STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case Nos. 02-3510 02-3512
AMERICAN SENIOR LIVING OF FORT WALTON BEACH d/b/a WESTWOOD HEALTH CARE,	)	
Respondent.	)	

RECOMMENDED ORDER

This cause came on for hearing before P. Michael Ruff, duly-designated Administrative Law Judge in Shalimar, Florida, on February 26, 2003. The appearances were as follows:

APPEARANCES

For Petitioner: Ursula Eikman, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308

For Respondent: Alex Finch, Esquire
Goldsmith, Grout & Lewis, P.A.
Post Office Box 2011
Winter Park, Florida 32790

STATEMENT OF THE ISSUES

The issues to be resolved in this proceeding concern whether the Respondent should be accorded a "Conditional" or "Standard" rating as to its licensure and whether it should be

subjected to an administrative fine and, if so, in what amount.

PRELIMINARY STATEMENT

This cause arose from a survey conducted of the above-named Respondent's facility (Westwood). Westwood is a skilled nursing facility located in Fort Walton Beach, Florida. The Agency conducted its annual re-certification survey on June 25-27, 2001. The Agency thereafter cited Westwood for a deficiency (known by the acronym "FTag 324"). This deficiency under the federal regulatory scheme adopted and enforced by the Agency has a scope of severity of "G." That severity rating equates to the State of Florida classification of the deficiency as a "Class II deficiency." Because of this the Agency would impose a conditional licensure status on Westwood and an administrative fine, proposed to be $2,500.00. Westwood maintains that the deficiency did not exist at the time of or prior to the survey, and that Westwood is entitled to a standard license and should not be subjected to a fine.

The Petitioner filed a formal Administrative Complaint on July 30, 2002, initiating this case and its transmittal to the Division of Administrative Hearings. The Complaint set forth allegations of fact supporting the Agency's intent to impose a conditional licensure rating and an administrative fine. The Respondent chose to contest the matter and timely filed a Petition as to both the licensure case and the administrative

fine proceeding which have been accorded the DOAH Case Nos. 02-3510 and 02-3512 (now consolidated under the lowest case number).

The cause came on for hearing as noticed. The Petitioner/Agency called two witnesses to testify at the hearing and offered 17 Exhibits which were admitted into evidence. The Respondent, Westwood, called three witnesses and offered two Exhibits which were admitted into evidence. The parties elected to transcribe the proceedings and avail themselves of the opportunity to submit Proposed Recommended Orders. The Proposed Recommended Orders have been considered in the rendition of this Recommended Order.

FINDINGS OF FACT

1. The Petitioner is an Agency of the State of Florida which conducts licensure surveys of nursing homes on an annual basis to ensure compliance with the state licensure requirements and federal certification requirements that the Petitioner Agency is statutorily charged with enforcing. A survey results in a report called a "Form 2567," which lists the deficiencies and their factual basis. A federal scope and severity classification, identified by the letters A-L, and a State classification scale or system identified by I-IV are assigned to any deficiency.

2. The Respondent is a licensed, skilled nursing home facility located at 1001 Mar Drive, Fort Walton Beach, Florida 32548. The Respondent at all times pertinent hereto was a long-term Medicare provider and subject to Title 42, Code of Federal Regulation (CFR) Section 483.

3. When a deficiency is determined to exist, changes in a facility licensure rating or status are determined by the level or scope and severity of such deficiencies, as determined under the state classification provided for in the statutory authority cited and discussed below. Fines are also based on the scope and severity and state classification of deficiencies.

4. Between June 25-27, 2001, an annual re-certification survey (survey) was conducted of Westwood by the Petitioner Agency. Pursuant to that survey the Petitioner cited the Respondent for a "Class II " deficiency "FTag 324," as to which it was alleged that the Respondent had failed to provide adequate supervision and assistive devices to prevent resident number two from suffering falls. FTag 324 was cited under the federal scope and severity matrix or scale as a Level "G" deficiency. A level "G" deficiency equates to a Class II state deficiency severity level.

