STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case Nos. 02-1421
	)	02-1905
DELTA HEALTH GROUP, d/b/a ROSEWOOD MANOR,	)	02-4040
Respondent.	)	

RECOMMENDED ORDER

Notice was provided, and a formal hearing was held on October 24 and 25, 2002, in Pensacola, Florida, and conducted by Harry L. Hooper, Administrative Law Judge with the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Lori C. Desnick, Esquire
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For Respondent: R. Davis Thomas, Jr., Esquire
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STATEMENT OF THE ISSUES

In DOAH Case No. 02-1421, addressing a survey concluded on October 23, 2001, the issue is whether Respondent Delta Health

Group, doing business as Rosewood Manor (Rosewood), violated Rule 59A-4.1288, Florida Administrative Code and should be assessed a civil penalty and costs. In DOAH Case Nos. 02-1905 and 02-4040, addressing the survey of January 22 through January 25, 2002, the issue is also whether Rosewood violated Rule 59A-4.1288, Florida Administrative Code. In DOAH Case No. 02-1905, the issue is whether a conditional license should issue. In DOAH Case No. 02-4040, the issue is whether civil penalties and costs should be assessed.

PRELIMINARY STATEMENT

On March 5, 2002, the Agency for Healthcare Administration (AHCA) filed an Administrative Complaint alleging a violation of Title 42, Code of Federal Regulations, Section 483.25(h)(2); Section 400.23, Florida Statutes; and Rule 59A-4.1288, Florida Administrative Code, in DOAH Case No. 02-1421. This action was based on a survey conducted on October 23, 2001. This complaint alleged in Count I that Rosewood failed to ensure that a resident's environment remained as free of accident hazards as possible and asserted that a Class II deficiency should be found. This count suggested the imposition of a $5,000 civil penalty and an assessment for costs related to the investigation and prosecution of the case. Count II alleged that two Class II

deficiencies had arisen within a 60-day period and suggested that Rosewood be subject to a six-month survey cycle and a $6,000 civil penalty.

On March 18, 2002, Rosewood filed a Petition for Formal Administrative Hearing. The matter was forwarded to the Division of Administrative Hearings (Division) where it was filed April 10, 2002. The case was set for hearing on July 31, 2002, in Pensacola, Florida. On July 19, 2002, Rosewood moved for a continuance. AHCA did not object to the continuance. Accordingly, the parties were advised to determine an appropriate time for the hearing. After receiving responses from both parties, the case was set for hearing on October 22, 2002, in Pensacola, Florida. Subsequently, Rosewood moved to consolidate this case with DOAH Case No. 02-3405, and in response, an Order of Consolidation was entered.

On April 9, 2002, AHCA issued a Notice of Intent to Assign Conditional Licensure Status as a result of a survey completed on January 25, 2002. This action was based on alleged Class II violations of Rule 59A-4.1288, Florida Administrative Code, for failure to prevent the recurrence of a pressure sore and failure to ensure residents received adequate supervision to prevent accidents.

On April 18, 2002, a Petition for Formal Administrative Hearing was filed with AHCA. On May 9, 2002, the case was

forwarded to the Division for hearing. The case was set for hearing on August 8 and 9, 2002, in Pensacola, Florida. On July 30, 2002, AHCA filed a Motion for Continuance. Accordingly, the parties were advised to determine an appropriate time for the hearing. After receiving responses from both parties the case was set for hearing on October 23 and 24, 2002, in Pensacola, Florida.

On September 11, 2002, AHCA filed a Motion to Reschedule Hearing. After a status conference the case was set to be heard with DOAH Case Nos. 02-1421 and 02-3405, on October 23 and 24, 2002, in Pensacola, Florida.

On October 10, 2002, counsel for AHCA signed an Administrative Complaint, in the case of Rosewood, which was also based on the survey completed January 25, 2002. This complaint sought civil penalties and an assessment for costs related to the investigation and prosecution of the case. This action alleged violations of Rule 59A-4.1288, Florida Administrative Code, based on allegations that Rosewood failed to ensure that a resident with pressure sores received necessary treatment and services to promote healing, to prevent infection, and to prevent new sores from developing.

Rosewood filed a Petition for Formal Administrative Hearing on October 11, 2002. The matter was filed with the Division on October 17, 2002. It was agreed by the parties that this case,

DOAH Case No. 02-4040, would be consolidated with DOAH Case Nos. 02-1421, 02-1905, and 02-3405, on October 24 and 25, 2002.

