STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case Nos. 02-0033
	)	02-1788
HEALTHPARK CARE CENTER,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was conducted in these consolidated cases on June 11, 2002, via video teleconference in Fort Myers and Tallahassee, Florida, before Lawrence P. Stevenson, a duly-designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Dennis L. Godfrey, Esquire
Agency for Health Care Administration
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For Respondent: Karen L. Goldsmith, Esquire
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STATEMENT OF THE ISSUES

DOAH Case No. 02-0033: Whether Respondent's licensure status should be reduced from standard to conditional.

DOAH Case No. 02-1788: Whether Respondent committed the violations alleged in the Administrative Complaint dated March 13, 2002, and, if so, the penalty that should be imposed.

PRELIMINARY STATEMENT

By letter dated October 24, 2001, Healthpark Care Center ("Healthpark") 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 two Class II deficiencies found in a licensure and certification survey completed on October 18, 2001. Healthpark timely filed an Election of Rights on November 7, 2001, disputing the allegations of fact and contesting the proposed Agency action. On January 2, 2002, AHCA forwarded the matter to the Division of Administrative Hearings ("DOAH") for assignment of an Administrative Law Judge and conduct of a formal hearing. This matter was assigned DOAH Case No. 02-0033 and set for hearing on March 7, 2002. A joint motion for continuance was granted and the hearing was rescheduled for April 4, 2002. A second motion for continuance was filed by Healthpark on March 21, 2002, in anticipation of a challenge to the Administrative Complaint discussed in the next

paragraph. This motion was granted by order dated March 22, 2002.

By Administrative Complaint dated March 13, 2002, AHCA notified Healthpark of its intent to impose a civil penalty of $2,500 each for the two Class II deficiencies found in the survey completed on October 18, 2001. Healthpark timely filed a Request for Formal Hearing on April 8, 2002, contesting the proposed Agency action. On May 8, 2002, AHCA forwarded the matter to DOAH for assignment of an Administrative Law Judge and conduct of a formal hearing. This matter was assigned DOAH Case No. 02-1788. On May 14, 2002, Healthpark filed a Motion to Consolidate, which was granted by order dated May 20, 2002. The consolidated cases were set for hearing on June 11, 2002. The final hearing took place on that date, via video teleconference in Fort Myers and Tallahassee, Florida.

At the formal hearing, AHCA presented the testimony of Diane Ashworth, a registered nurse ("RN") for the Agency and expert in nursing practices and procedures; Maria Donohue, an RN for the Agency and expert in nursing practices and procedures; and Lori Riddle, a public health nutrition consultant for the Agency and expert in dietetics and nutrition. AHCA's Exhibits 1 through 29 were accepted into evidence.

Healthpark offered the testimony of Mona Joseph, a certified nursing assistant ("CNA") at Healthpark; Caroline

Nicotra, a licensed practical nurse ("LPN") and supervisor of the long-term care unit at Healthpark; Alexandria Antoni, a registered dietician at Healthpark and expert in the field of nutrition; and Carol Morris, an RN employed as Medicare clinical coordinator at Healthpark and expert in geriatric nursing. Healthpark's Exhibits 1 through 9 were accepted into evidence. These exhibits included the deposition testimony of Diane Ashworth and Maria Donohue.

A Transcript of the proceeding was filed at the Division of Administrative Hearings on July 22, 2002. Both parties timely filed Proposed Recommended Orders.

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. Healthpark operates a licensed nursing home at 16131 Roserush Court, Fort Myers, 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 October 15 through 18, 2001, AHCA conducted an annual licensure and certification survey of Healthpark, to evaluate the facility's compliance with state and federal regulations governing the operation of nursing homes.

6. The survey team alleged three deficiencies during the survey, two of which are at issue in these proceedings. At issue are deficiencies identified as Tag F224 (violation of 42 C.F.R. Section 483.13(c)(1)(i), relating to neglect of residents) and Tag F325 (violation of 42 C.F.R. Section 483.25(i)(l), relating to maintenance of acceptable parameters of nutritional status).

7. Both of the deficiencies alleged in the survey were 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. Both of the deficiencies alleged in the survey were cited at a federal scope and severity rating of G, meaning that each deficiency was isolated, caused actual harm that is not immediate jeopardy, and did not involve substandard quality of care.

9. Based on the alleged Class II deficiencies in Tags F224 and F325, AHCA imposed a conditional license on Healthpark, effective October 18, 2001. The license expiration date was September 30, 2002.

I. Tag F224

10. The survey allegedly found violations of 42 C.F.R. Section 483.13(c)(1)(i), which states:

> (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.

(1) The facility must--

(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion....

In the parlance of the federal Health Care Financing Administration Form 2567 employed by AHCA to report its findings, this requirement is referenced as "Tag F224." The Agency's allegations in this case involved neglect of a resident rather than any form of abusive treatment.