5. The Agency cited Westwood under Section 400.23(8)(b), Florida Statutes (2001), for failure to provide the necessary care and services, thereby compromising Resident two's ability

to attain or maintain her highest practicable physical, mental and psychosocial well-being, in accordance with a resident assessment and plan of care.

6. The deficiency was originally cited by the four licensed surveyors on the survey team as being a Class III deficiency, but was later changed to a Class II deficiency (more severe) after the completion of an informal dispute resolution (IDR) process. In that dispute resolution process the Respondent was allowed to participate, but was not allowed to argue the scope and severity of the alleged deficiency and was not accorded the right to counsel.

7. The Agency at hearing presented the testimony of Ms. Jackie Klug, a licensed surveyor who is trained and is registered as dietician. She was a surveyor responsible for the clinical record review, as to Resident two, and for interview of the staff at the Westwood facility, relating to the care provided to Resident two. She performed a limited clinical review of the records of Resident two. Ms. Klug is not a licensed nurse and does not have nursing training.

8. The Agency also presented the testimony of Ms. Susan Acker, who is the Agency representative responsible for supervision of the long-term care, quality monitoring program and who is responsible for determining compliance of facilities receiving Medicare and Medicaid funding. She was

qualified as an expert in nursing practice, surveying and survey practices. She was the Agency representative responsible for making the final determination as to the federal scope and severity of any potential deficiency and therefore the appropriate state classification of the deficiency.

9. Ms. Acker performed a limited record review of portions of Resident two's records supplied by facility representatives after an informal dispute resolution hearing. Ms. Acker did not perform an independent clinical review of the resident, but relied upon the records gathered by Ms. Klug.

10. After reviewing the documents provided to her after the IDR hearing, Ms. Acker determined that a federal scope and severity level of "G" existed, which equates to a state Class II deficiency or violation.

11. State surveyors apply a Long-Term Care Facility Enforcement Grid to determine the scope and severity of a potential deficiency. After the scope and severity is determined under the federal scale, a corresponding state classification is assessed. There is not a separate state classification determination apart from the federal scope and severity determination. When a level "G" federal scope and severity is determined, a state classification of Class II deficiency is automatically applied.

12. Under the Long-Term Care Facility Enforcement Grid and the state classification system, the alleged deficient practice must result in more than actual minimal harm and more than minimal discomfort in order to support a Class II designation.

13. Resident two was admitted to the facility on November 10, 2000. She was admitted to the facility with the diagnoses of tardive dyskinesia, Alzheimer's disease and an unsteady gait.

14. Within 11 days of being admitted to the facility, Resident two was assessed, which triggered a resident assessment plan or profile, and was determined to be at risk for falls. Resident two experienced approximately five falls starting on April 30, 2001, through June 23, 2001.

15. Resident two suffered no physical injuries after any of the falls except for the fall on June 23, 2001. She suffered minor injuries in that fall, consisting of a bruised chin and abrasion in the area of her eye and a small skin tear to her right wrist. The injuries were minimal in nature and required only basic first aid normally associated with common minor skin abrasions.

16. Resident two suffered no discomfort as a result of any fall other than the fall of June 23, 2001. Resident two was able to communicate pain or discomfort and had done so to the facility staff on a number of occasions. The records of

Resident two contain no indication of any complaints of pain or discomfort resulting from any of the falls, and Resident two denied experiencing discomfort or pain as a result of any of the falls, including the fall of June 23, 2001.

17. The facility documents and the testimony of the Respondent's witnesses established that Resident two exhibited no sign of decreased or limited functioning subsequent to any recorded fall incidents. Resident two continued her daily social, mental and physical activities in the same manner as prior to any fall, after each of the falls she experienced. Resident two experienced no falls from the time of her admission on November 10, 2001, through April 29, 2002.

18. The Respondent was cited by the Petitioner in the Form 2567 for failure to provide adequate supervision and adequate assistive devices to prevent falls. Neither of the Agency witnesses at hearing was able to testify as to the exact level of supervision provided Resident two by the facility staff, nor could either witness testify as to the manner of the supervision of Resident two by the facility. Neither Agency witness provided any concrete evidence or recommendation as to what might constitute adequate supervision sufficient to ensure fall prevention of a resident in Resident two's physical and mental status and condition.

