STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. AVANTE AT LEESBURG, INC., d/b/a AVANTE AT LEESBURG, Respondent.	)	Case Nos. 02-3254 02-3255

RECOMMENDED ORDER

A hearing was held pursuant to notice on October 23, 2002, by Barbara J. Staros, assigned Administrative Law Judge of the Division of Administrative Hearings, in Leesburg, Florida.

APPEARANCES

For Petitioner: Jodi C. Page, Esquire
Agency for Health Care Administration
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For Respondent: Karen L. Goldsmith, Esquire
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STATEMENT OF THE ISSUE

Whether Respondent committed the violations alleged in the Administrative Complaints and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (AHCA) filed an Administrative Complaint on July 12, 2002, for the imposition of an administrative fine alleging an uncorrected Class III deficiency. Specifically, the Administrative Complaint alleged that Respondent failed to meet professional standards of quality by its failure to properly follow and implement physician orders. Avante at Leesburg, Inc. (Avante) requested a formal administrative hearing, and AHCA forwarded the case to the Division of Administrative Hearings on or about August 19, 2002.

AHCA filed a second Administrative Complaint against Avante on July 12, 2002. The second Administrative Complaint again alleges an uncorrected Class III deficiency and seeks to assign a conditional license. Specifically, the second Administrative Complaint alleges that Avante was not in substantial compliance with applicable laws and rules by failing to meet professional standards of quality by its failure to properly follow and implement physician orders. Avante requested a formal administrative hearing and the case was forwarded to the Division of Administrative Hearings on or about August 19, 2002.

Respondent filed a Motion to Consolidate which was granted, consolidating Case Nos. 02-3254 and 02-3255. A hearing was scheduled for October 23, 2002, in Leesburg, Florida.

At hearing, Petitioner presented the testimony of two witnesses, Stephen Burgin and Selena Beckett. Petitioner's Exhibits numbered 1 through 10, 14 and 15 were admitted into evidence. Respondent presented the testimony of Nancy Strake, Theresa Miller, Vicki Cannon, and Alice Markhan. Respondent's composite Exhibit numbered 1 was admitted into evidence.

A Transcript, consisting of one volume, was filed on November 4, 2002. The parties requested more than ten days after the filing of the Transcript in which to file proposed recommended orders. That request was granted. The parties timely filed Proposed Recommended Orders which have been considered in the preparation of this recommended order.

FINDINGS OF FACT

Stipulated facts

1. AHCA is the agency responsible for the licensing and regulation of skilled nursing facilities in Florida pursuant to Chapter 400, Part II, Florida Statutes, and Chapter 59A-4, Florida Administrative Code.

2. At all times material hereto, Avante was licensed by Petitioner as a skilled nursing facility. Avante operates a 116-bed nursing home located in Leesburg, Florida.

3. On or about March 28, 2002, AHCA conducted a complaint investigation at Avante.

4. Based on AHCA's findings during the March 28, 2002, complaint investigation, federal tag F281(D) was cited against Avante.

5. On or about May 13, 2002, AHCA conducted a survey at Avante.

6. Based on AHCA's findings during the May 13, 2002, survey, federal tag F281(D) was cited against Avante.

7. Resident E.S. was admitted to Avante on March 11, 2002, with diagnoses including e. coli sepsis, anemia, and schizophrenia with an order for serum albumin levels to be performed "now and yearly."

8. Resident E.S.'s resident chart failed to reflect that a serum albumin test had been performed for Resident E.S. at any time from the date of his admission on March 11, 2002, until March 28, 2002. Avante failed to follow the orders of Resident E.S.'s physician due to its failure to perform a serum albumin test on Resident E.S. at any time between March 11, 2002, and March 28, 2002.

9. Resident R.L. was admitted to Respondent's facility on May 6, 2002 with diagnoses including gastrointestinal hemorrhage, congestive heart failure, coronary artery disease, A-fib, pneumonia, diverticulitis, gout, fracture of right arm, and cancer of the prostate.

10. Resident R.L.'s resident chart reflects that Resident R.L. was neither offered or administered Tylenol by Avante's staff at any time between May 9, 2002, and May 13, 2002.

Facts Based Upon the Evidence of Record

11. The correction date given to Respondent for the deficiency cited, Tag F281(D), as a result of the March 28, 2002, complaint investigation was April 28, 2002.

12. Respondent does not dispute the deficiency cited by AHCA as a result of the March 28, 2002, complaint investigation. Thus, facts and circumstances surrounding the May 13, 2002, survey visit to Avante is the source of this dispute.

13. The purpose of the May 13, 2002 survey visit to Avante by AHCA was for annual certification or licensure. In an annual license survey, a group of surveyors goes to a facility to determine if the facility is in compliance with state and federal requirements and regulations. Part of the process is to tour the facility, meet residents, record reviews, and talk to families and friends of the residents. During the licensure visit on May 13, 2002, the records of 21 residents were reviewed.

