STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 02-1586
THE HEALTHCARE CENTER OF PORT CHARLOTTE, d/b/a CHARLOTTE HARBOR HEALTHCARE,	)	
Respondent.	)	
CHARLOTTE HARBOR HEALTHCARE,	)	
Petitioner,	)	
vs.	)	Case No. 02-1917
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to Notice, a formal hearing was held in this case on September 24, 2002, in Punta Gorda, Florida. The hearing was conducted by Fred L. Buckine, Administrative Law Judge, Division of Administrative Hearings (DOAH). The authority for conducting the hearing is set forth in Sections 120.569 and 120.57(1), Florida Statutes.

APPEARANCES

For Agency for Health Care Administration:

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For The Healthcare Center of Port Charlotte, d/b/a Charlotte Harbor Healthcare:

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STATEMENT OF THE ISSUES

The issues for determination are: (1) whether the noncompliance as alleged during the August 30, 2001, survey and identified as Tags F324 and F242, were Class II deficiencies; (2) whether the "Conditional" licensure status, effective August 30, 2001, to September 30, 2001, based upon noncompliance is appropriate; and (3) whether a fine in the amount of $5,000 is appropriate for the cited noncompliance

PRELIMINARY STATEMENT

The Agency for Health Care Administration (hereinafter AHCA), by letter dated September 12, 2001, informed The Healthcare Center of Port Charlotte, d/b/a Charlotte Harbor Healthcare (hereinafter Charlotte) that it intended to assign a conditional licensure status based on the referenced deficiencies related to discontinuation of facility-sponsored

field trips and failure to prevent repeated falls by a resident from the survey completed on August 30, 2001. Charlotte's request of October 2, 2001, for a formal hearing was forwarded to DOAH and assigned Case No. 01-4333. By Order dated April 8, 2002, DOAH Case No. 01-4333 was closed without prejudice by the assigned Administrative Law Judge. Charlotte filed a motion to reopen DOAH Case No. 01-4333. The reopened complaint was assigned DOAH Case No. 02-1917.

AHCA filed a two-count Administrative Complaint dated March 13, 2002, based upon the same referenced deficiencies related to discontinuation of field trips and failure to prevent repeated falls by a resident from the August 30, 2001, survey. This administrative complaint was assigned DOAH Case No. 02-1586 and alleged that Charlotte violated various provisions of the Florida Statutes and the Florida Administrative Code and sought to impose a $5,000 fine. Charlotte filed a motion to consolidate DOAH Case No. 01-4333 and 02-1586, and by order dated May 14, 2002, DOAH Case Nos. 02-1586 and 02-1917 (formerly Case No. 01-4333) were consolidated.

By stipulation, the parties agreed that AHCA bore the burden of proof in this proceeding to show that there was a basis for the two intended fines of $2,500 each for a total of $5,000.

At the final hearing, AHCA presented the testimony of two witnesses, each who is an AHCA employee: Nancy Furdell, a Surveyor, and Maria Garcia Donohue, a Surveyor and Team Leader. AHCA offered two composite exhibits in evidence, identified as AHCA's Exhibit numbered R-1, documents relating to Resident 24, and AHCA's Exhibit numbered R-2, documents relating to provision of outside activities of all residents. Charlotte presented the testimony of: Grace Glasser, an expert in nursing; Dr. John Janick (via deposition), a medical doctor; and three Charlotte employees, Deborah Francis, a Licensed Practical Nurse; Lynn Finnerman, Director of Nursing; and Matthew Logue, Charlotte's Administrator. Charlotte offered three exhibits into evidence: two composite exhibits, identified as Charlotte's Exhibit P-A, Resident 24's complete facility file, and Charlotte's Exhibit P-C, a compilation of exhibits and demonstrative aids; and one transcript of Dr. Janick's deposition testimony, identified as Charlotte's Exhibit P-B. Charlotte's Exhibit P-A, after being admitted in evidence and by agreement of the parties, was returned to Charlotte's counsel for redaction of names and other means of identification and was to be returned to the court reporter after redaction.