11. The Form 2567 listed two incidents under Tag F224, both involving Resident 10, or "R-10." The surveyor observations read as follows:

> Based on observations, record review and interviews with a resident and a Certified Nursing Assistant (CNA), the facility failed to provide toileting needs as care planned for 1 (Resident #10) of 8 sampled residents reviewed for incontinence and toileting programs. The resident was not toileted for more than 5 hours causing multiple creased areas and redness to her left groin, perineum and buttocks.
>
> The findings include:
>
> 1. On 10/15/2001, Resident #10 was in her room, #141, in bed A at 2:20 P.M. Resident stated she was wet. The call bell cord was clipped to the sheet, but the bell mechanism was off the side of the bed, out of the resident's reach. Surveyor walked to the North nurse's station and continued to observe the resident's room entrance.
>
> Record review revealed Resident #10's most recent quarterly Minimum Data Set (MDS) completed 8/27/2001, assessed her with

> bladder incontinence at 3 (frequently incontinent), bowel incontinence at 1 (less than once weekly), activity is assessed as bed mobility 3/3 (needs extensive assistance to move in bed), and toilet use at 3/2 (needs extensive assistance).
>
> At 4:15 P.M., the resident requested the surveyor to get someone to change her as no one had come in and the call bell was still out of her reach. The resident's request was given to the nurse at 4:20 P.M.
>
> 2. On 10/16/01, Resident #10 was observed in her wheelchair in the hall outside her room from 8:55 A.M. until 12:05 P.M., when she was escorted to the main dining room. At 2:20 P.M., resident was still sitting in her wheelchair. After surveyor intervention, the CNA put the resident to bed at 2:30 P.M. When the adult diaper was removed, it revealed the resident to be incontinent of feces and urine. The odor of urine was very strong in the room. The resident's perineum and buttocks were red and moist, with multiple creased areas. The left groin was especially red.
>
> During an interview with the CNA, she stated the resident was last toileted before lunch at approximately 11:00 A.M. This was during the time of direct observation by the surveyor of the resident in the hall outside her room.
>
> Review of the resident's Care Plan revealed that she was to have the call bell in place at all times and scheduled toileting.

12. Diane Ashworth was the survey team member who recorded the observation of R-10. Ms. Ashworth was assigned the task of observing R-10, and based her findings on a review of the resident's medical records, observations and interviews.

13. R-10 was a 96-year-old diabetic female who had been admitted to Healthpark on March 28, 2000. R-10's most recent Minimum Data Set ("MDS"), completed on August 27, 2001, indicated that R-10 had short and long-term memory difficulties and moderately impaired decision making as to tasks of daily life. R-10 was generally confused as to place and time. She could make herself understood, and had no difficulty understanding what was said to her. She was easily angered and could be physically abusive to staff.

14. R-10 required extensive assistance to move, dress, toilet, and maintain general hygiene. She was confined to her bed or to a wheelchair, and required assistance to move the wheelchair. R-10's MDS indicated a loss of voluntary movement in her hands, including her wrists and fingers.

15. The MDS indicated that R-10 experienced daily incontinence of the bladder, and bowel incontinence once a week on average. The nurse's notes for R-10 indicated that she was able to make her needs known and that she was encouraged by staff to call for assistance as needed.

16. The care plan for R-10 stated that she should have "scheduled toileting," but set forth no firm schedule. Ms. Ashworth testified that she would have expected R-10 to be toileted before meals, before bed, and upon rising, at a minimum.

17. Mona Joseph was the CNA who attended R-10 on a daily basis. Ms. Joseph testified that R-10, like all residents who wore adult diapers, was scheduled for toileting every two hours and whenever necessary. In practice this meant that Ms. Joseph would inquire as to R-10's need for toileting every two hours.

18. Ms. Joseph testified that R-10 would ask her for toileting at least twice a day, and that she never refused the request. She always toileted R-10 before lunch, and testified that on October 16 she toileted R-10 at about 11 a.m. before taking her to lunch.

19. Toileting R-10 required the use of a Hoyer lift to move the resident from her wheelchair to the bed. Ms. Joseph estimated that the entire process of toileting R-10 took seven to eight minutes.

20. Caroline Nicotra, the supervisor of the long-term care unit in which R-10 resided and Ms. Joseph's supervisor, confirmed that Healthpark's CNAs were trained to make rounds every two hours and ask those residents requiring assistance if they needed to be toileted. R-10 was capable of making that decision, and her wishes regarding her need for toileting would be respected by the CNA.

