STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

INTEGRATED HEALTH SERVICES OF PORT CHARLOTTE,	)	
Petitioner,	)	
vs.	)	Case No. 02-1420
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was conducted in this case on June 20, 2002, in Port Charlotte, Florida, before Lawrence P. Stevenson, a duly-designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Jonathan S. Grout, Esquire
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For Respondent: Michael P. Sasso, Esquire
Agency for Health Care Administration
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STATEMENT OF THE ISSUE

Whether Petitioner's licensure status should be reduced from standard to conditional.

PRELIMINARY STATEMENT

By letter dated February 22, 2002, Integrated Health Services of Port Charlotte ("IHS") was notified by the Agency for Health Care Administration ("AHCA") that its Skilled Nursing Facility license had been subjected to a rating change from "standard" to "conditional" as a result of one Class II deficiency found in a licensure and certification survey completed on February 7, 2002. IHS timely filed a Petition for Formal Administrative Hearing on March 20, 2002, disputing the allegations of fact and contesting the proposed Agency action. On April 10, 2002, AHCA forwarded the Petition to the Division of Administrative Hearings for assignment of an Administrative Law Judge and conduct of a formal hearing.

On May 2, 2002, AHCA filed a consented Motion for Leave to Serve an Administrative Complaint, which sought to provide IHS with particular notice of the alleged violations. The Motion was granted by Order entered on May 7, 2002.

The case was set for hearing on June 20, 2002. The final hearing took place on that date.

At the formal hearing, AHCA presented the testimony of Cynthia Lehman, a public health nutrition consultant for the Agency; Laurie Anne Pettigrew, a laboratory surveyor for the Agency and expert in laboratory technology; Mary Maloney, a health services and facilities consultant for the Agency and

expert dietician; and Carol Mackey, a public health nutrition consultant for the Agency and expert dietician. AHCA's Exhibits 1 through 15 were accepted into evidence.

IHS offered the testimony of Carol Gathy, a registered and expert dietician at IHS; Chrisanna Harrington, a clinical and expert dietician at IHS; and Jane Cornwell, a registered nurse employed as director of nursing at IHS and an expert in long-term care nursing. IHS' Exhibits 1 through 3 were admitted into evidence.

By stipulation of the parties, IHS was granted leave to submit the late-filed deposition testimony of the attending physician. By notice filed on July 19, 2002, IHS informed the undersigned and opposing counsel that the deposition would not be submitted.

A Transcript of the proceeding was filed at the Division of Administrative Hearings on July 31, 2002. On August 7, 2002, the parties filed a Motion for Extension of Time, requesting that the deadline for submitting proposed recommended orders be extended to August 23, 2002. The undersigned granted the Motion ore tenus on the date it was filed. Both parties filed Proposed Recommended Orders on August 23, 2002.

FINDINGS OF FACT

Based on the oral and documentary evidence adduced at the final hearing, and the entire record in this proceeding, the following findings of fact are made:

1. AHCA is the state Agency responsible for licensure and regulation of nursing homes operating in the State of Florida. Chapter 400, Part II, Florida Statutes.

2. IHS operates a licensed nursing home at 4033 Beaver Lane, Port Charlotte, Florida.

3. The standard form used by AHCA to document survey findings, titled "Statement of Deficiencies and Plan of Correction," is commonly referred to as a "2567" form. The individual deficiencies are noted on the form by way of identifying numbers commonly called "Tags." A Tag identifies the applicable regulatory standard that the surveyors believe has been violated and provides a summary of the violation, specific factual allegations that the surveyors believe support the violation, and two ratings which indicate the severity of the deficiency.

4. One of the ratings identified in a Tag is a "scope and severity" rating, which is a letter rating from A to L with A representing the least severe deficiency and L representing the most severe. The second rating is a "class" rating, which is a numerical rating of I, II, or III, with I representing the most

severe deficiency and III representing the least severe deficiency.

5. On February 4 through 7, 2002, AHCA conducted an annual licensure and certification survey of IHS to evaluate the facility's compliance with state and federal regulations governing the operation of nursing homes.

