for Health Care Administration
525 Mirror Lake Drive, North
Room 310L
St. Petersburg, Florida 33701

R. Davis Thomas, Jr.
Qualified Representative
Broad and Cassel
215 South Monroe Street, Suite 400
Post Office Drawer 11300
Tallahassee, Florida 32302

Lealand McCharen, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Valda Clark Christian
Acting General Counsel
Agency for Health Care Administration
2727 Mahan Drive
Fort Knox Building, Suite 3431
Tallahassee, Florida 32308

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.