STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 02-0868
ADVENTIST HEALTH SYSTEMS/SUNBELT, INC., d/b/a SUNBELT HEALTH CARE AND SUBACUTE CENTER,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case on May 9, 2002, in Orlando and Tallahassee, Florida, via video teleconference before Susan B. Kirkland, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Michael P. Sasso, Esquire
Agency for Health Care Administration
525 Mirror Lake Drive, North
Suite 310-G
St. Petersburg, Florida 33701

For Respondent: Karen L. Goldsmith, Esquire
Goldsmith, Grout & Lewis, P.A.
2180 North Park Avenue
Suite 100
Winter Park, Florida 32789

STATEMENT OF THE ISSUES

Whether Respondent violated Sections 400.022(1)(l) and 400.022(1)(o), Florida Statutes; Rule 59A-4.1288, Florida Administrative Code; and 42 C.F.R. Sections 483.13(b) and 483.13(c), and, if so, should Respondent be issued a conditional license, effective November 17, 2001.

PRELIMINARY STATEMENT

By letter dated January 10, 2002, Petitioner, Agency for Health Care Administration (Agency), notified Respondent, Adventist Health Systems/Sunbelt, Inc., d/b/a Sunbelt Healthcare and Subacute Center (Sunbelt), that the Agency intended to impose a conditional license effective November 17, 2001, as a result of a survey completed on November 17, 2001, in which the Agency had cited Sunbelt for a Class II deficiency for failure to provide care and services to ensure that a resident was free from physical abuse from other residents. Respondent filed a Petition for Formal Administrative Hearing. The case was forwarded to the Division of Administrative Hearings on February 28, 2002, for assignment to an Administrative Law Judge.

The case was originally assigned to Administrative Law Judge Daniel Manry and was reassigned to Administrative Law Judge Susan B. Kirkland to conduct the final hearing.

On April 3, 2002, an Order Granting Amended Motion for Leave to Serve Administrative Complaint was entered. On May

1, 2002, an Order Granting Motion for Leave to Serve an Amended Administrative Complaint was issued.

At the final hearing, Petitioner called Mindy Seltzer and Donna Robert as its witnesses. Petitioner's Exhibits 1-9 were admitted in evidence. At the final hearing, Respondent called the following witnesses: Diana Rodriguez, Elizabeth Wright, Rosa Peterson, Jaymie Seward, and Amy Dickens. Respondent's Exhibits 1-4 and 5B-5G were admitted in evidence. Respondent requested to submit Respondent's Exhibit 5A as a late-filed exhibit; however, as of the date of this Recommended Order, Respondent has failed to do so.

The parties agreed to file proposed recommended orders within ten days of the filing of the transcript. The Transcript was filed on May 24, 2002. On June 7, 2002, Petitioner filed a Motion for Extension of Time, requesting that the time for filing proposed recommended orders be extended to June 14, 2002. The motion was granted. The parties timely filed their Proposed Recommended Orders, which have been considered in rendering this Recommended Order.

FINDINGS OF FACT

1. Sunbelt operates a licensed nursing home at 305 East Oak Street, Apopka, Florida.

2. On November 5, 2001, Patient M.L., hereinafter referred to as Resident 2, and Patient M.S., hereinafter

referred to as Resident 4, were living at the Sunbelt facility. Resident 2 had been living at the facility for over a year. In September 2001, staff at Sunbelt completed a Resident Assessment Protocol on Resident 2 in which Resident 2 was described as follows:

> [Resident 2] at times will vecome [sic] physically combative with staff members. She does not like showers and will slap at the staff if they invade her personal space. She has a dx of senile dementia, and has a reduced ability to make herself understood and understand others.

3. Prior to November 4, 2001, Resident 2 did not have a history of being physically combative with other residents. She shared a room with another resident, who would approach Resident 2 and touch Resident 2's things, including removing food from Resident 2's plate. Resident 2 had never attempted to harm her roommate. Her aggressive actions were directed at Sunbelt staff members when they tried to undress her and shower her. Nursing notes dated October 9, 2001, describe Resident 2 as withdrawn but getting along well with other residents.