21. Ms. Ashworth's testimony was generally consistent with her written findings. She met R-10 on the afternoon of October 15. R-10 was lying in bed, and told Ms. Ashworth that

she was wet. Ms. Ashworth noted that the call bell cord was clipped to R-10's bed, but that the bell mechanism itself was not within R-10's reach. Ms. Ashworth left the room and took a position at the nurses' station, from which she could see the door to R-10's room. She watched to see if any staff person from Healthpark went into R-10's room. She saw no one enter the room between 2:20 p.m. and 4:15 p.m., at which time she asked a CNA to toilet R-10.

22. Ms. Ashworth returned at 8:55 a.m. on October 16, and observed R-10 sitting in her wheelchair in the hallway outside her room. Ms. Ashworth took up her post at the nurses' station and watched R-10 until 12:05 p.m. At no time in the morning did Ms. Ashworth see R-10 being moved or taken for toileting, though Ms. Joseph testified that she toileted R-10 at about 11 a.m.

23. The evidence established that R-10's room was at the opposite end of a corridor from the nurses' station. The corridor was approximately 200 feet long from the nurses' station to R-10's room. The corridor was busy. Medications were passed at 9:00 a.m., meaning that medication carts went up and down the corridor. Staff carried breakfast trays in and out of rooms. Housekeeping and treatment carts were in the hallway. Given the distance of the nurses' station from R-10's room and the constant activity in the corridor, it is unlikely that Ms. Ashworth's view of R-10 was unobstructed at all times.

24. Moreover, the nurses' station itself was a hub of activity. At the end of the nurses' station where Ms. Ashworth stood was the fax machine. The fax machine was kept constantly busy sending physicians' orders to the pharmacy. The unit secretary was stationed in this location. Nurses passed through this area to retrieve forms from the filing cabinets or to go to the medication room.

25. The likelihood that Ms. Ashworth was unable from her vantage point to view R-10 at all times makes credible Ms. Joseph's testimony that she regularly checked with R-10 to ask whether she required toileting. However, it is unlikely that R-10 was ever out of Ms. Ashworth's sight for the period of seven to eight minutes necessary to actually toilet the resident. Ms. Ashworth's testimony that R-10 was not toileted at 11 a.m. on October 16 is therefore credited.

26. At 12:05 p.m., R-10 was taken to the dining room for lunch. Ms. Ashworth followed and observed R-10 in the dining room. After lunch, R-10 was wheeled back to the outside of her room. Ms. Ashworth observed her from the nurses' station until 2:20 p.m. Ms. Ashworth did not see R-10 being taken for toileting between 12:05 and 2:20 p.m.

27. At 2:30 p.m. on October 16, Ms. Ashworth approached Mona Joseph, the CNA responsible for R-10, and asked her to put R-10 to bed so that Ms. Ashworth could examine her buttocks.

Ms. Ashworth asked another AHCA surveyor, Maria Donohue, to accompany her to confirm her observations. There was some delay while Ms. Joseph finished a task for another resident, but eventually Ms. Joseph wheeled R-10 into the room and placed her into bed.

28. Ms. Joseph changed R-10's adult brief in the presence of Ms. Ashworth and Ms. Donohue. Ms. Ashworth testified that there was a strong smell of urine in the room, even before the brief was removed, though she noticed no smell of urine about R-10 prior to entering the room. When Ms. Joseph removed the adult brief, Ms. Ashworth noted that it was wet and that there was a large amount of feces in the brief and on R-10's buttocks.

29. Ms. Ashworth noted that the skin on R-10's perineum and buttocks was creased and red. The area of R-10's left groin was so red that Ms. Ashworth at first thought there was no skin. Ms. Ashworth stated that this kind of redness is associated with not being toileted as scheduled, though she conceded that such redness can also result from pressure. Ms. Ashworth also conceded that this was her first observation of R-10's buttocks, and thus that she had no baseline to judge how abnormal the redness was at the time Ms. Joseph changed the adult brief.

30. Ms. Donohue also recalled a strong urine smell as soon as they entered the room. She agreed that R-10's buttocks were red in some areas, but recalled no further details. She could

not recall if there was feces in the adult brief, but did recall that it was saturated with urine.

31. Mona Joseph, the CNA who changed R-10's adult brief, believed that the urine smell in the room came from the next bed, because she had just changed the adult brief of the person in that bed. Ms. Joseph smelled no odor of urine or feces about R-10. Ms. Joseph testified that R-10's brief was dry, and that she began having a bowel movement while being changed. She noted no redness on R-10's buttocks.

32. Caroline Nicotra was the supervisor of the long-term care unit in which R-10 resided. She knew R-10, and stated that R-10 regularly used her call bell, and would call out for help if she could not reach the call button clipped to her bed. She noted that all of the rooms to which Ms. Joseph was assigned were in the same area of the corridor, so that Ms. Joseph would always be able to hear R-10 call out. There would also be nurses in the area who could hear R-10.