19. Neither the facility personnel nor the Agency personnel testifying were able to determine a cause or pattern for the falls of Resident two. Agency witnesses were unable to determine what, if any, facility action or inaction might have caused the falls. There is some indication in the evidence that Resident two may have experienced fluctuations in blood pressure which under certain circumstances can cause dizziness and, potentially, falling. Additionally, as to one of the falls, there is indication in the evidence that the resident's shoes or type of shoes and the edge or corner of a carpet may have caused her to trip. If it has not already done so, the Respondent should take all possible steps to ensure that areas where Resident two, or any other resident, may walk are free of hazards which might contribute to falling, should closely monitor blood pressure and take appropriate clinical steps to ensure, if possible, the stability of blood pressure to try to prevent falls. Similar steps should be taken as to any other medical or clinical condition which may contribute to falling.

20. Tardive dyskinesia is a condition resulting from the long-term use of psychotropic drugs. Although tardive dyskinesia may contribute to falls, if motor skills are affected, not all people affected by tardive dyskinesia have symptoms affecting their gait or ambulation. Resident two did not exhibit physical dysfunction to gross motor skills, but

rather exhibited "tongue thrusting" and "spitting." Ms. Acker, the Agency nursing expert testifying, indicated that tardive dyskinesia could not be determined within reasonable medical certainty to be the cause of any of Resident two's falls.

21. Although Resident two suffered from fluctuating blood pressure, which can contribute to falls if attendant dizzy spells occur, Resident two did not exhibit blood pressure symptoms or complications which actually caused physical dysfunction to her motor skills. Ms. Ackers indicated that blood pressure symptoms could not definitely be determined to be the cause of Resident two's falls. While such a fluctuation in blood pressure could not be determined to be the cause, based upon the evidence offered by Ms. Ackers or otherwise at the hearing, blood pressure fluctuation as a possible cause of the falling cannot be ruled out.

22. Resident two was subject to the facility's general falls policy and a special fall prevention program known as "falling leaves." The facility's fall prevention policies were in conformance with generally accepted nursing home standards and customary policies utilized within the skilled nursing community or industry. The representatives of the Agency did not review the fall prevention policies of the facility when determining the existence of a deficiency and were unaware of

the content of the facility policies for fall prevention at the time of the hearing.

23. The fall prevention policies of the Respondent's facility were applied to Resident two. The Respondent supervised Resident two by placing her at a nurses station, within four feet of a charge nurse, so that she could be closely monitored. The Respondent also provided assistive devices in the form of a walker, to assist Resident two in safely ambulating. The walker is intended and designed to prevent falling which might result from the unsteady gait of Resident two.

24. Resident two suffered from Alzheimer's disease. She was thus unable to remember simple instructions or to use assistive devices provided to her by the facility on a consistent basis. This behavior is consistent with certain stages of Alzheimer's disease, where patients or residents are unable to remember even simple instructions for any period of time.

25. The Respondent did provide memory assistive devices, such as tethered alarms and visual aids, on her walker to assist Resident two in remembering to use her walker. She would sometimes impulsively arise and walk on her own, without the protection of using a walker.

26. Physical therapy training to assist Resident two in ambulation was not appropriate. Resident two was unable to assimilate, incorporate and remember such training in her daily activities because of her Alzheimer's condition. Ms. Watson, a trained physical therapist, testified that physical therapy would have been unavailing in regard to Resident two, essentially because she was unable to remember physical therapy instructions or training modalities.

27. In fact, Resident two was physically able to quickly rise from a sitting position and to ambulate without any real notice to staff members. Although staff members were positioned in close proximity to Resident two on a frequent basis, Resident two could still begin to ambulate quickly, without notice in time for the staff to act to protect her in all circumstances. As a result of her Alzheimer's condition, restraints were an inappropriate measure to prevent unexpected ambulation. Prior to using restraints, a treating physician must provide a physician's order for such restraints. The treating physician for Resident two was aware of her falls, but still did not provide an order for restraints.

CONCLUSIONS OF LAW

28. The Division of Administrative Hearings has jurisdiction of the subject matter of and the parties to this

proceeding. Section 120.57, Florida Statutes, and Section 120.569, Florida Statutes, (2001).