Official Recognition was taken of Chapter 42 Code of Federal Regulations Sections 483.15 and 483.25; Sections 120.569 and 120.57(1), Florida Statutes; Chapter 400, Part II,

Sections 409.175, 400.23(7), and 400.23(8), Florida Statutes; and Rules 59A-4.1288 and 28-106.216, Florida Administrative Code.

The identity of the witnesses, exhibits, and any attendant evidentiary rulings are set forth in the two-volume Transcript of the hearing filed on October 10, 2002.

Proposed recommended orders were scheduled to be filed not later than 20 days after the filing of the transcript. The request of Charlotte for additional time to file its proposed recommended order was granted. By these arrangements, the parties have waived the requirement that the Recommended Order be entered within 30 days of receipt of the hearing transcript. Rule 28-106.216, Florida Administrative Code. Proposed Recommended Orders were filed on November 27, 2002, by AHCA and Charlotte and have been considered in rendering this Recommended Order.

FINDINGS OF FACT

1. Charlotte is a nursing home located at 5405 Babcock Street, Northeast, Fort Myers, Florida, with 180 residents and is duly licensed under Chapter 400, Part II, Florida Statutes.

2. AHCA is the state agency responsible for evaluating nursing homes in Florida pursuant to Section 400.23(7), Florida Statutes. As such, in the instant case it is required to evaluate nursing homes in Florida in accordance with Section

400.23(8), Florida Statutes (2000). AHCA evaluates all Florida nursing homes at least every 15 months and assigns a rating of standard or conditional to each licensee. In addition to its regulatory duties under Florida law, AHCA is the state "survey agency," which, on behalf of the federal government, monitors nursing homes that receive Medicaid or Medicare funds.

3. On August 27 through 30, 2001, AHCA conducted an annual survey of Charlotte's facility and alleged that there were deficiencies. These deficiencies were organized and described in a survey report by "Tags," numbered Tag F242 and Tag F324. The results of the survey were noted on an AHCA form entitled "Statement of Deficiencies and Plan of Correction." The parties refer to this form as the HCFA 2567-L or the "2567." The 2567 is the document used to charge nursing homes with deficiencies that violate applicable law. The 2567 identified each alleged deficiency by reference to a Tag number. Each Tag on the 2567 includes a narrative description of the allegations against Charlotte and cites a provision of the relevant rule or rules in the Florida Administrative Code violated by the alleged deficiency. To protect the privacy of nursing home residents, the 2567 and this Recommended Order refer to each resident by a number (i.e., Resident 24) rather than by the name of the resident.

4. AHCA must assign a class rating of I, II or III to any deficiency that it identifies during a survey. The ratings reflect the severity of the identified deficiency, with Class I being the most severe and Class III being the least severe deficiency. There are two Tags, F242 and F324 at issue in the instant case, and, as a result of the August 2001 survey, AHCA assigned each Tag a Class II deficiency rating and issued Charlotte a "Conditional" license effective August 30, 2001.

Tag F242

5. Tag F242 generally alleged that Charlotte failed to meet certain quality of life requirements for the residents, based on record review, group interviews, and staff interviews, and that Charlotte failed to adequately ensure that the residents have a right to choose activities that allow them to interact with members of the community outside the facility.

6. On or about August 24, 2001, AHCA's surveyors conducted group interviews. During these interviews, 10 of 16 residents in attendance disclosed that they had previously been permitted to participate in various activities and interact with members of the community outside the facility. They were permitted to go shopping at malls, go to the movies, and go to restaurants. Amtrans transportation vans were used to transport the residents to and from their destinations. The cost of transportation was paid by Charlotte. An average of 17 to 20 residents

participated in those weekly trips to dine out with other community members at the Olive Garden and other restaurants. During those trips, Charlotte would send one activity staff member for every four to six residents. The record contains no evidence that staff nurses accompanied those select few residents on their weekly outings. The outings were enjoyed by those participants; however, not every resident desired or was able to participate in this particular activity.