4. Resident 4 was admitted to the Sunbelt facility on November 1, 2001. Based on the Comprehensive Resident Assessment of Resident 4 performed by the Sunbelt staff on the date of Resident 4's admission, Resident 4 had a diagnosis of

altered mental status, dementia, coronary artery disease, hypertension, depression and questionable bronchial asthma.

5. By the second day of her admission, Sunbelt staff had determined that Resident 4 would wander, would disrobe, and would rummage among her things. It became apparent that because of her wandering that Resident 4 was at risk for elopement from the facility. A care plan was developed on November 2, 2001, to deal with these behaviors. The care plan included trial visits to the special dementia unit, which was a locked unit. Resident 4 was also outfitted with a wander guard to alert staff if she tried to leave the facility.

6. At approximately 11:55 p.m. on November 4, 2001, Resident 4, accompanied by a Certified Nursing Assistant (CNA), was in the day room on the Floral Wing of the facility. The day room has glass windows, making the interior of the room visible to a person standing at the nearby nurses' station. The CNA responded to a call light from another resident and went to attend to the other resident, leaving Resident 4 alone in the day room watching television. When the CNA left Resident 4, she notified the nurse on duty and another CNA that she was leaving Resident 4 alone. Resident 4 was calm and appeared to be engrossed in the television program when the CNA left the room.

7. Unbeknownst to the Sunbelt Staff, Resident 4 left the day room and went to Resident 2's room, which was located near the day room. When Resident 2 asked Resident 4 to leave her room, Resident 4 would not leave and hit Resident 2. Resident 2 picked up a glass vase and proceeded to beat Resident 4 with the vase.

8. Resident 4 left Resident 2's room and went to the nearby dining room, where she was found by Sunbelt staff at approximately midnight, bleeding about the face. Resident 4 sustained a laceration on the left side of her head, a raised area on the back of her head, a lump under her right eye, and the beginning of discoloration on her left arm. She was cleaned up by Sunbelt staff and transported to the hospital by ambulance.

9. Sunbelt has developed policies and procedures dealing with wandering residents and prevention of residents "being subjected to inappropriate acts by anyone . . . ." The policies and procedures include assessment of the resident for inappropriate behavior and development of care plans to address the behavior.

10. In the instant case, Sunbelt did assess Resident 4 and implemented procedures to prevent her from wandering and leaving the facility. Based on the short time that Resident 4 had been in the facility, Sunbelt had no reason to believe

that Resident 4's wandering included going uninvited into other residents' rooms. The assessment did not indicate that Resident 4 should have one-on-one supervision.

11. Sunbelt was aware of Resident 2's aggressive behavior to staff when they would undress her and give her a shower, thereby invading her personal space. A care plan had been developed to address this inappropriate behavior. The evidence does not establish that Resident 2 would exhibit aggressive behavior toward other residents prior to the incident involving Resident 4. The only notations in the facility records of Resident 2 showing aggression against other residents were made after the incident in question.

12. On November 17, 2001, a complaint investigation was conducted at the Sunbelt facility by an Agency staff member, Mindy Seltzer. By letter dated November 20, 2001, the Agency advised Sunbelt of alleged deficiencies that were noted during the survey made by Ms. Seltzer. Among the deficiencies noted was a violation of 42 C.F.R. Section 483.13(b). This deficiency dealt with the incident involving Resident 2 and Resident 4 and was labeled F223. The deficiency was identified as a Class III deficiency.

13. An Informal Dispute Resolution was held, and the Agency advised Sunbelt that the Agency was changing the

deficiency F223 to deficiency F224, which was classified as a Class II deficiency.

14. By letter dated January 10, 2002, the Agency notified Sunbelt that as a result of the survey conducted by Ms. Seltzer it intended to imposed a conditional licensure status on Sunbelt effective November 17, 2001, for a Class II deficiency for failure to provide care and services to ensure that a resident was free from physical abuse from other residents.