33. Ms. Nicotra knew the surveyors had gone into R-10's room with Ms. Joseph, and she went into the room moments after the surveyors left the room to ascertain whether anything had occurred that she needed to address. Ms. Joseph told Ms. Nicotra what had happened. Ms. Nicotra asked R-10 for permission to examine her body and R-10 assented.

34. Ms. Nicotra removed R-10's adult brief and inspected R-10's buttocks. She observed no creasing or redness of the perineum or the buttocks. R-10's skin was intact and no different than Ms. Nicotra had seen it on other occasions. R-10 told Ms. Nicotra that she was not experiencing pain or discomfort in her buttocks area.

35. Ms. Nicotra stated that R-10 weighed about 180 pounds, and that the creasing and redness observed by the surveyors could have been caused by the pressure of sitting in her wheelchair for a long time.

36. Ms. Nicotra examined the adult brief that had been removed from R-10. She observed that it was slightly damp, which she attributed to sweat, and that it contained a smear of bowel movement. It did not smell strongly of urine.

37. Viewing the evidence in its entirety, and crediting the honesty of the testimony of each witness, it is found that AHCA failed to prove the elements of Tag F224 by a preponderance of the evidence. Ms. Ashworth did not observe R-10 being toileted. However, Ms. Ashworth's observation does not establish that R-10 required toileting or that the facility was negligent in not toileting the resident. After the first meeting on October 15, Ms. Ashworth did not ask R-10 whether she needed to be toileted. Ms. Joseph inquired as to R-10's toileting needs every two hours. R-10 was able to make her

needs known to facility staff, and she did so on a daily basis. If her call bell was out of reach, she would call out to staff. Ms. Joseph's testimony that the adult brief was dry of urine and contained only a slight amount of fecal material is supported by that of Ms. Nicotra, the only other witness who actually handled the adult brief, and is therefore credited.

38. The only harm alleged by AHCA was the irritation to R-10's bottom, claimed to be the result of R-10's sitting in a soiled adult brief for an extended period of time. The surveyors' testimony that R-10's perineum, buttocks, and left groin were creased and red at the time of changing is credited. Also credited, however, is Ms. Nicotra's testimony that R-10's perineum, buttocks and left groin were no longer creased or red a few minutes after the changing. Ms. Nicotra's testimony indicates that the creasing and redness were caused, not by irritation from urine and/or feces in the adult brief, but by an extended period of sitting in her wheelchair. The evidence indicates no neglect of R-10, and that R-10 suffered no harm during the sequence of events described in the Form 2567.

II. Tag F325

39. The survey allegedly found a violation of 42 C.F.R. Section 483.25(i)(1), which states:

> (i) Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident--

> (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible....

This requirement is referenced on Form 2567 as "Tag F325."

40. The survey found one instance in which Healthpark allegedly failed to ensure that a resident maintained acceptable parameters of nutritional status. The surveyor's observation on Form 2567 concerned Resident 17, or "R-17":

> Based on record review and staff (Unit Manager and Registered Dietician) interviews, the facility failed to adequately assess and revise the care plan to address the significant weight loss of 1 (Resident #17) of 15 from a sample of 21 residents reviewed for nutritional concerns. This is evidenced by: 1) After Resident #17 had a significant weight loss of 6.8% in 4 weeks, the facility did not have an adequate nutritional assessment and did not revise the care plan to prevent the resident from further weight loss.
>
> The findings include:
>
> 1. Resident #17 was admitted to the facility on 9/6/01 with diagnoses that include Sepsis, S/P Incision and Drainage (I&D) of the Right Knee and GI Bleed. The resident has a history of Coronary Artery Disease (CAD). During the clinical record review, it revealed [sic] that the resident's physician ordered Ancef (antibiotic) 2 grams every 8 hours on 9/6/01, to be given for 25 days.
>
> During the review of the resident's initial MDS (Minimum Data Set) completed on 9/19/01, it revealed [sic] he weighed 185 lbs (pounds) and is 72 inches tall. Review of

the MDS also revealed the resident is independent with his cognitive skills for daily decision making. Further review of the MDS also revealed he requires set up and supervision during meals. He requires extensive assistance with dressing, bathing, and ambulation.

Review of the nutritional assessment revealed the RD assessed the resident on 9/10/01. The assessment stated, "Resident has decreased appetite which may be R/T (related to) current meds (medications); Resident's wife feels he has lost wt (weight) but wt is increased due to edema in feet. Resident's current diet meets assessed needs. Will include food preferences to increase intake." Under "Ethnic/Religious Food Preferences" it stated, "No cultural preferences stated." The nutritional assessment completed by the RD on 9/10/01, stated that the resident weighs 185 lbs. His UBW (usual body weight) is 182 lbs.