7. Since 1985, outside-the-facility activities had been the facility's written policy. However, in August 2000, one year prior to the survey, Matthew Logue became Administrator of the facility and directed his newly appointed Activities Director, Debbie Francis, to discontinue facility sponsored activities outside the facility and in its stead to institute alternative activities which are all on-site functions. Those residents who requested continuation of the opportunity to go shopping at the mall or dine out with members of the community were denied their request and given the option to have food from a restaurant brought to the facility and served in-house. The alternative provided by the facility to those residents desiring to "interact with members of the community outside the facility" was for each resident to contact the social worker, activity staff member, friends or family who would agree to take them off the facility's premises. Otherwise, the facility would assist

each resident to contact Dial-A-Ride, a transportation service, for their transportation. The facility's alternative resulted in a discontinuation of all its involvement in "scheduling group activities" beyond facility premises and a discontinuation of any "facility staff members" accompanying residents on any outing beyond the facility's premises.

8. As described by its Activities Director, Charlotte's current activities policy is designed to provide for residents' "interaction with the community members outside the facility," by having facility chosen and facility scheduled activities such as: Hospice, yard sales, barbershop groups for men and beautician's day for women, musical entertainment, antique car shows, and Brownie and Girl Guides visits. These, and other similar activities, are conducted by "community residents" who are brought onto the facility premises.

9. According to the Activities Director, Charlotte's outside activities with transportation provided by Amtrans buses were discontinued in October of 2000 because "two to three residents had been hurt while on the out trip, or on out-trips."[1]

10. Mr. Logue's stated reason for discontinuing outside activities was, "I no longer wanted to take every member of the activities department and send them with the resident group on an outing, thereby leaving the facility understaffed with activities department employees." The evidence of record does

not support Mr. Logue's assumption that "every member of the facility's activities department accompanied the residents on any weekly group outings," as argued by Charlotte in its Proposed Recommended Order.

11. Charlotte's Administrator further disclosed that financial savings for the facility was among the factors he considered when he instructed discontinuation of trips outside the facility. "The facility does not sponsor field trips and use facility money to take people outside and too many staff members were required to facilitate the outings."

12. During a group meeting conducted by the Survey team, residents voiced their feelings and opinions about Charlotte's no longer sponsoring the field trips on a regular basis in terms of: "feels like you're in jail," "you look forward to going out," and being "hemmed in." AHCA's survey team determined, based upon the harm noted in the Federal noncompliance, that the noncompliance should be a State deficiency because the collective harm compromised resident's ability to reach or maintain their highest level of psychosocial well being, i.e. how the residents feel about themselves and their social relationships with members of the community.

13. Charlotte's change in its activities policy in October of 2000 failed to afford each resident "self-determination and participation" and does not afford the

residents the "right to choose activities and schedules" nor to "interact with members of the community outside the facility." AHCA has proved the allegations contained in Tag F242, that Charlotte failed to meet certain quality of life requirements for the residents' self-determination and participation. By the testimonies of witnesses for AHCA and Charlotte and the documentary evidence admitted, AHCA has proven by clear and convincing evidence that Charlotte denied residents the right to choose activities and schedules consistent with their interests and has failed to permit residents to interact with members of the community outside the facility.

Tag F324

14. As to the Federal compliance requirements, AHCA alleged that Charlotte was not in compliance with certain of those requirements regarding Tag F324, for failing to ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

15. As to State licensure requirements of Sections 400.23(7) and (8), Florida Statutes (2000), and by operation of Florida Administrative Code, Rule 59A-4.1288, AHCA determined that Charlotte had failed to comply with State established rules, and under the Florida classification system, classified Tag F324 noncompliance as a Class II deficiency.

