STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case Nos. 02-3950 02-3951
ROCKLEDGE NH, L.L.C., d/b/a ROCKLEDGE HEALTH AND REHABILITATION CENTER,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its duly-designated Administrative Law Judge, Jeff B. Clark, held a formal administrative hearing in this case on December 19, 2002, in Viera, Florida.

APPEARANCES

For Petitioner: Joanna Daniels, Esquire
Agency for Health Care Administration
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For Respondent: Alex Finch, Esquire
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STATEMENT OF THE ISSUES

(1) Whether Respondent, Rockledge NH, L.L.C., d/b/a Rockledge Health and Rehabilitation Center, should be given a

"Conditional" or "Standard" license effective February 12, 2002, or March 7, 2002; (2) Whether Respondent is subject to an administrative fine in the amount of $2,500.

PRELIMINARY STATEMENT

On August 6, 2002, Petitioner, Agency for Health Care Administration, filed two Administrative Complaints notifying Respondent that it intended to (1) impose a Conditional licensure status effective March 7, 2002, based on one Class II deficiency as defined by Subsection 400.23(8)(b), Florida Statutes (2001), and (2) impose an administrative fine in the amount of $2,500 pursuant to Subsections 400.022(1)(o), 400.022(3), 400.102(1)(a), 400.102(2), 400.121(1), and 400.23(8)(b), Florida Statutes.

On September 20, 2002, and October 2, 2002, Respondent filed its Amended Petitions for Formal Administrative Hearing, Motions to Dismiss and Answers in the Alternative to Administrative Complaints.

On October 11, 2002, Petitioner forwarded a Notice to the Division of Administrative Hearings advising of Respondent's request for formal administrative hearing. On October 14, 2002, an Initial Order was sent to both parties. On October 28, 2002, Respondent filed a Motion to Consolidate in both cases. On November 1, 2002, an Order of Consolidation was entered.

On November 5, 2002, the consolidated cases were scheduled for final hearing in Viera, Brevard County, Florida, on December 19, 2002.

On November 15, 2002, an Order Denying Motions to Dismiss was entered. Petitioner had filed a Motion to Strike Respondent's Motion to Dismiss on November 8, 2002, which was not docketed by the Clerk of the Division of Administrative Hearings. Denying Respondent's Motion to Dismiss effectively denies Petitioner's Motion to Strike. Petitioner's Motion to Supplement Docket filed January 29, 2003, as amended January 30, 2003, is granted.

The final hearing took place as scheduled on December 19, 2002. Petitioner presented one witness, Theresa DeCanio, R.N., who was qualified as an expert witness, and presented ten exhibits which were received into evidence and marked Petitioner's Exhibits 1 through 10. A portion of the December 12, 2002, deposition of Theresa DeCanio, as identified in the Transcript, was also considered. Respondent presented one witness, Elaine Leslie, R.N. Respondent did not offer any exhibits.

The Transcript was filed with the Division of Administrative Hearings on January 10, 2003. By agreement of the parties, confirmed by the undersigned, the parties had

30 days from the filing of the Transcript to submit proposed recommended orders. Both parties timely filed Proposed Recommended Orders, which were thoughtfully considered.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing, the following findings of fact are made:

1. Respondent operates a skilled nursing home located at 587 Barton Boulevard, Rockledge, Brevard County, Florida.

2. Petitioner is the State of Florida agency responsible for licensure and regulation of nursing home facilities in Florida. Respondent was, at all times material to this matter, licensed by Petitioner and required to comply with applicable rules, regulations, and statutes, including Sections 415.1034 and 400.022, Florida Statutes.

3. On or about March 7, 2002, Petitioner conducted a complaint survey of Respondent.

4. Petitioner's surveys and pleadings assign numbers to residents in order to maintain the residents' privacy and confidentiality. The resident who was the subject of the Class II deficiency from the March 7, 2002, complaint survey has been identified as Resident number 1, with the initials "H.C."

5. Resident number 1 is 82 years old and was admitted to Respondent's facility on January 19, 2002, with diagnoses of dementia, back pain from multiple falls, hypertension,

osteoarthritis, recurrent bronchitis, and chronic obstructive pulmonary disease.