On October 24 the hearing commenced on all four cases. Rosewood moved for a recommended order of dismissal in DOAH Case No. 02-3405, based on res judicata. AHCA objected for failure to comply with the time periods set forth in Rule 28-106.204, Florida Administrative Code. Accordingly, the motion was not decided and evidence was taken on all four cases.

On October 31, 2002, in a telephonic hearing, argument was heard on the motion. On November 7, 2002, a Recommended Order of Dismissal was entered in DOAH Case No. 02-3405. No final order in this case has been provided to the Administrative Law Judge. This Recommended Order is written on the basis that Case No. 02-3405 has been concluded.

At the final hearing AHCA called the following witnesses: Marcia Steel, R.N.; Sandra Corcoran, R.N.; and Judith Salpetr, R.N.; and had 14 exhibits admitted into evidence. Rosewood called one witness, Howard Thomas Hulsey, R.N., and had seven exhibits admitted.

A Transcript was filed on November 12, 2002. Proposed Recommended Orders were timely filed on December 4, 2002, by both parties and considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. AHCA is the state agency responsible for licensure and enforcement of all applicable statutes and rules governing nursing homes in Florida pursuant to Sections 400.021 and 400.23(7), Florida Statutes.

2. Rosewood is a skilled nursing facility located at 3107 North H Street, Pensacola, Florida, holding license no. SNF1482096, which was issued by AHCA.

3. Although not found in any rule, an unofficial standard in the industry requires that a resident be observed every two hours. This standard, when complied, is usually not documented.

4. On September 11, 2001, AHCA conducted a survey of Rosewood's skilled nursing facility. During the survey AHCA concluded that the facility failed to ensure that a resident's environment remained as free as possible of accident hazards. Specifically, the AHCA surveyors determined that the door to a bio-hazardous storage area had been, either purposely or inadvertedly, propped open instead of being locked, and as a result, a resident entered the area, and injured himself with used hypodermic needles stored therein.

5. Subsequently, on December 6, 2001, AHCA filed a Notice of Intent to Assign Conditional Licensure Status, based on the September 11, 2001, survey. The Notice was dated November 29, 2001. The Notice had attached to it an Election of Rights for

Notice of Intent. Prior to December 10, 2001, the Election of Rights for Notice of Intent was returned to AHCA indicating that the factual allegations contained in the Notice of Intent to Assign Conditional Licensure Status were not disputed.

6. On January 30, 2002, ACHA filed its Final Order. This Final Order incorporated the Notice of Intent dated November 29, 2001, and recited, that by not disputing the facts alleged, Rosewood admitted the allegations of fact. However, Rosewood did not admit the facts alleged. Rosewood merely stated that it would not contest the facts.

The Survey of September 11, 2001.

7. Resident 1 suffered from dementia, congestive heart failure, and epilepsy. He had a history of psychiatric problems. He was known by the staff to engage in aggressive behavior. Resident 1 was a "wanderer," which, in nursing home jargon, is a person who moves about randomly and who must constantly be watched.

8. On May 24, 2002, Resident 1 attempted to get in another resident's bed and when a staff member attempted to prevent this, he swung at her but missed.

9. On the morning of August 28, 2001, Resident 1 wandered in the biohazard storage room, which was unlocked and unguarded. Resident 1 succeeded in opening a Sharp's container which was used for the storage of used hypodermic needles. His handling

of these needles resulted in numerous puncture wounds. These wounds could result in Resident 1 contracting a variety of undesirable diseases. Because he died soon after of other causes it was not determined if he contracted any diseases as a result of the needle sticks.

10. This incident resulted from Rosewood's failure to prevent Resident 1 from wandering and from Rosewood's failure to ensure that harm did not befall their resident.

The Survey of October 23, 2001.

Resident 1A

11. Resident 1A was admitted to Rosewood on May 31, 2001. At times pertinent he was 87 years of age. He suffered from a urinary tract infection, cardiomyopathy, congestive heart failure, hypertension, degenerative joint diseases, and a past history of alcoholism.

12. On May 16, 2001, he struck a nursing assistant.

13. He was diagnosed by a psychiatrist on October 31, 2001, as having dementia. He was also known by Rosewood staff to be a wanderer.