During an interview with the Unit Manager and Registered Dietician (RD) on 10/18/01 at approximately 11:00 AM, they stated that the resident's weight of 185 lbs., which is documented in the initial MDS, was inaccurate. The resident's accurate weight on admission was 175 lbs.

During the review of the weight record, it revealed [sic] the resident remained 175 lbs. on 9/11/01. On 9/18/01, the resident weighed 168 lbs., indicating a weight loss of 7 lbs. in 7 days.

During the review of the Resident Assessment Protocol (RAP) completed on 9/19/01, it revealed [sic] she [sic] triggered for "Nutritional Status." The care plan developed on 9/19/01 stated, "Res. (resident) leaves 25% or more of food uneaten at most meals. Weight: 168 lbs; UBW (usual body weight) 182 lbs." The goal

stated, "Res will maintain weight up or down within 1-2 lbs. through next quarter: 10/17/01." The following approaches are listed:
- "Diet as ordered."
- "Encourage fluids."
- "Monitor weights."
- "Food preferences and substitute for uneaten foods."
- "Assist with tray set-ups, open all packages."

Review of the physician's order dated 9/18/01 revealed the resident was started on TwoCal HN (supplements) 60cc's four times a day, ice cream everyday [sic] at 8:00 P.M., fruit everyday [sic] at 10:00 A.M. and peanut butter, cracker, and juice everyday [sic] at 2:00 P.M. During the review of the Medication Administration Record (MAR) for the months of 9/01 and 10/01, it confirmed [sic] that this additional supplements were given to the resident, however there is no documentation to indicate the resident's consumption of each supplement.

Interview with the Unit Manager on 10/18/01 at approximately 11:15 A.M. also confirmed there is no documentation in the clinical record to indicate the resident's consumption of each snack.

Review of the CNA (Certified Nursing Assistant) Care Plan for the month of 9/01 revealed no documentation being offered at bedtime and no documentation for the month of 10/01 that the resident received bedtime snacks.

Further review of the resident's weight record revealed the resident weighed 163 lbs on 10/2/01. This indicates a significant weight loss of 12 lbs or 6.8 percent of his total body weight in 4 weeks. Review of the nurses' notes revealed that this significant weight loss had been identified on 9/26/01, 20 days after the resident's admission to

the facility. The nurse's notes dated 9/26/01 stated that the care plan to address the risk for weight loss was reviewed.

Review of the care plan confirmed it was reviewed on 9/26/01 and 10/6/01. The goal stated, "Will lose no more weight, 11/6/01." Added to approaches stated, "Nutritional supplements as ordered." However, further review of the clinical record and the care plan revealed no documentation to indicate that a comprehensive nutritional assessment was done. There is no documentation in the resident's clinical record to indicate that the care plan was revised.

During an interview with the Unit Manager on 10/18/01 at approximately 2:15 P.M., she confirmed that after the resident's admission to the facility on 9/6/01, the resident was refusing to eat, but his appetite improved in the beginning of 10/01. He was consuming 75 percent-100 percent of his meals. She also stated that the resident had "pedal (foot and ankle) edema" on admission to the facility. There is no documentation in the resident's clinical record to indicate that this edema was monitored. There is no documentation in the clinical record that the resident was on a diuretic. She further stated that the final report on the blood culture done on the resident, dated 10/1/01, was positive for Candida sp (yeast infection).

During the review of the clinical record, it did not have [sic] documentation to indicate that an assessment of the resident's protein intake was assessed at this time. There is no documentation in the resident's clinical record to indicate that the resident's albumin and protein levels were assessed.

During an interview with the Unit Manager on 10/18/01, at approximately 2:15 P.M., she stated that the resident's family members were encouraged to visit more often and

> encourage to bring foods that he likes. She stated that the resident liked Italian food. This is in contrary to [sic] the RD's nutritional assessment completed on 9/10/01. She also stated that the facility staff continued to honor resident's food preferences and provided alternatives. There is no documentation in the resident's clinical record to indicate that an assessment of the resident's nutritional status, based on his current weight of 163 lbs. and current food intake was done. Further review of the resident's weight record revealed he weighed 158 lbs. on 10/9/01. This reveals a weight loss of 5 more lbs. in 12 days. During the interview on 10/18/01 at approximately 2:15 P.M., she did not have an explanation why the resident continued to lose weight despite an improvement in his appetite.

41. Maria Donohue was the survey team member who recorded the observation of R-17. This resident was initially assigned to Ms. Ashworth, who briefly assessed R-17 in his room and commenced a review of his medical records. Ms. Ashworth noted R-17's weight loss and that his situation required further investigation. Because Ms. Ashworth was busy with her observations of R-10, the survey team shifted responsibility for R-17 to Ms. Donohue. Ms. Donohue based her findings on a review of the resident's medical records and interviews with Healthpark staff. She did not speak to or observe R-17. She did not interview R-17's physician, and could not recall speaking to R-17's family.