6. The survey team alleged several deficiencies during the survey, only one of which is at issue in these proceedings. At issue is a deficiency identified as Tag F322 (violation of 42 C.F.R. Section 483.25(g)(2), relating to a facility's duty to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers in residents who are fed via naso-gastric or gastrostomy tube).

7. The deficiency alleged in the survey was classified as Class II under the Florida classification system for nursing homes. 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." Section 400.23(8)(b), Florida Statutes.

8. The deficiency alleged in the survey was cited at a federal scope and severity rating of G, meaning that the

deficiency was isolated and caused actual harm that is not immediate jeopardy.

9. Based on the alleged Class II deficiency in Tag F322, AHCA imposed a conditional license on IHS, effective February 7, 2002.

10. The survey found one instance in which IHS allegedly failed to ensure appropriate treatment for a resident fed by a naso-gastric or gastrostomy tube. The surveyor's observation on Form 2567 concerned Resident No. 2:

> Based on observation, review of resident record and facility policy and procedure, and interview with the nutrition and administrative, and nursing staff, the facility failed to notify the Registered Dietician of a physician ordered consult requested secondary to elevated laboratory values and need for reassessment of resident's nutritional and fluid needs; failed to complete the physician ordered dietary consult; failed to review physician orders and review resident laboratory values when completing the January 2002 tube feeding review resulting in no reassessment of the resident's nutritional needs and no readjustment in the resident's tube feeding with the subsequent negative outcome of metabolic abnormalities and dehydration secondary to excessive protein intake for 1 (Resident No. 2) of 7 residents reviewed for tube feeding from a total sample of 22 active sampled residents.
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> The findings include:
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> 1. Resident No. 2 was admitted to the facility on 09/07/01 with diagnoses including Type 2 Diabetes, Senile Dementia, Chronic Bronchitis, Aspiration Pneumonia and

Depression. The resident had a gastronomy tube for feeding and was receiving nothing by mouth.

Review of the resident hospital laboratory data dated 9/5/01, indicated that the resident was admitted to the facility with normal laboratory values except an elevated Glucose level of 195 (reference range 75-109 mg/dL). The resident's Blood Urea Nitrogen (BUN) was within normal limits at 12 mg/dL (reference range 5-25 mg/dL); Creatinine was within normal limits at 1.2 mg/dL (reference range 0.5-1.4 mg/dL); BUN/Creatinine Ratio was 10:1 within normal limits of 10:1. The resident's albumin level dated 9/1/01, indicated a moderate depletion of protein stores at 2.6 g/dL (reference range 3.4-5.0 g/dL). The resident had clear urine with a normal urine specific gravity of 1.010 (reference range 1.001-1.030).

Review of the initial Nutritional Assessment completed on 09/10/01, revealed that the resident's estimated nutritional needs were 1320 calories and 64 grams of protein (1.5 grams/kg body weight) with 1290 cc of fluid (30 cc/kg body weight). The resident's weight on admission was 94.4 pounds with an ideal body weight range of 95 pounds +/- 10 percent. The resident's weight in August 01 was documented as 96.8 pounds. Resident's height was 50 inches. The Registered Dietician (RD) recommended a change in the tube feeding to Resource Diabetic at 60 cc per hour with 100 cc of water every shift (300 cc of additional water) to provide 1440 calories, 90 grams of protein (2.1 grams of protein/kg body weight) and 1509 cc of free water. The RD documented that the resident had a need for extra protein secondary to a low albumin. (This tube feeding provided an additional 120 calories and 26 grams of protein a day beyond the resident's estimated nutrient needs.)