29. Chapter 59A-4, Florida Administrative Code, is the applicable administrative code chapter governing nursing home facilities. The Petitioner Agency has the authority to survey and rate skilled nursing home facilities pursuant to Section 400.23(7), Florida Statutes (2001). It has jurisdiction over the Respondent, pursuant to Chapter 400, Part II, Florida Statutes, and Chapter 59A-4, Florida Administrative Code. Moreover, the Agency has the authority under Section 400.23(8), Florida Statutes (2001), to indicate the classification of a deficiency, and under Section 400.23(7)(b), Florida Statutes (2001), to assign a conditional rating.

30. Section 400.23(7)(b), Florida Statutes (2001), provides in part that "A conditional license status means that a facility, due to the presence of one or more Class I or Class II deficiencies . . . is not in substantial compliance at the time of the survey."

31. Through Section 400.23(2)(f), Florida Statutes (2001), the federal statutes and regulations relating to ". . . the care, treatment, and maintenance of residents and measurement of the quality and adequacy thereof" have been adopted in state law. The Agency has adopted the federal matrix as the determination of a deficiency classification.

32. The Agency has the burden of proof and persuasion in this matter in that it is asserting the affirmative of the issue. See 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).

33. Section 400.23(8), Florida Statutes, defines class deficiencies as follows:

> (a) 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. . .
>
> (b) A Class III deficiency is a deficiency that the agency determines will result in no more than minimal physical, mental or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable physical, mental, or psychosocial well-being as defined. . . (emphasis added)
>
> (c) A Class IV deficiency is a deficiency that the agency determines has the potential for causing no more than a minor negative impact on the resident . . . Section 400.23(8)(b), Florida Statutes, (2001).

34. Section 400.34(7)(b), Florida Statutes (2001), provides that the Petitioner shall issue a Conditional License to the Respondent if the Respondent has any Class I or II

deficiencies at the time of an inspection or any Class III deficiencies that are uncorrected on re-inspection. This matter involves an alleged Class II deficiency.

35. The Agency must show by clear and convincing evidence that there exists a deficiency warranting the imposition of a conditional license or rating an administrative fine. See Department of Banking and Finance Division of Securities and Investor Protection v. Osborne Stern and Company, 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981).

36. Applying this standard of proof, the Petitioner has not established that a deficiency, under FTag 324, sufficient to support a Class II violation and imposition of conditional licensure against the Respondent, existed at the time of the survey. The Agency has asserted a violation of 42 CFR 483, a failure to provide appropriate supervision and adequate assistive devices to prevent falls. The Agency did not establish the precise manner of supervision or assistive devices and their nature including memory assistive methods provided for Resident two by the facility. The Agency witnesses, in essence, opined that they were inadequate because the resident was falling.

37. The Petitioner did not establish that the supervision and assistive measures provided were inadequate or insufficient to ensure that Resident two or persons with a similar clinical condition, would have a decreased risk of falls, although it is undisputed that she did suffer the five falls between the dates in question.

38. Ms. Ackers, the Agency expert, however had no definitive opinion as to what further assistive devices or measures, in addition to those actually utilized by the facility, could have been taken to help prevent the falling by Resident two. The Petitioner, through its witness, conceded that the fact that a fall occurs is not necessarily evidence of a deficient or failed practice or level of care by a facility.

39. Nevertheless, Resident two had started as of April 29, 2001, to exhibit a pattern of falling, having fallen five times in less than two months. Consequently, it certainly may be inferred that heightened supervision and preventive devices, methods or modalities should have been employed to prevent such falling in the future, to the extent possible. Other devices may be necessary, in addition to a walker, which would prevent the resident from suddenly arising and walking before the staff has an opportunity to observe her ambulation, so that she could not fall before she could be observed. Closer monitoring of the patient and more aggressive steps to stabilize

the resident's blood pressure might be indicated. In any event, inferentially, supervision needed to be closer and more effective in order to prevent the falls.