42. R-17 was an 84-year-old male with a history of coronary artery disease who was admitted to Healthpark from a hospital. About a year and a half before his admission to Healthpark, R-17 had a total knee replacement. He was admitted to the hospital because of a fever. A medical work-up revealed that he was septic, with infection throughout his body. The infection stemmed from his knee, and an incision and drainage was performed.

43. The infection was severe, requiring the parenteral administration of the cephalosporin Ancef for a period of 25 days, beginning September 6, 2001. Anorexia is a known adverse reaction to Ancef. Upon admission to Healthpark, R-17 was experiencing pain that was controlled by Percocet, an analgesic with the potential to affect appetite. R-17 was prescribed Zanaflex, a muscle relaxant that can affect appetite. R-17 was also diagnosed as prone to constipation and took laxatives.

44. R-17 also had swelling in his feet and ankles that caused discomfort when he walked. On September 9, an attending nurse documented edema from his ankles to his feet. On September 10, R-17's physician prescribed T.E.D. hose (compressive stockings) for the edema. R-17 refused to wear them. On the same date, R-17's pain increased and his physician ordered a low-dosage Duragesic patch in addition to his other medications. The dosage was increased on September 12, when his

pain became so severe that he was screaming out and having spasms.

45. By September 13, R-17's spasms were abating. On September 14, the pain had lessened and he was able to move about, though he continued to voice complaints about the pain. On September 18, R-17 was weighed and it was noted that he had lost seven pounds in the week since his admission. This weight loss was attributed to his pain and the combination of drugs R-17 was taking, as well as some subsidence of the edema.

46. Healthpark's nursing staff reported the weight loss to R-17's physician, who ordered the snacks and the TwoCal protein drinks described in Ms. Donohoe's observation. The physician visited on September 24 because R-17's pain level had increased and he was again experiencing constipation. The physician ordered blood cultures and Methotrexate for his pain.

47. The physician was making continued efforts to determine the cause of R-17's pain. After the blood cultures were performed, R-17 was referred to a rheumotologist. The blood cultures revealed the presence of another organism in R-17's system besides that being treated with Ancef. On October 2, R-17 was also seen by an infectious disease specialist.

48. R-17's condition improved for about a week. By October 10, the physician was preparing to order his discharge

from Healthpark. However, in the early morning hours of October 11, R-17 became confused, incontinent, and had greatly increased pain. His physician ordered new lab work, including a total protein array and electrolyte tests. The record shows that on October 12, R-17 was screaming out in pain and his appetite, which had shown some improvement in early October, was very poor.

49. Though R-17's condition and appetite showed some improvement over the next few days, on October 16 his physician decided to admit him to a hospital to determine the cause of R-17's weight loss and why his pain could not be controlled.

50. Ms. Donohue explained the protocol followed by AHCA surveyors assessing a resident's nutritional status. First, the surveyor determines whether the resident has been assessed comprehensively, adequately, and accurately. If the assessment found that the resident was at risk for nutritional problems, then the facility must determine the interventions necessary to prevent the problems.

51. The surveyor next assesses how the facility implemented the interventions. If the interventions do not work, the facility must show that it has re-evaluated the interventions and reassessed the resident to determine why the interventions failed. The facility must demonstrate that it has looked at all relevant factors, including intake of food and

supplements and the resident's underlying medical condition. This re-evaluation and reassessment should lead to revisions in the interventions.

52. The essential allegation under Tag F325 was that Healthpark failed to make a nutritional reassessment after finding that R-17 experienced a significant weight loss over a period of four weeks.

53. Ms. Donohue's testimony at the hearing essentially confirmed her observation on the Form 2567, quoted above. R-17 was weighed weekly, and his weight record confirmed that between September 11, 2001 and October 9, 2001, R-17's weight dropped from 175 to 158 pounds.

54. Lori Riddle, AHCA's expert in dietetics and nutrition, was also involved in the decision to cite R-17's treatment as a deficiency. Her review of the records led her to conclude that Healthpark was aware of R-17's weight loss and put in place approaches to counter that weight loss, but that these approaches were not well planned. Healthpark did not adequately monitor R-17's nutritional intake, such that the record indicated amount of food that was offered but not how much R-17 actually consumed.

55. Ms. Riddle found that Healthpark's approaches were "fairly generic." Healthpark added snacks and nutritional supplements to R-17's diet, but did not indicate in its written

care plan whether or how these would meet R-17's nutritional needs. After the initial nutritional assessment on September 10, Healthpark did not formally reassess R-17's caloric needs, even after he began losing weight. Ms. Riddle saw indications in the record that Healthpark recognized the weight loss and stated a goal of maintaining R-17's weight, but saw no recalculation of how many calories would be needed to maintain his weight.