Review of the Enteral Feeding Flow Sheet revealed that the RD recommended increasing the tube feeding further on 10/03/01, secondary to weight loss to Resource Diabetic at 75 cc per hour with no recommendation to increase the fluid flushes. It was documented that the resident's weight decreased 3.2 percent without a specified period of time. The resident's current weight was documented as 93.8 pounds. The RD did not recalculate the nutritional needs based on the current weight. She documented that the increase in tube feeding would provide 1800 calories (41 grams/kg) with 113 grams of protein (approximately 2.7 grams/kg body weight) and 1812 cc of free fluid plus 30 cc of fluids with medications. (This tube feeding provided an additional 480 calories and 49 additional grams of protein beyond the resident's estimated nutrient needs.) The note further documented that the resident's blood sugars were ranging from 122-141 mg/dL, no other labs were documented or requested.

Review of the Enteral Feeding Flow Sheet dated 11/20/01, revealed that the resident remained on this tube feeding and water flushes and gained an additional 4 pounds in one month. The RD documented to continue with the current Plan of Care. The resident continued to receive an additional 480 calories (40 calories/kg) and 49 grams of protein (approximately 2.5 grams/kg) from this formula.

Review of the Enteral Feeding Flow Sheet dated 12/07/01, revealed that the resident continued on the tube feeding and flushes and gained another 2 pounds.

Review of physician telephone orders dated 12/19/01, revealed that the physician increased the water flushes to 150 cc every 6 hours to provide 600 cc of fluid per day

in addition to the tube feeding, an increase of 300 cc per day.

Review of the physician's progress notes dated 12/22/01 at 4:50 P.M., indicated that the resident had an elevated BUN of 84 mg/dL and an elevated glucose of 128. The physician documented that the resident had azotemia without increased sodium and questioned a gastrointestinal bleed. He further documented that the resident did not look dehydrated clinically and that her Type 2 Diabetes was improved. The physician ordered labs, check the stool for blood and was receiving [sic] increased water through the PEG tube (feeding tube in the stomach).

Review of nurses notes dated 12/22/01 at 1800, revealed the stools were checked for blood with negative results.

Review of the resident's lab data dated 12/18/01, revealed that the resident had a normal sodium and potassium level and an elevated BUN of 84 mg/dL (reference range 6-28 mg/dL). The resident's creatinine level was normal at 1.1 mg/dL (reference range .2-1.5 mg/dL). Glucose was elevated at 128 mg/dL (reference range 60-115 mg/dL). The BUN/Creatinine Ration [sic] had increased from normal to 76:1 and the calculated serum osmolality was 323 mOsm/kg H2O (normal values 285-295 mOsm/kg H2O). (These lab values were indicative of excessive protein intake and possible dehydration).

Review of lab data obtained 12/24/01, indicated that the resident's BUN remained at 84 mg/dL, Glucose was normal at 90 mg/dL and the resident had an elevated white blood cell count indicative of infection. Serum osmolality remained elevated at 316 mOsm/kg H2O. BUN/Creatinine Ratio remained at 76:1, indicative of excessive protein intake and possible dehydration. The nurse had noted on the lab work form that the resident had

tested negative for blood in her stool X 2 on 12/25/01 and the resident's whiteblood cells had been normal in September 2001. The labs were faxed to the physician on 12/26/01.

Further review of the physician's telephone orders revealed that a dietary consult was ordered on 12/28/02 [sic]. Review of the dietary progress notes and Enteral Feeding Flow Sheets revealed that the consult had not been completed. The resident remained on the tube feeding at 75 cc per hour which provided 1800 calories, 113 grams of protein and 2112 cc of free fluid. (480 additional calories: 40 calories/kg; 49 grams additional protein: 2.5 grams/kg and approximately 35 cc of fluid/kg per day).

The next documented nutritional review was completed on 1/14/02. The RD reassessed the resident's calorie needs to add 500 calories for weight gain with a total of 1820 calories per day. Protein needs were reassessed at 72 grams per day (1.5 grams/kg based on current weight). Fluid needs were reassessed at 30 to 34 cc/kg body weight or 1440 to 1632 cc per day. The resident's weight was documented at 106 pounds, a 6.4 pound weight gain (6.4 percent) in one month. There was no indication that the RD addressed the consult ordered 12/28/01 or the abnormal lab data from 12/18/01 and 12/24/01. Accuchecks (blood sugar levels) were noted on the flow sheet an [sic] ranging from 123-170 mg/dL. It was noted that the resident was receiving multivitamins with minerals. Review of the progress note that accompanied the flow sheet revealed that the RD documented on 01/14/-2, that the resident continued to gain weight on the tube feeding, that the accuchecks were elevated and "MD aware." Her recommendation was to continue with the current Plan of Care.