CONCLUSIONS OF LAW

15. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. Sections 120.569 and 120.57, Florida Statutes.

16. The agency has the burden to establish the allegations in the Amended Administrative Complaint that would warrant the imposition of a conditional license. Beverly Enterprises-Florida v. Agency for Health Care Administration, 745 So. 2d 1133 (Fla. 1st DCA 1999). The Agency has alleged that Sunbelt violated Sections 400.022(1)(l) and 400.022(1)(o), Florida Statutes, and Rule 59A-4.1288, Florida Administrative Code, which adopts by reference 42 C.F.R. Sections 483.13(b) and 483.13(c).

17. Sections 400.022(1)(l) and 400.022(1)(o), Florida

Statutes, provide:

> (1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement: The statement shall assure each resident the following:
>
> * * *
>
> (l) The right to receive adequate and appropriate health care and protective support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.
>
> * * *
>
> (o) The right to be free from mental and physical abuse . . . .

18. Rule 59A-4.1288, Florida Administrative Code, incorporates by reference 42 C.F.R. Sections 483.13(b) and 483.13(c), which provide:

> (b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
>
> (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

19. Section 400.23(7)(b), Florida Statutes, provides that the Agency may impose a conditional licensure status on a facility when a Class II deficiency is found during a survey

performed by the Agency. A Class II deficiency is defined in Section 400.23(8)(b), Florida Statutes, as 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."

20. The evidence does not establish that Sunbelt is guilty of the violations as set forth in the Amended Administrative Complaint. Sunbelt had performed assessments and created plans of care for both Resident 2 and Resident 4. The assessment of Resident 2 revealed that she had aggressive behaviors toward staff when they tried to undress or bathe her, and Sunbelt developed a plan to address those behaviors. Because there was no history of physical aggression by Resident 2 toward other residents there was no need to develop and implement a care plan that dealt with that behavior. The nurses' notes indicate that Resident 2 got along well with the other residents.

21. Sunbelt's assessment of Resident 4 showed that Resident 4 was a wanderer, but that her wandering was related to exiting the building rather than visiting other residents' rooms. Sunbelt addressed Resident 4's wandering behavior by placing a wander guard on her and putting her in the dementia

unit, which was a locked unit, thereby preventing her from leaving the unit and eloping. Sunbelt's assessment of Resident 4 did not reveal that Resident 4 was in need of one-on-one supervision.

22. When the CNA left Resident 4 in the day room alone, she advised the other CNA and the nurse on duty that she was leaving Resident 4 alone. The day room was visible from the nursing station. When the CNA left the day room, Resident 4 was calm, watching a television program, and exhibiting no signs of wandering. Sunbelt cannot be an absolute insurer that no physical harm will come to a resident. Sunbelt took the necessary measures to prevent the behaviors that their assessments of Resident 2 and Resident 4 revealed.

23. Having failed to establish the deficiencies alleged in the Amended Administrative Complaint, the Agency does not have a basis for the imposition of a conditional license.

RECOMMENDATION

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

RECOMMENDED that a Final Order be entered eliminating the imposition of the conditional licensure status effective November 17, 2001.

DONE AND ENTERED this 15th day of July, 2002, in Tallahassee, Leon County, Florida.

_____

SUSAN B. KIRKLAND
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 15th day of July, 2002.

COPIES FURNISHED:

Karen L. Goldsmith, Esquire
Goldsmith, Grout & Lewis, P.A.
2180 North Park Avenue, Suite 100
Winter Park, Florida 32789

Michael P. Sasso, Esquire
Agency for Health Care Administration
525 Mirror Lake Drive, North
Suite 310-G
St. Petersburg, Florida 33701

William Roberts, Acting General Counsel
Agency for Health Care Administrative
2727 Mahan Drive
Fort Knox Building, Suite 3431
Tallahassee, Florida 32308

Virginia A. Daire, Agency Clerk
Agency for Health Care Administrative
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.