16. Based upon Charlotte's patient record reviews and staff interviews, AHCA concluded that Charlotte had failed to adequately assess, develop and implement a plan of care to prevent Resident 24 from repeated falls and injuries.

17. Resident 24 was admitted to Charlotte on April 10, 2001, at age 93, and died August 6, 2001, before AHCA's survey. He had a history of falls while living with his son before his admission. Resident 24's initial diagnoses upon admission included, among other findings, Coronary Artery Disease and generalized weakness, senile dementia, and contusion of the right hip. On April 11, 2001, Charlotte staff had Resident 24 evaluated by its occupational therapist. The evaluation included a basic standing assessment and a lower body assessment. Resident 24, at that time, was in a wheelchair due to his pre-admission right hip contusion injury.

18. On April 12, 2001, two days after his admission, Resident 24 was found by staff on the floor, the result of an unobserved fall, and thus, no details of the fall are available. On April 23, 2001, Resident 24 was transferred to the "secured unit" of the facility. The Survey Team's review of Resident 24's Minimum Data Set, completed April 23, 2001, revealed that Resident 24 required limited assistance to transfer and to ambulate and its review of Resident 24's Resident Assessment Protocols (RAPs), completed on April 23, 2001, revealed that

Resident 24 was "triggered" for falls. Charlotte's RAP stated that his risk for falls was primarily due to: (1) a history of falls within the past 30 days prior to his admission; (2) his unsteady gait; (3) his highly impaired vision; and (4) his senile dementia.

19. On April 26, 2001, Charlotte developed a care plan for Resident 24 with the stated goal that the "[r]esident will have no falls with significant injury thru [sic] July 25, 2001," and identified those approaches Charlotte would take to ensure that Resident 24 would not continue falling. Resident 24's care plan included: (1) place a call light within his reach; (2) do a falls risk assessment; (3) monitor for hazards such as clutter and furniture in his path; (4) use of a "Merry Walker" for independent ambulation; (5) placing personal items within easy reach; (6) assistance with all transfers; and (7) give Resident 24 short and simple instructions. Charlotte's approach to achieving its goal was to use tab monitors at all times, to monitor him for unsafe behavior, to obtain physical and occupational therapy for strengthening, and to keep his room free from clutter. All factors considered, Charlotte's care plan was reasonable and comprehensive and contained those standard fall prevention measures normally employed for residents who have a history of falling. However, Resident 24's medical history and his repeated episodes of falling imposed

upon Charlotte a requirement to document his records and to offer other assistance or assistive devices in an attempt to prevent future falls by this 93-year-old, senile resident who was known to be "triggered" for falls. Charlotte's care plan for Resident 24, considering the knowledge and experience they had with Resident 24's several falling episodes, failed to meet its stated goal.

20. Charlotte's documentation revealed that Resident 24 did not use the call light provided to him, and he frequently refused to use the "Merry Walker" in his attempts of unaided ambulation. On June 28, 2001, his physician, Dr. Janick, ordered discontinuation of the "Merry Walker" due to his refusal to use it and the cost involved. A mobility monitor was ordered by his physician to assist in monitoring his movements. Charlotte's documentation did not indicate whether the monitor was actually placed on Resident 24 at any time or whether it had been discontinued.

21. Notwithstanding Resident 24's refusal to cooperatively participate in his care plan activities, Charlotte conducted separate fall risk assessments after each of the three falls, which occurred on April 12, May 12, and June 17, 2001. In each of the three risk assessments conducted by Charlotte, Resident 24 scored above 17, which placed him in a Level II, high risk for falls category. After AHCA's surveyors reviewed

the risk assessment form instruction requiring Charlotte to "[d]etermine risk category and initiate the appropriate care plan immediately," and considered that Resident 24's clinical record contained no notations that his initial care plan of April 23, 2001, had been revised, AHCA concluded that Charlotte was deficient.