Observation of the resident on 02/04/02 at 11:32 A.M., revealed a petite, frail woman sitting in a geri-chair propped up with pillows and a splint on her left hand. The resident's tube feeding was running at 75 cc per hour. Skin appeared smooth with good skin turgor, lips were dry. Resident had mild temporal wasting. Observation of the Foley catheter bag 02/05/02 at 11:15 A.M., revealed 125 cc of moderately yellow urine in the bag with sediment in the tubing.

Interview on 02/04/02 at 2:05 P.M., with the consultant RD, who had completed the assessment on 01/14/02, revealed that she had not reviewed the physician orders or lab data when she completed the assessment. She stated she did check the resident's daily blood sugar levels. She stated the resident's fluid needs were being met at the time of the assessment and the resident was gaining weight. She confirmed that she did not assess the resident's protein intake from the formula versus the resident's estimated needs. The RD stated that the Resource Diabetic is high in protein but that is the only diabetic formula available on the formulary. She stated that after discussion with the surveyor, she would reassess the resident today and check with the physician regarding the rate of the tube feeding to provide less protein.

Further interview with the RD on 02/04/02 at 3:00 P.M., revealed that she had spoken to the RD who covers the C wing and that RD told her that she had been on vacation during the time the RD consult was ordered. The consultant RD confirmed that the facility had not contacted her regarding the consult during her visits to the facility. She again stated that she was planning to decrease the protein in the tube feeding and keep the fluid flushes at 150 cc every 6 hours. She further stated that it would be difficult to decrease the protein to the

resident's estimated needs due to the need for use of the diabetic formula.

Review of the dietary progress note completed on 02/04/02, after surveyor intervention, indicated that the resident had increased to 107.2 pounds and was now above ideal body weight. Recalculation of the the [sic] resident's calorie needs was estimated to be approximately 1400 calories per day. Protein was reestimated [sic] at 1.2 grams/kg body weight or 57.6 grams per day. Fluid needs were calculated at 30-34 cc/kg body weight or 1440 to 1632 cc per day. The RD recommended to decrease the tube feeding to Resource Diabetic at 55 cc per hour to provide 1399 calories with 83 grams of protein (1.6 to 1.7 grams/kg body weight). Total free fluids provided would be 1708 cc per day (approximately 35 cc/kg/body weight). The RD also recommended lab data to assess hydration status and visceral protein stores.

Review of the physician telephone orders dated 2/4/02, revealed that the physician approved the decreased [sic] in the tube feeding.

Review of the lab data obtained 2/5/02, revealed that the resident's BUN remained elevated at 71 g/dL. The Creatinine was 0.9 mg/dL with the BUN/Creatinine ratio remaining elevated at 78:1. Calculation of the serum osmolality was 318, indicative of continued excessive protein intake and possible dehydration. The resident serum albumin did improve to 3.2 grams/dL.

Further review of the dietary progress notes written 02/06/02, revealed that the RD recommended contacting the physician regarding the abnormal labs. She recommended increasing the fluid flushes to 150 cc every 4 hours which would provide an additional 900 cc of free fluid per day. The RD further documented that if the BUN