40. The falling did not cause other than minimal physical discomfort, which was transitory. It does however have the potential to compromise the resident's ability to maintain or reach her highest practicable physical, mental or psychosocial well-being. Consequently, although a Class II deficiency has not been established, the evidence does establish the existence of a Class III deficiency because the physical discomfort was minimal, but the falling risk has the potential to compromise the residents ability to maintain physical well-being.

41. In order to establish a Class II deficiency, the Agency would have to prove by clear and convincing evidence that the resident suffered more than minimal harm or discomfort as a result of a deficient practice. Although Section 400.23(8)(b), Florida Statutes, does not set forth a specific standard for determining a "compromise" of mental, physical or psychosocial well-being, sufficient to support a Class II citation, the Agency expert, Ms. Ackers, and the license surveyor, Ms. Klug, both testified that the State adopts and automatically applies a state classification which correlates to a federal scope and severity level. Therefore, since the Agency has adopted and uses the federal scope and severity level "G" to correspond to

the state classification of Class II, the Agency must demonstrate that, as a result of a deficient facility practice, Resident two suffered actual harm which was more than minimal and involved discomfort. The Agency failed to show that Resident two suffered harm which was more than minimal in nature and which involved discomfort. The evidence is un-controverted that Resident two suffered physical injuries only after the fall of June 23, 2001. These injuries were minimal in nature. Additionally, Resident two showed no signs of and described no discomfort after the falls. When she was asked if she was feeling pain or discomfort, she denied having such.

42. The Agency must demonstrate the harm suffered by Resident two caused her to fail to maintain or attain her highest practicable level of physical, mental or psychosocial well-being. See Section 400.23(8)(b), Florida Statutes (2001). The Agency did not establish that Resident two's physical, psychosocial or mental functioning was impaired in any fashion as a result of any of the falls. The Agency witnesses testified that the clinical records showed no change in functioning of the resident as a result of any fall. The overwhelming weight of evidence was that, other than minor bruising and a scratch, Resident two remained essentially unchanged in all material respects after any of the falls established by the evidence. Therefore, the Petitioner did not establish that the mental,

psychosocial or physical well-being of Resident two was compromised by any deficient practice of the facility or by the occurrence of any fall.

43. Section 400.23(8)(a)-(c), Florida Statutes (2001), provides the basis upon which the Petitioner may impose a civil monetary penalty upon the Respondent for a cited deficiency. This Section provides.

> (b) . . . A Class II deficiency is subject to a civil penalty in an amount not less than $1,000.00 and not exceeding $10,000.00 for each and every deficiency. . . If a Class II deficiency is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.
>
> (c). . . A Class III deficiency is subject to a civil penalty in an amount not less than $500.00 and not exceeding $2,500.00 for each and every deficiency. . . If a Class III deficiency is corrected within the time specified, no civil penalty shall be imposed, unless it is repeated offense.

44. The Agency has the burden to establish the existence of the violation or deficiencies. The Agency has established by clear and convincing evidence that a Class III violation has occurred for the reasons and in the manner delineated above. It has not established that the violation is continuing uncorrected.

45. Having considered the foregoing Findings of Fact, Conclusions of Law, and the authority cited above, it is determined that a $500.00 fine for the Class III violation

should be imposed, and that no conditional licensure should be imposed but rather the Respondent be maintained with a standard license.

RECOMMENDATION

Having considered the foregoing Findings of Fact, Conclusions of Law, the evidence of record, the candor and demeanor of the witnesses, and the pleadings and arguments of the parties, it is, therefore recommended that the Agency for Health Care Administration enter a Final Order according a standard license to Westwood and imposing a fine in the amount of $500.00 for a Class III violation.

DONE AND ENTERED this 9th day of July, 2003, in Tallahassee, Leon County, Florida.

P. MICHAEL RUFF
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 9th day of July, 2003.

COPIES FURNISHED:

Ursula Eikman, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308

Alex Finch, Esquire
Goldsmith, Grout & Lewis, P.A.
Post Office Box 2011
Winter Park, Florida 32790

Lealand McCharen, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Valda Clark Christian, General Counsel
Agency for Health Care Administration
Fort Knox Building, Suite 3431
2727 Mahan Drive
Tallahassee, Florida 32308

NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the final order in this case.