14. Stephen Burgin is a registered nurse and is employed by AHCA as a registered nurse specialist. He has been employed by AHCA for three years and has been licensed as a nurse for six years. He also has experience working in a hospital ER staging

unit and in a hospital cardiology unit. Nurse Burgin has never worked in a nursing home. Nurse Burgin conducted the complaint investigation on March 28, 2002, and was team leader for the licensure survey visit on May 13, 2002, at Avante. He was accompanied on the May 13, 2002, visit by Selena Beckett, who is employed by AHCA as a social worker. Both Nurse Burgin and Ms. Beckett are Surveyor Minimum Qualification Test (SMQT) certified.

15. During the course of the May 13, 2002, licensure survey visit, Ms. Beckett interviewed Resident R.L. As a result of this interview, Ms. Beckett examined Resident R.L.'s medication administration record (MAR) to determine whether he was receiving pain medication for his injured left elbow.

16. As a result of reviewing Resident R.L.'s record, Ms. Beckett became aware of a fax cover sheet which related to Resident R.L. The fax cover sheet was dated May 8, 2002, from Nancy Starke, who is a registered nurse employed by Avante as a staff nurse, to Dr. Sarmiento, Resident R.L.'s attending physician. The box labeled "Please comment" was checked and the following was hand written in the section entitled "comments": "Pt refused Augmentin 500 mg BID today states it causes him to have hallucinations would like tyl for pain L elbow."

17. According to Nurse Starke, the fax to Dr. Sarmiento addressed two concerns: Resident R.L.'s refusal to take Augmentin and a request for Tylenol for pain for Resident R.L.'s left elbow. She faxed the cover sheet to Dr. Sarmiento during the 3:00 p.m. to 11:00 p.m. shift on May 8, 2002. Despite her fax to Dr. Sarmiento, which mentioned pain in R.L.'s left elbow, her daily nurse notes for May 8, 2002, reflect that Resident R.L. was alert, easygoing, and happy. He was verbal on that day meaning that he was able to make his needs known to her. Her daily nurse notes for May 8, 2002 contain the notation: "Pt refused augmentin today. Dr. Sarmiento faxed." According to Nurse Starke, she personally observed Resident R.L. and did not observe any expression of pain on May 8, 2002, nor did Resident R.L. request pain medication after she sent the fax to Dr. Sarmiento.

18. The fax cover sheet also contained the hand written notation: "Document refused by PT. OK 5/9/02" with initials which was recognized by nurses at Avante as that of Dr. Sarmiento. The fax sheet has a transmission line which indicates that it was faxed back to Avante the evening of May 9, 2002.

19. Nurse Starke also provided care to Resident R.L. on May 11, 2002. According to Nurse Starke, Resident R.L. did not complain of pain on May 11, 2002.

20. Theresa Miller is a registered nurse employed by Avante as a staff nurse. Nurse Miller provided care to Resident R.L. on May 9 and 10, 2002, during the 7:00 a.m. to 3:00 p.m. shift. Nurse Miller's nurses notes for May 9 and 10, 2002, reflect that she observed Resident R.L. to be alert, easygoing, and happy. Her notes also reflect that Resident R.L. was verbal on those dates, meaning that he was able to tell her if he needed anything. She did not observe Resident R.L. to have any expression of pain on those dates, nor did Resident R.L. express to her that he was in any pain.

21. Vicki Cannon is a licensed practical nurse employed by Avante as a staff nurse. Nurse Cannon has been a licensed practical nurse and has worked in nursing homes since 1998. Nurse Cannon provided care to Resident R.L. on May 11 and 12, 2002, on the 7:00 a.m. to 3:00 p.m. shift. Her nurse's notes for May 11, 2002 reflect that Resident R.L. was sullen but alert and verbal. Resident R.L. had blood in his urine and some discomfort. Nurse Cannon contacted Dr. Sarmiento by telephone on May 11, 2002, to inform him of Resident R.L.'s symptoms that day. Nurse Cannon noted on Resident R.L.'s physician order sheet that she received a telephone order from Dr. Sarmiento to give Resident R.L. Ultram PRN and Levaquin, discontinue Augmentin, order BMP and CBC blood work, and a urology consult. Ultram is an anti-inflammatory and a pain medication. Ultram is

stronger than Tylenol. The notation "PRN" means as requested by the patient for pain. Levaquin is an antibiotic.

22. Nurse Cannon faxed the order to the pharmacy at Leesburg Regional Medical Center. By the time Nurse Cannon left Avante for the day on May 11, 2002, the Ultram had not arrived from the pharmacy.