22. On May 13, 2001, Dr. Janick visited with Resident 24 and determined that "there was no reason for staff to change their approach to the care of Resident 24." Notwithstanding the motion monitors, on June 17, 2001, Resident 24 fell while walking unaided down a corridor. A staff member observed this incident and reported that while Resident 24 was walking (unaided by staff) he simply tripped over his own feet, fell and broke his hip.

23. Charlotte should have provided "other assistance devices," or "one-on-one supervision," or "other (nonspecific) aids to prevent further falls," for a 93-year-old resident who had a residential history of falls and suffered with senile dementia. Charlotte did not document other assistive alternatives that could have been utilized for a person in the condition of Resident 24. AHCA has carried its burden of proof by clear and convincing evidence regarding the allegations contained in Tag F324.

CONCLUSIONS OF LAW

24. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this cause pursuant to Sections 120.659 and 120.57(1), Florida Statutes.

25. The Agency 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.

26. Section 400.23, Florida Statutes, provides that when minimum standards are not met, such deficiency shall be classified according to the nature and scope of the deficiency.

27. Charlotte is a nursing home licensed under Chapter 400, Part II, Florida Statutes.

28. AHCA evaluates nursing home facilities at least every 15 months to determine the degree of compliance by the licensee with regulatory rules adopted under Chapter 400, Florida Statutes, as a means to assign a license status to the nursing home facility. Section 400.23(7), Florida Statutes (2000).

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

30. Subsections 400.23(7)(a) and (b), Florida Statutes (2000), defines Standard and Conditional licensure status and sets forth criteria for evaluation as follows:

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

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

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

32. AHCA has authority to adopt rules to classify deficiencies. Sections 400.23(2) and (8), Florida Statutes. Rule 59A-4.128, Florida Administrative Code, refers to nursing homes participating in Title XVIII or XIX and the need to follow certification rules and regulations found at 42 C.F.R. Chapter 483. Charlotte must comply with 42 C.F.R. Chapter 483.

33. The parties assert, and it is accepted, that Charlotte is substantially affected by the issuance of the Conditional license for the period in question. See Daytona Manor Nursing Home v. AHCA, 21 FALR 119 (AHCA 1998). Thus, Charlotte has standing to oppose AHCA's intent to rate Charlotte's nursing home license as Conditional for the period of January 8, 2001 through March 5, 2001. In this context, AHCA bears the burden of proof of alleged deficiencies and consequences for the deficiencies. Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981); and Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977). AHCA's burden of proof relating to conditional rating is by a preponderance of the evidence, failing a contrary instruction set forth in Chapter 400, Part II, Florida Statutes. Section 120.57(1)(j), Florida Statutes. The burden of proof is on AHCA. See Beverly Enterprises v. Agency For Health Care Administration, 745 So. 2d 1133 (Fla. 1st DCA 1999). The burden of proof to impose an administrative fine

is by clear and convincing evidence. Department of Banking and Finance v. Osborne Stern and Company, 670 So. 2d 932 (Fla. 1996).

34. A nursing home licensed in this state is given a quality rating on the basis of its substantial compliance with two independent bodies of law: state law and federal law. The quality rating of nursing homes is unique to the State of Florida. While federal law deficiencies, for purposes of sanctions, may fall under any of the regulations in 42 C.F.R. Part 483, Rule 59A-4.128, Florida Administrative Code, effective October 13, 1996 through May 5, 2002, for rating purposes, limits the consideration of federal deficiencies to those federal deficiencies constituting "substandard quality of care." "Substandard quality of care" refers only to a certain level of noncompliance with three particular sections of 42 C.F.R. Part 483: to wit, Sections 483.13, 483.15, and 483.25. Florida Administrative Code Rule 59A-4.128's use of "substandard quality of care" was added by the amendment to the rule of October 13, 1996, and was recognized in rule challenge proceedings as an appropriate reference to federal law in Florida Health Care Association v. Agency for Health Care Administration, 18 F.A.L.R. 3458, 3471 (DOAH 7/16/96).