14. On September 7, 2001, this resident engaged in combat with his roommate. Resident 1A was the loser in this contest. When found by staff, his fellow combatant had him in a headlock

and was hitting him with a metal bar. The resident suffered facial lacerations as a result. The facility responded to this event by moving Resident 1A into another room.

15. Resident 1A's care plan of September 10, 2001, had a goal which stated that, "Resident will have no further incident of physical abuse toward another resident by next care plan review."

16. On October 4, 2001, the resident entered the room of a female resident and physically abused her. This resulted in this resident's being beaten by the resident with the help of another. Resident 1A suffered cuts and bruises from this encounter. As a result, Rosewood implemented a plan on October 4, 2001, which required that Resident 1A be observed every 15 minutes. Prior to that time he was observed at least every two hours, which is the standard to which Rosewood aspires. Subsequent to this altercation Resident 1A was evaluated by a psychiatrist. The psychiatrist did not recommend additional observation.

17. On October 5, 2001, early in the morning, the resident was physically aggressive to staff and backed a wheelchair into another resident. The other resident struck Resident 1A twice in response. Later in the day, the resident also attempted to touch a female nurse's breasts and to touch the buttocks of a female nursing assistant.

18. The evening of October 21, 2001, Resident 1A was found holding another resident by the collar while another was hitting the resident with his fist. Resident 1A suffered skin tears as a result.

19. There was no documentation that Resident 1A was or was not observed every 15 minutes as required by the care plan of October 4, 2001. He was provided with drugs on October 5, 2001, and October 17, 2001, in an attempt to ameliorate his aggressive behavior; however, the pharmaceuticals provided were unlikely to modify his behavior until four to six weeks after ingestion. On October 31, 2001, Resident 1A was discharged because he was determined to be a danger to others. He died in November 2001.

Resident 5

20. Resident 5 was admitted to Rosewood August 15, 1998.

21. Resident 5 suffered from atrial fibrillation, cardiovascular accident, and pneumonia, among other maladies. Resident 5 was at high risk for accidents. Specifically, he was at risk from falling. In his admissions history dated August 15, 1998, it was noted by Dr. Michael Dupuis that, "If he attempts to stand, he falls." Indeed, the record reveals dozens of falls which occurred long before the survey of October 23, 2001.

22. In response to Resident 5's propensity to fall, Rosewood tried self-opening seat belts while in his wheelchair,

placement in a low bed, instituted a two-hour toileting schedule, and attempted to increase the resident's "safety awareness." Rosewood prepared a "Rehabilitation Department Screen" on June 8, 2001, to address the risk. This document indicated that the resident needed assistance with most activities.

23. In the evening of July 28, 2001, Resident 5 was found on the floor of his room. It was believed that he fell when trying to self-transfer from his bed to his wheelchair. He suffered no apparent injury.

24. On August 14, 2001, Resident 5 was found on the floor in the bathroom. He stated that he was trying to get into his wheelchair. He was not injured.

25. On August 29, 2001, Resident 5 was found lying on his side on the floor in a bathroom because he had fallen. He received two small skin tears in the course of this event.

26. On September 12, 2001, Resident 5 was found on the floor holding onto his bed rails. He was on the floor because he had fallen. He told the nurse that he fell while trying to get in bed. He did not suffer any injury during this event.

27. On October 5, 2001, Resident 5 was found lying on the floor in a puddle of blood. He had fallen from his wheelchair.

28. On October 7, 2001, Resident 5 fell in the bathroom while trying to get on the toilet.

29. On October 8, 2001, Resident 5 fell out of his wheelchair and was found by nursing staff lying on the floor in a puddle of blood. This event required a trip to a hospital emergency room. He received three stitches on his forehead and suffered a skin tear on his lower left forearm.

30. On October 14, 2001, Resident 5 was discovered by a nurse to be crawling on the floor. He denied falling and stated that he was just trying to get back in his wheelchair.

31. On October 20, 2001, Resident 5 fell out of his wheelchair.

32. Resident 5's care plan dated September 19, 2001, noted a history of falls and injury to himself and defined as a goal to prevent fall with no report of injury or incidents due to falling by the next review date. Methods to be used in preventing falls included assistance with all transfers, verbally cuing resident not to stand or transfer without assistance, ensurance that a call light and frequently used items were in reach, the provision of frequent reminders, and ensurance that his living areas were kept clean and free from clutter. Rosewood implemented a plan to encourage the resident to ask for assistance when transferring.