23. On May 12, 2002, Resident R.L. had edema of the legs and blood in his urine. Nurse Cannon notified Dr. Sarmiento of Resident R.L.'s symptoms. Resident R.L. was sent to the emergency room for evaluation based on Dr. Sarmiento's orders. Additionally, Nurse Cannon called the pharmacy on May 12, 2002, to inquire about the Ultram as it had not yet arrived at the facility. Resident R.L. returned to Avante the evening of May 12, 2002.

24. Alice Markham is a registered nurse and is the Director of Nursing at Avante. She has been a nurse for more than 20 years and has been employed at Avante for a little over two years. She also has worked in acute care at a hospital. Nurse Markham is familiar with Resident R.L. She described Resident R.L. as alert until the period of time before he went to the hospital on May 12, 2002. She was not aware of any expressions of pain by Resident R.L. between May 9, 2002 until he went to the hospital on May 12, 2002. Nurse Markham meets

frequently with her nursing staff regarding the facility's residents.

25. During the licensure survey, Nurse Markham became aware of Ms. Beckett's concerns regarding Resident R.L. and whether he had received Tylenol. She called Dr. Sarmiento to request an order for Tylenol for R.L. The physician order sheet for R.L. contains a notation for a telephone order for Tylenol "PRN" on May 14, 2002, for joint pain and the notation, "try Tylenol before Ultram." The medical administration record for R.L. indicates that Resident R.L. received Ultram on May 13 and 14 and began receiving Tylenol on May 15, 2002.

26. AHCA 's charge of failure to meet professional standards of quality by failing to properly follow and implement physician orders is based on the "OK" notation by Dr. Sarmiento on the above-described fax and what AHCA perceives to be Avante's failure to follow and implement that "order" for Tylenol for Resident R.L.

27. AHCA nurse and surveyor Burgin acknowledged that the "OK" on the fax cover sheet was not an order as it did not specify dosage or frequency. He also acknowledged that the nursing home could not administer Tylenol based on Dr. Sarmiento's "OK" on the fax cover sheet, that it would not be appropriate to forward the "OK" to the pharmacy, that it should not have been placed on the resident's medication

administration record, and that it should not have been administered to the resident. However, Nurse Burgin is of the opinion that the standard practice of nursing is to clarify such an "order" and once clarified, administer the medication as ordered. He was of the opinion that Avante should have clarified Dr. Sarmiento's "OK" for Tylenol on May 9, 2002, rather than on May 14, 2002. Nurse Burgin also was of the opinion that it should have been reflected on the resident's medication administration record and treatment record or TAR.

28. In Nurse Markham's opinion, "OK" from Dr. Sarmiento on the fax cover sheet does not constitute a physician's order for medication as it does not contain dosage or frequency of administration. Nurse Markham is also of the opinion that it should not have been forwarded to the pharmacy, transcribed to the medication administration record, or transcribed on the treatment administration record. According to Nurse Markham, doctor's orders are not recorded on the treatment administration record of a resident. Nurse Markham is of the opinion that the nursing staff at Avante did not deviate from the community standard for nursing in their care of Resident R.L. from May 8, 2002 to May 14, 2002.

29. Nurse Cannon also is of the opinion that the "OK" by Dr. Sarmiento does not constitute a physician's order for medication.

30. The Administrative Complaints cited Avante for failure to meet professional standards of quality by failing to properly follow and implement a physician's order. Having considered the opinions of Nurses Burgin, Markham, and Cannon, it is clear that the "OK" notation of Dr. Sarmiento on the fax cover sheet did not constitute a physician's order. Without Dr. Sarmiento's testimony, it is not entirely clear from a review of the fax cover sheet that the "OK" relates to the reference to Tylenol or the reference to Resident R.L.'s refusal of Augmentin. Accordingly, Avante did not fail to follow a physician's order in May 2002.

31. As to AHCA's assertion that Avante failed to meet professional standards by not clarifying the "OK" from Dr. Sarmiento, this constitutes a different reason or ground than stated in the Administrative Complaints. Failure to clarify an order is not the equivalent of failure to follow an order. There is insufficient nexus between the deficiency cited on March 28, 2002 and the deficiency cited on May 13, 2002. Accordingly, Avante did not fail to correct a Class III deficiency within the time established by the agency or commit a repeat Class III violation.

32. Moreover, the evidence shows that the nursing staff responded to the needs of Resident R.L. Resident R.L. expressed pain in his left elbow to Nurse Starke on May 8, 2002.

Resident R.L. was alert and could make his needs known. He did not express pain or a need for pain medication to Nurse Miller on May 9 or 10, 2002 or to Nurse Cannon on May 11 or 12, 2002. Rather, Nurse Cannon noted a change in his condition, notified Dr. Sarmiento which resulted in Resident R.L. being sent to the emergency room. Resident R.L. returned to Avante the evening of May 12, 2002, and received Ultram for pain on May 13, 2002, when the medication reached Avante from the pharmacy.