56. Alexandria Antoni was the registered dietician at Healthpark and an expert in the field of nutrition. Ms. Antoni performed the initial nutritional assessment of R-17 and monitored his status throughout the relevant period. She testified as to her relationship with R-17 and her efforts to maintain his food intake. R-17 was very alert and oriented, but had adjustment problems because he had always been an independent, relatively healthy person and had never been in a facility like Healthpark. As a result, R-17 was not receptive to staff's offering food. He did not want to be in the facility at all and resented being bothered by staff.

57. Ms. Antoni noted that R-17 was in much pain and had a hard time dealing with it. The pain affected his ability to sit up or be mobile, and he was on many medications for his pain and infection, any or all of which could have affected his appetite. On her initial visit, Ms. Antoni brought R-17 a copy of the

Healthpark menu and reviewed it with him and his family. Ms. Antoni credibly testified that R-17 stated no ethnic food preferences at this initial meeting, though he did tell her that he liked soup at lunch, prune juice in the morning, and a banana on his breakfast tray.

58. Ms. Antoni's initial strategy was to increase R-17's intake by offering foods he liked to eat. His family was there with him every day, and she encouraged them to bring in foods that R-17 liked. Ms. Antoni saw R-17 daily. He would wait for her in the hallway and ask her to come in and tell him what was on the menu. R-17 would often directly phone the kitchen staff to discuss his meal preferences.

59. Ms. Antoni disagreed that R-17's caloric needs were not properly documented. In her initial nutritional assessment, she calculated his caloric needs, based on his height, weight and medical condition, at 1,900 to 2,300 calories per day. She relied on the nursing admission assessment, which listed R-17's weight at 185 pounds, rather than his accurate weight of 175 pounds.

60. Thus, Ms. Antoni's calculation resulted in R-17's getting more calories than his actual weight would have indicated. In her later approaches to R-17's situation, Ms. Antoni kept in mind that R-17 was already being offered more calories than his weight required. She opined that if R-17 had

consumed what she calculated, his nutritional needs would have been met and he should not have lost weight.

61. Ms. Antoni could not say why R-17 was losing weight. For the most part, he was eating 75 percent of his meals, which provided between 1,800 and 2,000 calories per day. The TwoCal supplement and the snacks ordered by the physician provided an additional 1,000 calories per day, providing a total well in excess of the 1,900 to 2,300 calorie range calculated by Ms. Antoni.

62. Healthpark staff, including Ms. Antoni and R-17's physician, held meetings every week to discuss the residents' weight status. At each of these weight meetings, Ms. Antoni brought up the subject of R-17's weight loss with his doctor.

63. Ms. Antoni disagreed with AHCA's conclusion that no reassessment was performed. She contended that reassessment occurred at the weekly weight meetings. She followed R-17's caloric intake daily. She could think of nothing else she could have done to increase R-17's weight. Any further action, such as ordering further laboratory tests or a feeding tube, would have required a physician's order.

64. Carol Morris, an RN, was Medicare clinical coordinator at Healthpark and an expert in geriatric nursing. She concurred that the diet ordered for R-17 was adequate to meet his needs. He was cognitively aware, responsive, and could not be forced to

eat. Ms. Morris confirmed that Healthpark staff tried to encourage R-17 to eat. The staff gave nutritional advice to R-17's family members so that they could assist in offering him foods that might help his appetite.

65. Ms. Morris noted that pain can be a factor in weight loss. She also observed that the edema would have added to his weight on admission, and its resolution would naturally cause some weight loss. Resolution of his constipation also could have affected his weight. Healthpark staff considered all these factors in care planning to deal with R-17's weight loss. Staff communicated with R-17's physician and with his family on a daily basis. The nursing staff was following doctor's orders, and expected to see R-17's weight stabilize at some point.

66. Ms. Morris testified that Healthpark's assessment of R-17's weight loss took into account his edema, constipation, adjustment to the facility, disease process, and the amount he was eating. She did not think there was anything else Healthpark could have done, given that R-17's physician was also perplexed as to why he was losing weight.

67. Ms. Morris attributed the AHCA citation for failure to document R-17's caloric intake to a simple failure to understand Healthpark's method of charting. The nurses did not explicitly note the amount eaten by R-17 at every meal or snack. The nurse's initials indicated that R-17 ate 100 percent of the meal

or snack. An amount was noted only when R-17 ate less than 100 percent of the food offered. If R-17 declined a meal or snack, it was noted and his physician was informed.

68. Ms. Morris testified that R-17's preference for Italian food came up in a conversation with his family, after the nutritional assessment was done. When Healthpark staff saw that R-17 was losing weight, they to the family about what he might like to eat.