33. Subsequent to the June 8, 2001, evaluation, and the September 19, 2001, care plan, which called for a number of interventions, as noted above, Resident 5 continued to

experience falls. Resident 5's feisty personality and determination to transfer himself without assistance made it difficult for the facility to guarantee that he did not experience falls. It was noted by Nurse Steele that a care plan requiring one-on-one supervision is not required by AHCA. Nurse Steele, however, opined that perhaps one-on-one supervision would be the only practice which would guarantee that the resident would experience no falls.

The Survey of January 22-25, 2002.

Resident 12

34. Resident 12 suffered from osteoporosis, dementia, hyperthyroidism, transient ishemic attacks, urinary tract infection, urinary incontinence, anemia, and hypoglycemia, among other things.

35. Resident 12 was receiving nutrition through a tube so it was necessary to elevate the head of her bed to prevent pneumonia or aspiration.

36. Resident 12, at times pertinent, was immobile and was dependent on facility staff to accomplish all of her transfers and all activities of daily living including turning and repositioning.

37. As evidenced by numerous observations recorded on the "Braden Scale for Predicting Pressure Sore Risk," Resident 12 was at risk for developing pressure sores.

38. Resident 12 was observed by the facility with a pressure sore on the coccyx on December 21, 2001. A care plan had been created on October 12, 2002, providing that she was to be turned every two hours, and was to be provided with a pressure reduction mattress, and was to be kept clean and dry, among other actions. On December 24, 2001, it was noted in a "Data Collection Tool," that the resident's coccyx area was healed. On January 10, 2002, it was noted in Resident 12's care plan that the sore was fully healed.

39. During the survey Nurse Brown on one occasion observed a member of the facility's staff change a dressing over the resident's coccyx, observed the area, and determined that the resident had a pressure sore.

40. A pressure sore is a wound, usually over a bony area, such as the coccyx, which is caused by the weight of the body compressing flesh between the bony area and a bed or chair. Depending on the severity of the sore, pressure sores require a substantial period of time to heal. Pressure sores are graded as Stages I, II, III, or IV, with Stage IV being the most severe. Nurse Brown evaluated Resident 12 as having a Stage II pressure sore during the survey.

41. Nurse Brown observed Resident 12 on two occasions on January 22, 2002; on four occasions on January 23, 2002; on two occasions on January 24, 2002; and on four occasions on

January 25, 2002. On each of these occasions Resident 12 was lying on her back with her head elevated. She also observed the resident on several occasions sitting in a wheelchair. A wheelchair does not cause pressure on the coccyx.

42. A "Data Collection Tool" with an assessment date of January 18, 2002, indicated that on January 20, 2002, that there was present on Resident 12, a "coccyx split .25 cm superficial open area, left buttocks 2 cm dark gray rough area." On January 21, 2002, the "tool" noted, "left buttocks 2 cm open area darkened, coccyx split .25 cm remains." A "tool" dated January 25, 2002, noted, "open area on coccyx 2 cm." A "tool" dated February 1, 2002, noted "red area on buttocks" as did a "tool" dated February 8, 2002. A "tool" dated February 15, 2002, noted, "excoriation on buttocks" and on February 22, 2002, the notation was "red area on buttocks." A "Data Collection Tool" dated March 1, 2002, noted, "No open areas."

43. There is nothing in the records maintained by the facility which indicate that subsequent to the healing of the pressure sore on January 10, 2002, another pressure sore developed on Resident 12's coccyx.

44. Nurse Brown was an expert on pressure sores and she saw the area on the coccyx and determined it was a Stage II pressure sore. Thomas Hulsey, also a nurse and also an expert in nursing, observed the wound and concluded that it was merely

a skin split or excoriation likely caused by the resident's urinary incontinence. He also observed that after a short passage of time the wound disappeared, which is inconsistent with a pressure sore.

45. Considering the evidence as a whole, it is determined that the redness described subsequent to January 20, 2002, was something other than a pressure sore. The absence of a pressure sore tends, moreover, to indicate that what Nurse Brown observed was not indicative of the general care Resident 12 was typically receiving.

Resident 10

46. Resident 10, a woman 64 years of age, suffered from cardiovascular accident, dysphasia, decubitus ulcers, urinary tract infections, sclera derma, and seizures. She was unable to move any part of her body except for her left arm. Two to three caregivers were required to accomplish transfers.