6. At all times material to this matter, Resident number 1 was a "vulnerable adult" as defined in Subsection 415.102(26), Florida Statutes.

7. On February 5, 2002, at approximately 9:50 p.m., a certified nursing assistant employed by Respondent went into Resident number 1's room to see why Resident number 1 was yelling.

8. Upon entering the room, the certified nursing assistant found Resident number 1's bed positioned in such a way that his head was down and his feet were up. A blanket had been tied across the "up" end of the bed securing Resident number 1's feet allowing him to be held in a "head down" position. The certified nursing assistant who investigated the yelling "pulled on the blanket to verify that it was tied down."

9. There were no prescriptions or written orders justifying the restraint of Resident number 1.

10. The certified nursing assistant who found Resident number 1 in the above-described position identified a different certified nursing assistant, one provided to Respondent by a staffing agency, as the caregiver for the shift in question. The alleged abusive act was perpetrated by the certified nursing assistant provided by the staffing agency.

11. The certified nursing assistant provided by the staffing agency placed Resident number 1 in a position that was contraindicated for a person with a diagnosis of chronic obstructive pulmonary disease.

12. Respondent's certified nursing assistant waited approximately two days before reporting the alleged abusive act to the abuse hotline, Respondent's abuse coordinator or the Director of Nursing.

13. A medical record review indicated that Resident number 1 was sent to the hospital on February 22, 2002, for shortness of breath and again on February 26, 2002, for difficulty in breathing and lung congestion. The History and Physical from the hospital, dated February 23, 2002, revealed that Resident number 1 was sent to the hospital because of progressive shortness of breath. Resident number 1's lower extremities were documented to have been severely edematous with "skin changes subsequent to chronic stasis and edema with excoriation, loss of circulation, blisters, etc."

14. The certified nursing assistant provided by the staffing agency had a full resident assignment and cared for several residents the day of the alleged abusive act. After the discovery of the alleged abuse, the certified nursing assistant provided by the staffing agency continued to care for Resident

number 1 and other residents assigned to her for approximately one hour or until the end of her shift.

15. Documentation, dated March 8, 2002, from the staffing agency, confirmed that the certified nursing assistant provided by the staffing agency did have education in the current rules and regulations related to the abuse and neglect of the elderly.

16. Petitioner's surveyor believed that the failure to immediately report the alleged abuse constituted a Class II deficiency because the certified nursing assistant provided by the staffing agency was allowed to continue to care for Resident number 1 and other residents until the shift ended and could have further abused Resident number 1 or other residents in her care.

CONCLUSIONS OF LAW

17. Division of Administrative Hearings has jurisdiction over the parties and subject matter of this proceeding. Section 120.569 and Subsection 120.57(1), Florida Statutes.

18. Petitioner is the regulatory authority responsible for licensure and enforcement of all applicable statutes and rules governing nursing home facilities pursuant to Chapter 400, Part II, Florida Statutes, and Chapter 59A-4, Florida Administrative Code.

19. Petitioner has the burden of proof. It must establish that the allegations contained in the Administrative Complaints

warrant the imposition of a Conditional license and an administrative fine. 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).

20. The quantum of proof required to change Respondent's license from Standard to Conditional is a preponderance of the evidence. Subsection 120.57(j), Florida Statutes. The quantum of proof required to impose an administrative fine is clear and convincing evidence. 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).

21. In its Administrative Complaints, Petitioner asserts that Respondent violated Section 415.1034, Florida Statutes, which requires nursing home staff to immediately report abuse of a vulnerable adult to the central abuse hotline; that the foregoing constitutes a violation of Subsections 400.022(1)(o) and 400.022(3), Florida Statutes, which require Respondent to ensure the residents' right to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by emergency. Petitioner

alleges this inaction was also an intentional or negligent act materially affecting the health or safety of the residents of the facility, a violation of Subsection 400.102(1), Florida Statutes.

22. Subsection 415.1034(1), Florida Statutes, reads, in pertinent part, as follows:

> (a) Any person, including, but not limited to, any:
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> * * *
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> 4. Nursing home staff; assisted living facility staff; adult day care center staff; adult family-care home staff; social worker; or other professional adult care, residential, or institutional staff;
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> * * *
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> who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the central abuse hotline.