> did not show improvement in one week with the increased fluid flushes, a change in the type of formula would be necessary. She recommended Fibersource that has a protein level of 45 grams/1000 cc versus the resident's current Resource Diabetic which has 63 grams/1000 cc.
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> Interview on 02/06/02 at 2:30 P.M., with the Administrator, Director of Nursing and 2 RD's confirmed that the RD's had not been notified of the 12/28/01 consult, that they do not get notified when lab data is abnormal unless they are verbally told by nursing. The full-time RD stated that she had originally assessed the resident's protein needs at 1.5 grams/kg body weight secondary to the low albumin and the resident's poor appetite. She stated that she was providing the extra protein secondary to having to use the diabetic tube feeding formula that was available in the formulary and meet the resident's calorie needs. The Director of Nursing stated that they had formulas from other companies in the building and that the facility could get a different diabetic formula if needed. The RD's agreed that the resident needed to be reassessed.
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> Interview with the Director of Nursing on 02/07/02 at 12:05 P.M., revealed that she had reviewed the resident's record and had nothing else to bring the surveyors after reviewing the record and nothing else to offer. She stated that she that [sic] there were issues and that the facility would work on them.

11. Cynthia Lehman, a public health nutrition consultant, was the survey team member who recorded the observation of Resident No. 2. Ms. Lehman's findings were based on her observations of Resident No. 2, a review of the resident's

medical records and of the facility's policies and procedures, and interviews with IHS staff. At the hearing, IHS did not contest the accuracy of the factual findings set forth by Ms. Lehman, though it did contest AHCA's conclusion that Resident No. 2's elevated BUN level was caused by excessive protein intake.

12. Resident No. 2 was a 82-year-old female first admitted to IHS on August 15, 2001, after a hospital stay for intravenous hydration. She had been admitted to the hospital with severe dehydration with azotemia, which is the retention of excess nitrogenous compounds in the blood caused by the failure of the kidneys to remove urea from the blood. Azotemia is associated with a high blood urea nitrogen ("BUN") level. Resident No. 2's BUN level on August 10, 2001, was 37 mg/dL. Normal limits of BUN are 5-25 mg/dL.

13. Resident No. 2 was a small woman, 4'2" tall, and weighed 96.8 pounds. She suffered from diabetes, chronic obstructive pulmonary disease ("COPD"), chronic pancreatitis, hypothyroidism and heart disease. Upon admission to IHS, Resident No. 2 was bed-bound in a fetal position, lethargic and uncommunicative. She had skin tears on her heels and coccyx.

14. During her first admission, Resident No. 2 ate poorly and had difficulty swallowing. The speech therapist at IHS

determined that she would require tube feeding to maintain nutrition. Resident No. 2 was therefore readmitted to the hospital for placement of a percutaneous endoscopic gastrostomy tube, or "PEG tube." She was readmitted to IHS on September 6, 2001. Her condition was the same as on her first admission, with the exception of the PEG tube.

15. Laboratory values were taken of Resident No. 2 during her second hospital stay. Of relevance to this proceeding, her blood urea nitrogen ("BUN") level on September 5 was 12 mg/dL, within normal limits of 5-25 mg/dL. She showed a moderate protein deficiency. Her albumin level was 2.6 g/dL, below normal limits of 3.4-5.0 g/dL.

16. The IHS dietician, Carol Gathy, assessed Resident No. 2 upon her September 6 admission. She estimated that the resident required 1,320 calories and 64 grams of protein per day to maintain nutrition. Ms. Gathy noted that Resident No. 2 had a history of poorly controlled diabetes and that her accuchecks (blood sugar monitoring tests) were high. Resident No. 2's medical history indicated that she was prone to fall into azotemia.

17. Ms. Gathy determined that the first priority was bringing Resident No. 2's diabetes under control, and for that reason recommended a product called Resource Diabetic for her tube feeding. Resource Diabetic is recommended for diabetics

because it has a lower ratio of simple sugars than other tube feeding formulas. The tube feeding was initially provided at 60 cc/hour, with water flushes of 300 cc/day. This provided Resident No. 2 with 1,440 calories and 90 grams of protein per day.

18. At the recommended levels, Resource Diabetic provided calories and protein in excess of Resident No. 2's estimated needs. Ms. Gathy thought this necessary to assist Resident No. 2 in gaining weight and replenishing her protein stores. The resident's thinness made her prone to pressure sores, as indicated by the skin tears on her heels and coccyx. Ms. Gathy thought that the extra protein would raise Resident No. 2's low albumin levels and enable healing of the existing skin tears, and that the extra calories would provide some "padding" to prevent future skin tears.