47. On December 16, 2001, at about 9:45 in the morning, Lula Andrews, a certified nursing assistant, reported finding Resident 10 lying on her side or back on the floor of her room. At 9:10 a.m. Resident 10 had been seen in her bed so she could have been residing on the floor for as long as 35 minutes. Ms. Andrews and two other certified nursing assistants put her back in her bed. Resident 10 weighed about 150 pounds.

48. Ms. Andrews inquired of Resident 10 as to how she came to be resting on the floor and she replied she had, "blackened out." Resident 10 did not receive injuries in connection with this event. The bed was three to four feet above the floor. Ms. Andrews was suspended during an investigation of this incident.

49. Based on the evidence of record it could be deduced that Resident 10 fell from her bed or it could be deduced that Ms. Andrews attempted to transfer Resident 10 without assistance with the result that Resident 10 was dropped or deposited on the floor due to Ms. Andrews' inability to cope with Resident 10's bulk. The evidence of record fails to provide a basis for resolving this question. Neither scenario demands a finding that there was a failure to provide adequate supervision.

Resident 16

50. Resident 16 had a diagnosis of schizophrenia. She also had a seizure disorder, osteoarthritis, and hypothyroidism. She had a care plan addressing her potential to suffer falls.

51. On May 4, 2001, Resident 16 had a grand mal seizure while sitting on a piano stool. The 72-hour report generated by this event noted that she was not injured and refused all medications.

52. On September 29, 2001, Resident 16 had a seizure while sitting on a piano bench. She was playing the piano prior to

suffering the seizure. As a result of the seizure she fell backward and bumped her head. She denied experiencing pain from this event.

53. On October 3, 2001, Resident 16 was in the visitor's bathroom, alone, washing her hands. She was upright before the lavatory and when she attempted to sit down in her wheelchair she did not notice that it was not directly behind her. Therefore she missed the seat of the wheelchair and landed on the floor. She sustained no injuries. Nurse Brown opined that had Resident 16 been supervised properly this fall would not have occurred.

54. On December 17, 2001, Resident 16 was sitting on a piano bench when it appeared that she was fainting. One of the staff prevented her from actually falling over. The resident insisted that she was fine.

55. On January 18, 2002, a facility staff person saw Resident 16 about to fall forward from her wheelchair and attempted to catch her before she reached the floor. The staff member was unsuccessful and the resident struck her head on the floor, which resulted in a four-centimeter by four-centimeter bump on her head.

56. Resident 16's care plan required that facility staff closely supervise the resident. The facility also failed to

ensure that she received adequate doses, and properly prepared doses of her anti-seizure medicine.

Resident 20

57. Resident 20, during times pertinent, was a man of 96 years of age. He had a history of seizure disorder, depression, vascular dementia, gastro esophageal reflux disease, peptic ulcer disease, chronic obstructive pulmonary disease, coronary artery disease, and osteoporosis. He entered the facility on January 22, 1995.

58. On September 7, 2001, Resident 20 had a physical encounter with Resident 1A, who was his roommate. Resident 20 was found holding Resident 1A in a headlock and was pounding Resident 1A with a metal seat spine. As a result, Resident 1A received cuts and bruises. The facility was negligent in permitting Resident 20 access to the metal seat spine which could be used as a weapon.

59. The facility staff determined that Resident 20 was very territorial and that the appropriate solution would be to assign him a room so that he could be alone. Nevertheless, on November 10, 2001, a roommate was assigned to Resident 20. The resident complained and the new roommate was moved to another room. Resident 20's care plan was not revised to reflect his territorial nature.

60. On December 28, 2001, another resident was moved into Resident 20's room. On January 2, 2002, Resident 20 told a nursing assistant that the new roommate was wearing his, Resident 20's, clothes. The nursing assistant pacified Resident 20 and left the room. Shortly thereafter Resident 20 attacked his new roommate with a reach/grab device causing the new roommate to receive a cut. One of the surveyors, Nurse Salpetr opined that the nursing assistant was derelict in leaving Resident 20 alone with his new roommate. As a result of this incident Resident 20, pursuant to the Baker Act, was sent to a psychiatric hospital for evaluation.

CONCLUSIONS OF LAW

61. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding pursuant to Sections 120.57(1) and 435.07(3), Florida Statutes.