69. Viewing the evidence in its entirety, it is found that AHCA failed to prove the elements of Tag F325 by a preponderance of the evidence. It is unquestioned that R-17 lost a significant amount of weight during the four weeks from September 11, 2001, to October 9, 2001. However, the evidence does not demonstrate that R-17's weight loss was caused by Healthpark's failure to provide adequate nutrition. To the contrary, the record indicates that R-17 was provided more than enough calories through meals to maintain his weight, and that supplements were ordered by his physician when he began to lose weight. While R-17's appetite was diminished, he continued to consume 75 percent of his meals on average and to take the snacks and TwoCal supplement. Healthpark's staff and R-17's physician were perplexed as to the reasons for his weight loss, with the physician ultimately ordering R-17 admitted to a

hospital for further testing as to both his persistent pain and his weight loss.

70. AHCA correctly noted that Healthpark failed to perform a nutritional reassessment of R-17, but the evidence indicates that such a reassessment would merely have constituted a written rendition of the actions the facility was taking. Healthpark was fully aware of R-17's weight loss and reacted in a reasonable manner. Staff encouraged R-17 to eat by offering him dietary options and enlisting the aid of his family.

71. AHCA criticized Healthpark for failure to perform follow-up laboratory tests or to consider a feeding tube for R-17. However, only R-17's physician could have ordered laboratory tests or a feeding tube. The record makes it apparent the physician was concerned with the weight loss, but that his primary concern was R-17's multiple infections and his unexplained and intractable pain.

72. R-17's edema subsided during his stay at Healthpark, which could account for some weight loss. His constipation was resolved to some extent, which could also have had some effect on his weight. R-17 was taking multiple medications, including powerful antibiotics and analgesics, that could affect his appetite. R-17 was having emotional difficulty adjusting to the facility and to his physical condition. Finally, R-17 was cognitively alert and within his rights simply to refuse to eat.

Aside from the weight loss itself, R-17 showed no indications of a lack of proper nutrition. Healthpark took all these factors into account in its treatment of R-17. A formal nutritional reassessment would have had no substantive effect on R-17's treatment. At most, Healthpark failed adequately to document the steps it took in caring for R-17 and addressing his weight loss.

CONCLUSIONS OF LAW

73. 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.

74. 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. Section 400.23(7), Florida Statutes, requires AHCA to "at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance." AHCA's evaluation must be based on the most recent inspection report, taking into consideration findings from official reports, surveys, interviews, investigations, and inspections. AHCA must assign either a standard or conditional rating to each facility after it surveys the facility. Section 400.23(7), Florida Statutes.

75. 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 Jacaranda Manor'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).

76. As to the allegations of the Administrative Complaint, the standard of proof for imposition of an administrative fine is clear and convincing evidence. Department of Banking and Finance v. Osborne Stern and Co., 670 So. 2d 932, 935 (Fla. 1996).

77. 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.
>
> * * *
>
> (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.

78. 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.

79. The October 2001 survey of Healthpark included deficiencies identified as Tag F224 (violation of 42 C.F.R.

Section 483.13(c)(1)(i), relating to neglect of residents) and Tag F325 (violation of 42 C.F.R. Section 483.25(i)(l), relating to maintenance of acceptable parameters of nutritional status). These deficiencies were identified as Class II and thus subjected the facility to conditional licensure. Because the deficiencies were isolated, the agency seeks to impose a $2,500 fine for each of them.

80. The preponderance of the evidence failed to establish that either of the cited deficiencies occurred. As to Tag F224, the evidence was ambiguous, largely because the surveyor stood 200 feet away from the resident for most of her observation on the key date of October 16. She could not be certain the Healthpark staff ignored the resident, though she implied such in her findings. The surveyor failed to take the simple step of asking the resident whether she needed toileting or whether staff was ignoring her requests. The evidence failed to demonstrate that the creasing or redness on the resident's buttocks, perineum, and left groin were caused by the facility's failure to toilet the resident.

81. As to Tag F325, the evidence presented at hearing failed to establish that the resident's weight loss was not fully addressed by the facility. While Healthpark's documentation could have been clearer and more complete, the

evidence established that the actual care provided met the standard of maintaining the resident's nutritional status.

82. The burden of proof on AHCA as to the phase of the proceeding involving the Administrative Complaint was to demonstrate the truthfulness of the allegations in the complaint by clear and convincing evidence. Osborne Stern; Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

83. The "clear and convincing" standard requires:

> [T]hat the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

84. Given the conclusion that the Agency failed to establish either of the deficiencies alleged in the October 2001 survey by a preponderance of the evidence, it must follow that the more exacting standard of clear and convincing evidence has not been met.

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 dismissing the Administrative Complaint in

DOAH Case No. 02-1788, and rescinding the notice of intent to assign conditional licensure status to Healthpark Care Center in Doah Case No. 02-0033 and reinstating the facility's standard licensure status.

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

LAWRENCE P. STEVENSON
Administrative Law Judge
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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.