35. The state "Class I," "Class II," and "Class III" scheme of deficiencies is simply broader than the federal

"substandard quality of care" scheme. There is no indication in Chapter 400, Part II, Florida Statutes, that the legislature intended for the statutory definitions to be limited by federal law. Thus, under Rule 59A-4.128(4), Florida Administrative Code, effective October 13, 1996 through May 5, 2002, a nursing home is rated as conditional if one of the state "class" deficiencies is found, or if one of the federal "substandard quality of care" deficiencies is found. In summary, a separate inquiry into substantial compliance with (1) state law and (2) federal law is required to ascertain the proper quality rating of a nursing home.

36. "F" Tags are Center for Medicare and Medicaid Services (formally Health Care Financing Administration) data tags assigned to each of the Federal regulatory requirements for long term care facilities and are found in 42 C.F.R., Section 483.

37. Interpretive guidelines are found in the State Operations Manual required of the states in conducting surveys for Medicare and Medicaid certification. In conducting a survey, the Agency's surveyors rely on these guidelines in determining whether a facility is in compliance with 42 C.F.R., Chapter 483. 42 C.F.R., Section 483.15(b), in relevant part, states that:

> A facility must care for its residents in a manner and in an environment that promotes

> maintenance or enhancement of each resident's quality of life.
>
> * * *
>
> (b) Self-determination and participation. The resident has the right to --
>
> (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;
>
> (2) Interact with members of the community both inside and outside the facility; and
>
> (3) Make choices about aspects of his or her life in the facility that are significant to the resident.

38. Since 1985 Charlotte sponsored and provided weekly outside-the-facility trips for those residents who wished to participate. The weekly restaurant outing program was consistent and in full compliance with the resident's right to "choose activities and schedules consistent with his or her interests" and "[I]nteract with members of the community . . . outside the facility."

39. Charlotte's current activity program of discontinuation of off-site-sponsored outings is not in compliance with the stated purpose of 42 C.F.R. Section 483.15(b). Neither does Administrator Logue's interpreted position that "bringing outside activities and people from the community into the facility" permits the residents to "interact"

with the community, suffice to meet the minimum intended purpose of 42 C.F.R. Section 483.15(b).

40. 42 C.F.R. Section 483.25(h)(2), in relevant part, states that:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care.
>
> * * *
>
> (h) Accidents. The facility must ensure that--
>
> * * *
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

41. Pursuant to Section 400.23(7), Florida Statutes, to assign a conditional licensure status to a facility, the Agency must show, at the time of the survey, the facility was not in "substantial compliance" with the criteria established under Part II of Chapter 400 of the Florida Statutes. Thus, substantial compliance with a particular statute, rule, standard, or requirement under this Part, would appear to mean assuring that in circumstances where a known and identified hazard or propensity of a particular resident could cause, may cause or in the past has caused injury to that particular resident, the hazard or propensity would be closely monitored

and preventative measures taken to preclude and prevent that particular resident from becoming a victim of the identified hazard or propensity.

42. In the instant case, with regard to Tag F324, Charlotte made an assessment of Resident 24 upon his admission into their facility and his known risks were identified. From the date of his admission until his death, Resident 24 was continuously assessed and determined by Charlotte's staff to be "triggered" for falls. His initial assessment of April 23, 2001, diagnosis revealed, among other problems, senile dementia, a decreased awareness of safety, highly impaired vision, and a history of falls. On May 12, 2001, Resident 24 was discovered on the floor with an abrasion of his knee. No knows how this falls occurred. On June 17, 2001, he was discovered with a laceration on his head resulting from falling. Still later, he was found to have suffered a fractured hip resulting from a fall. After each fall, Charlotte completed the required risk fall assessments. AHCA maintains that no documentation to support or demonstrate that Charlotte provided or attempted to provide alternative assistive devices sufficient to prevent further falls and injury. Those "alternative assistive" devices AHCA maintains Charlotte should have documented are not defined by either statute or rule.