23. Subsection 400.022(1)(o), Florida Statutes, reads, as follows:

> (1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:
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> * * *

(o) The right to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint, and, in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter. Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.

24. Subsection 400.22(3), Florida Statutes, reads as follows:

(3) Any violation of the resident's rights set forth in this section shall constitute grounds for action by the agency under the provisions of s. 400.102. In order to determine whether the licensee is adequately protecting residents' rights, the annual inspection of the facility shall include private informal conversations with a sample of residents to discuss residents' experiences within the facility with respect to rights specified in this section and general compliance with standards, and consultation with the ombudsman council in the local planning and service area of the Department of Elderly Affairs in which the nursing home is located.

25. Subsection 400.102(1), Florida Statutes, reads, as follows:

(1) Any of the following conditions shall be grounds for action by the agency against a licensee:

> (a) An intentional or negligent act materially affecting the health or safety of residents of the facility;
> (b) Misappropriation or conversion of the property of a resident of the facility;
> (c) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a nursing home resident;
> (d) Violation of provisions of this part or rules adopted under this part;
> (e) Fraudulent altering, defacing, or falsifying any medical or nursing home records, or causing or procuring any of these offenses to be committed; or
> (f) Any act constituting a ground upon which application for a license may be denied.

26. Petitioner has failed to demonstrate the applicability of Section 415.1034, Florida Statutes, to the reduction of licensure status and imposition of an administrative fine. Chapter 415, Florida Statutes, specifically calls upon "persons" to report abuse, not "facilities." Section 415.111, Florida Statutes, provides criminal penalties for "a person who knowingly and willfully fails to report a case of known or suspected abuse . . ." There is no provision in the Adult Protective Services Act (Chapter 415, Florida Statutes) to penalize a facility for failure of its employees to report abuse.

27. The Adult Protective Services Act makes a nursing home facility immune from vicarious liability for the acts or omissions of its agents or employees for civil actions brought

under Section 415.1111, Florida Statutes. In Mora v. South Broward Hospital District, 710 So. 2d 633 (Fla. 4th DCA 1998), there is an extensive discussion of legislative intent related to civil and criminal penalties and immunity. While dismissing a tort action against a nursing home facility based on the failure of an employee to report abuse, the court indicated reliance on PW Ventures, Inc. v. Nichols, 533 So. 2d 281 (Fla. 1988) (express mention of one thing implies the exclusion of another). Had the legislature intended the Adult Protective Services Act to extend responsibility to nursing homes for the failure of its employees to report cases of suspected abuse, it could have done so.

28. Had Respondent been charged with abuse of a resident through the acts of an employee for improperly restraining a resident, a violation may have existed. Unfortunately, the surveyor charged Respondent with failing to immediately report abuse of a vulnerable adult to the central abuse hotline. Chapter 415, Florida Statutes, does not require the facility, as opposed to the employees of the facility, to immediately report the alleged or suspected abuse.

29. Assuming, arguendo, that the certified nursing assistant who discovered the suspected abuse had immediately reported it at 9:50 p.m. to the Department of Children and Family Services abuse hotline, it is unlikely that a report of

the type of suspected abuse in the instant case would have evoked an "immediate" response, as defined in Section 415.103, Florida Statutes, as opposed to a "24 hour or next working day" response. In any event, no evidence was presented to support the position asserted by Petitioner that immediate reporting would have protected Resident number 1 and other residents from abuse.

30. A vulnerable adult's right to be free from physical abuse and restraint as contemplated by Subsection 400.022(1)(o), Florida Statutes, does not equate to the failure to report suspected abuse in violation of Chapter 415, Florida Statutes.

RECOMMENDATION

Based on the Foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that the Administrative Complaints in this matter be dismissed and Respondent's licensure status be returned to Standard for the period it was Conditional and that no administrative fine be levied.

DONE AND ENTERED this 18th day of February, 2003, in Tallahassee, Leon County, Florida.

JEFF B. CLARK
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 18th day of February, 2003.

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.