33. The evidence presented does not establish that Avante deviated from the community standard for nursing in its actions surrounding the "OK" from Dr. Sarmiento. In weighing the respective opinions of Nurses Burgin and Markham in relation to whether the community standard for nursing was met by the actions of Respondent, Nurse Markham's opinion is more persuasive.

CONCLUSIONS OF LAW

34. The Division of Administrative Hearings has jurisdiction over the parties and subject matter in this case. Sections 120.569 and 120.57, Florida Statutes.

35. The Amended Administrative Complaint in Case No. 02-3254 seeks to impose a $1,000.00 administrative fine for failure to meet professional standards of quality by its failure to properly follow physician orders in violation of Rule 59A-

4.1288, Florida Administrative Code, and 42 CFR 483.20 (k)(3)(i). The Administrative Complaint specifies that this is a Class III deficiency.

36. The Administrative Complaint in Case No. 02-3255 seeks to assign a conditional licensure status to Respondent based upon Petitioner's determination that Respondent was not in substantial compliance with applicable laws and rules due to the presence of an uncorrected Class III deficiency at the survey conducted on May 13, 2002. The Administrative Complaint asserts that the Class III deficiency was first cited during a complaint investigation conducted on March 28, 2002, and was uncorrected at the time the survey was conducted on May 13, 2002.

37. Further, the Administrative Complaint in Case No. 02-3255 seeks to assess costs related to the investigation pursuant to Section 400.121(10), Florida Statutes, in an unspecified amount.

38. The burden of proof in this proceeding is on the agency. Because of the proposed penalty of an administrative fine in Case No. 02-3254, the agency is required to prove the allegations against Respondent by clear and convincing evidence. Department of Banking and Finance v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996). In Case No. 02-3255, the agency is required to prove the allegations against Respondent

by a preponderance of the evidence. Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981).

39. Section 400.23(7)(b), Florida Statutes, provides that a conditional rating means that the facility, due to the presence of one or more Class I or Class II deficiencies, or a Class III deficiency not corrected within the time established by the agency, is not in compliance with established criteria.

40. Section 400.419, Florida Statutes, defines a Class III deficiency and sets forth the parameters of any administrative fine to be imposed regarding such deficiency. Section 400.419, Florida Statutes, reads in pertinent part as follows:

> 400.419 Violations; administrative fines.--
>
> (1) Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents. The agency shall indicate the classification on the written notice of the violation as follows:
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> * * *
>
> (c) Class 'III' violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of facility residents, other than class I or class II violations. A class III violation is subject to an administrative fine of not less then $500.00 and not exceeding $1,000.00 for each

> violation. A citation for a class III violation must specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, no fine may be imposed, unless it is a repeated offense.
>
> * * *
>
> (2) In determining if a penalty is to be imposed and in fixing the amount of the fine, the agency shall consider the following factors:
>
> (a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a resident will result or has resulted, the severity of the action or potential harm, and the extent to which the provisions of the applicable laws or rules were violated.
>
> (b) Actions taken by the owner or administrator to correct violations.
>
> (c) Any previous violations.
>
> (d) The financial benefit to the facility of committing or continuing the violation.
>
> (e) The licensed capacity of the facility.

41. Rule 59A-4.1288, Florida Administrative Code, incorporates by reference certification rules and regulations found in 42 CFR 483, Requirements for Long Term Care Facilities.

42. 42 CFR 483.20(k)(3)(i)(tag F281) provides, "The services provided or arranged by the facility must meet professional standards of quality."

43. AHCA has not met its burden of proof in regard to the imposition of a fine in that it failed to prove that Avante did

not correct a deficiency within the time specified or that it committed a repeat offense of a Class III deficiency. AHCA's assertion at hearing that Avante failed to meet professional standards by not clarifying the "OK" from Dr. Sarmiento constitutes a different reason or ground than stated in the Administrative Complaints. There is insufficient nexus between the deficiency cited on March 28, 2002, and the deficiency cited on May 13, 2002. Accordingly, Avante did not fail to correct a deficiency within the time specified and did not commit a repeat Class III violation to support the imposition of a fine as contemplated by Section 400.419(1)(c).

44. AHCA has not met its burden of proof as to the imposition of a conditional license in that it did not prove that a Class III deficiency was not corrected within the time frame established by the agency as contemplated by Section 400.23(7)(b), Florida Statutes.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law set forth herein, it is

RECOMMENDED:

That the Agency for Health Care Administration enter a final order dismissing the Administrative Complaints issued against Respondent, Avante at Leesburg.

DONE AND ENTERED this 13th day of December, 2002, in Tallahassee, Leon County, Florida.

BARBARA J. STAROS
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 December, 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.