19. On October 3, 2001, Ms. Gathy noted a three-pound weight loss for Resident No. 2 and recommended that the tube feeding be increased to 75 cc/hour. This increased Resident No. 2's intake to 1800 calories and 113 grams of protein per day.

20. From early October through November, IHS performed daily accuchecks and determined that Resident No. 2's blood sugar and glucose levels were normal. Resident No. 2 was adjusting well to tube feeding and gaining weight. Her skin

tears had healed and her skin was intact. Aside from the accuchecks, no other laboratory tests had been taken since her admission to IHS on September 6, 2001.

21. The attending physician ordered lab work on December 18, 2001. Resident No. 2's BUN level was 84 mg/dL, well above the normal limits of 5-25 mg/dL. Evidence produced at the hearing indicated that an elevated BUN level over a long period of time can have negative effects, including renal failure. A BUN level must reach 100 mg/dL to be considered "critical," but a level of 84 mg/dL is considered abnormally high. Because no lab work was performed between September 5 and December 18, 2001, IHS did not know how long Resident No. 2's BUN level had been elevated.

22. On December 19, 2001, the physician ordered an increase in the water flush through the PEG tube in an effort to bring down the BUN level. The "flush" is simply free water in the tube feeding that hydrates the resident and flushes out some of the excess protein.

23. On December 22, 2001, the physician diagnosed Resident No. 2 with azotemia, due to the elevated BUN level. The elevated BUN level could have several causes, including a gastrointestinal ("GI") bleed, dehydration, infections, or excess protein.

24. The physician ordered a stool culture to rule out a GI bleed. The culture tested negative for blood in the stool.

25. The physician ordered further lab work on December 24, 2001. Resident No. 2's BUN level remained at 84 mg/dL. Her creatinine and hematocrit (red blood cell) levels were within normal limits. These labs caused the physician to focus on excess protein as the cause of the elevated BUN level. On December 28, 2001, he ordered a dietary consultation regarding Resident No. 2's protein intake.

26. Staff of IHS did not perform the dietary consultation. Ms. Gathy was on vacation during this period, and no one at IHS informed the consulting dietician on duty, Chrisanna Harrington, that the consultation had been ordered. Resident No. 2 continued to receive the Resource Diabetic feedings at 75 cc/hour.

27. Ms. Harrington performed a nutritional assessment of Resdient No. 2 on January 14, 2002. She documented a significant unplanned weight gain of 6.4 pounds by Resident No. 2, from 99.6 to 106 pounds in one month. She recalculated the resident's caloric and protein needs upward, from 1320 to 1820 calories per day and from 64 to 72 grams of protein per day. Ms. Harrington recommended continuing the Resource Diabetic feedings at 75 cc/hour and otherwise continuing with the existing care plan.

28. When she performed her assessment on January 14, 2002, Ms. Harrington was unaware that the physician had ordered a dietary consult. She was also unaware of the laboratory tests performed the previous December. She did not know that Resident No. 2's BUN levels were elevated. Ms. Harrington only learned of the physician's orders and the lab tests when the agency surveyor, Ms. Lehman, informed her of them on February 4, 2002.

29. Ms. Harrington then performed a weight review of Resident No. 2 that showed her weight increased to 107.2 pounds. She recalculated the residents caloric and protein needs downward to 1400 calories and 57.6 grams of protein. She recommended reducing the tube feeding to 55 cc/hour, and recommended further laboratory testing. The labs performed on February 5, 2002, indicated that Resident No. 2's BUN level was at 71 mg/dL, reduced but still well above normal limits.

30. At the hearing, IHS contended that Resident No. 2's elevated BUN level was not necessarily caused by excessive protein intake. The resident suffered a urinary tract infection in early December. Infections can increase the BUN level. Throughout her stay at IHS, the resident was receiving Prinivil, a beta-blocker for hypertension that has a potential side effect of increasing the BUN level. In October 2001, the resident received Levaquin, an anti-infective drug, that could have influenced her BUN level.