43. The documentary and testimonial evidence presented by both the parties, clearly and convincingly, demonstrates that Resident 24 was faced with more than a minimal risk for harm and that Charlotte compromised his ability to maintain or reach his highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care and provisions for service. The record contains testimony that Charlotte's staff actually witnessed one episode of Resident 24 falling, for no apparent reason other than tripping over his feet, as he walked unaided down the hallway. From that fact alone, one could find reason to agree that "one-on-one" supervision may have been cost prohibitive.[2] However, closer supervision by staff, time checks, strict monitoring or spot checking of Resident 24 and/or having a certified nursing assistant monitor his unaided walks are alternatives that are not cost prohibitive. The record contains no evidence that these or other reasonable alternatives were documented by Charlotte's nursing staff.

44. The documentary and testimonial evidence presented by both AHCA and Charlotte clearly and convincingly demonstrates that with regard to Tag F242, the requirement imposed upon Charlotte to provide the residents with opportunities to select and participate in activities with members of the community outside the facility premises is intentionally not being

fulfilled. Under direction of the Administrator, the current Activities Director offers no facility-sponsored activities outside (off premises) the facility of which residents may select or participate. Based upon the testimony of the Administrator and the testimony of the Activities Director, it is unclear what Charlotte's current policy may be. It is clear that outside activities that were once provided under the policy in effect since 1985 until discontinued by the Administrator are no longer provided. It is equally clear that residents were quite vocal in their disapproval of being denied those opportunities to select an activity sponsored by the facility wherein they went into the community and interacted with members of the community. The absence of facility sponsored outside-the-facility activities clearly and convincingly compromised the residents' ability to reach their highest practicable psychosocial well being, and is a Class II deficiency. Accordingly, AHCA has proven by clear and convincing evidence the allegation made in support of Tag F242 that Charlotte has failed and refused to provide the residents with opportunities to select and to participate in facility sponsored activities with members of the community outside facility premises.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that:

The Agency enter a final order upholding the assignment of the Conditional licensure status for the period of August 30, 2001 through September 30, 2001, and impose an administrative fine in the amount of $2,500 for each of the two Class II deficiencies for a total administrative fine in the amount of $5,000.

DONE AND ENTERED this 13th day of February, 2003, in Tallahassee, Leon County, Florida.

FRED L. BUCKINE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 13th day of February, 2003.

ENDNOTES

1/ The mere hearsay statement of the Activities Director, "two or three resident had been hurt while on the out trip," without more, is insufficient to support a finding of fact that residents were, in fact, hurt while on an out trip. However, from her statement, a proper and reasonable inference is that the determinative concern of the facility's administration, in its decision to discontinue facility sponsored off premise activities for the residents, was financial.

2/ Charlotte's citing of Beverly Enterprises v. A.H.C.A., 20 F.A.L.R. (AHCA 1998), cited with approval in Pasadena Manor, Inc. v. A.H.C.A, 23 F.A.L.R. 3683 at 3691, paragraph 42 (AHCA, 2001), as controlling, is not on point. Substantial compliance

is determined from specific factual circumstances of each given situation. In Beverly, there were 11 residents who suffered falls. Under those circumstances, the fact-finder's rejection of one-on-one staff care for each of the 11 residents because of cost was reasonable. Based upon a totality of those circumstances, there was no preventable cause for any of the 11 residents who fell. In the case at bar however, there is only one resident triggered for falls, Resident 24. Additionally, other preventable assistive devices for Resident 24 (i.e. more and/or closer supervision, specific spot checks, etc.) were not documented as having been considered by Charlotte's staff. Acceptance of AHCA's position that "written care plans" and "investigation after each fall" equates to substantial compliance ignores the particular circumstances and known medical conditions and facts pertinent to Resident 24. A closer level of supervision of Resident 24 would not have "required a tremendous increase in staff" nor would it "result in a tremendous cost to the facility and its residents" and it was achievable.

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.