31. The weight of the evidence made it clear that, while these other causes were possibilities, the excessive protein was the most likely cause. The steps taken by the physician showed that he believed excessive protein was the most likely cause of the elevated BUN level, once he ruled out a GI bleed. Ms. Harrington, too, acted immediately to reduce Resident No. 2's protein intake as soon as she was informed of the elevated BUN level.

32. In any event, the cause of the elevated BUN level is less important than the fact that the facility's care ensured that the resident's BUN level would not be tested for a period of three and one-half months. Resident No. 2 was an elderly diabetic with a history of azotemia, and was being provided a diet with a level of protein well in excess of her assessed need, yet no laboratory blood levels were taken between September 5 and December 18, 2001. Even after the attending physician began to suspect excess protein as the culprit and ordered a dietary consultation, the facility failed to act on the order.

33. In summary, the evidence presented at the hearing demonstrated that IHS provided an excessive amount of protein in the tube feeding of this elderly diabetic resident, failed to monitor the resident's laboratory values, including BUN levels, despite a documented history of azotemia, and failed to follow

physician orders calling for a dietary consultation. All of these factors placed Resident No. 2 in unnecessary jeopardy of sustaining kidney damage. That she displayed no outward physical signs of kidney damage was fortuitous, not the result of the care provided by IHS.

34. The evidence demonstrated that IHS compromised Resident No. 2's ability to maintain or reach 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.

CONCLUSIONS OF LAW

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

36. AHCA is authorized to license nursing home facilities in the State of Florida, and pursuant to Chapter 400, Part II, Florida Statutes, is required to evaluate nursing home facilities and assign ratings.

37. The Agency has the burden to establish the allegations 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). AHCA must show by a preponderance of the evidence that there existed a

basis for imposing a conditional rating on IHS's license. Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981); Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977).

38. Section 400.23, Florida Statutes, provides in pertinent part:

> (7) The agency shall, at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a licensure status to that facility. The agency shall base its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. The agency shall assign a licensure status of standard or conditional to each nursing home.
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> (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 or with rules adopted by the agency. If the facility has no class I, class II, or class III deficiencies at the time of the followup survey, a standard licensure status may be assigned.

39. Section 400.23(8)(b), Florida Statutes, defines a Class II deficiency 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. A class II deficiency is subject to a civil penalty of $2,500 for an isolated deficiency, $5,000 for a patterned deficiency, and $7,500 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last annual inspection or any inspection or complaint investigation since the last annual inspection. A fine shall be levied notwithstanding the correction of the deficiency.

40. The survey of IHS included one deficiency identified as Tag F322 (violation of 42 C.F.R. Section 483.25(g)(2), relating to a facility's duty to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers in residents who are fed via naso-gastric or gastronomy tube). This deficiency was identified as Class II and thus subjected the facility to conditional licensure.

41. The Agency established by a preponderance of the evidence that the cited deficiency occurred. The evidence presented at hearing established that IHS provided an excessive amount of protein in the tube feeding of this elderly diabetic resident, failed to monitor the resident's laboratory values,

including BUN levels, despite a documented history of azotemia, and failed to follow physician orders calling for a dietary consultation. Resident No. 2 suffered from an elevated BUN level for an unknown period of time, placing her at unnecessary risk of renal damage.

42. ACHA properly characterized this as a Class II deficiency. IHS compromised Resident No. 2's ability to maintain or reach 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.

RECOMMENDATION

Upon the foregoing Findings of Fact and Conclusions of Law, it is recommended that the Agency for Health Care Administration enter a final order upholding its notice of intent to assign conditional licensure status to Integrated Health Services of Port Charlotte.

DONE AND ENTERED this 10th day of October, 2002, in Tallahassee, Leon County, Florida.

LAWRENCE P. STEVENSON
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 10th day of October, 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.