62. DOAH Case No. 02-1905 seeks to impose a conditional license upon the facility for violations of Rule 59A-4.1288, Florida Administrative Code. In these types of cases the agency has the burden to show by a preponderance of the evidence the facts alleged as the basis for the change in license statutes. Section 120.57(1)(j), Florida Statutes, and Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981). DOAH Case Nos. 02-1421 and 02-4040 seek civil

penalties and costs from the facility. In cases where the demand is for a civil penalty, the agency has the burden of proving by clear and convincing evidence that the facts allege support a civil penalty. Department of Banking and Finance v. Osborne Stern & Company, 670 So. 2d 932, 935 (Fla. 1996).

63. Section 59A-4.128 provides as follows:

> 59A-4.128. Evaluation of Nursing Homes and Licensure Status.
>
> (1) The agency shall, at least every 15 months, evaluate and assign a licensure status to every nursing home facility. The evaluation and licensure status shall be based on the facility's compliance with the requirements contained in this rule, and Chapter 400, Part II, F.S.
> (2) The evaluation shall be based on the most recent licensure survey report, investigations conducted by the AHCA and those persons authorized to inspect nursing homes under Chapter 400, Part II, F.S.
> (3) The licensure status assigned to the nursing home facility will be either conditional or standard. The licensure status is based on the compliance with the standards contained in this rule and Chapter 400, Part II, F.S. Non-compliance will be stated as deficiencies measured in terms of scope and severity.

64. Pursuant to Section 400.23, Florida Statutes, and Rule 59A4.1288, Florida Administrative Code, nursing homes of the category addressed herein are to follow certification rules and regulations found in Title 42 Code of Federal Regulations, Section 483.

65. Title 42, Code of Federal Regulations, Section 483.25(h), provides as follows:

> Section 483.25 Quality of care.
>
> 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.
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> * * *
>
> (h) Accidents. The facility must ensure that--
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> * * *
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> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

66. In deciding this case the fact-finder is guided by the definition of clear and convincing evidence provided in Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983) and quoted with approval by the Florida Supreme Court in In Re Davey, 645 So. 2d 398, 4004 (Fla. 1994).

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

67. Count I of DOAH Case No. 02-1421 alleged a failure to supervise Residents 1A and 5. Other than evidence as to unofficial standards requiring two-hour observations, no information is contained in the record which provides a written standard as to the requirements of "adequate supervision." Certainly 24-hour supervision would prevent most fights and falls as alleged in Count I. It is apparent, however, that nonstop supervision would be cost prohibitive and would encroach on the privacy of residents. Moreover, AHCA, according to Nurse Steele, does not require one-on-one supervision. Additionally, there are practical and legal limitations on the degree of restraint which may be applied to residents.

68. The issue of aggressive behavior was addressed in Woodstock Care Center v. HCFA, Decision No. CR623, U.S. Department of Health and Human Services, Departmental Appeals Board, dated November 1, 1999. Although this case does not define adequate supervision it does relate facts in which supervision was found to be inadequate. In Woodstock, one resident, 70 years of age, manifested 107 episodes of verbal aggression, 25 episodes of physical aggression, and was combative with caregivers on 28 occasions. Another resident attacked his fellow residents on at least six occasions. Many of these attacks were vicious and brutal and resulted in the victims being transported to the hospital.

69. In contrast, Resident 1A engaged in six recorded acts of violence and came out on the losing end of the combat in almost every case. Neither Resident 1A nor his victims suffered any serious injury. With the exception of the May 16, 2001, attack, all of the incidents occurred within a seven-week period leading up to his discharge from the facility.

70. In the case of Count I, addressing Resident 1A, AHCA did not prove by clear and convincing evidence that Rosewood failed to supervise the resident.

71. Resident 5 experienced at least nine documented falls during the period July 11, 2001, and October 20, 2001. At least one of the falls required a trip to the hospital. The genesis of most of these falls was the resident attempting to transfer himself out of the presence of caregivers, after he had been told repeatedly not to do so.

72. AHCA suggests that the cause and effect with regard to Resident 5 is obvious. In other words, it is postulated that because Resident 5 fell at least nine times during the time covered by the survey there was a lack of supervision. For that matter, Resident 5's record reveals that over a four-year period he fell dozens of times. His records also reveal a host of interventions. Nurse Steele had no suggestion as to how the falls could have been prevented absent one-on-one supervision.

73. The falls could have been a product of insufficient supervision. They also could have been, and likely were, the result of Resident 5's failure to adhere to instructions to request assistance. They could have been the result of bad luck or because Resident 5 was a risk taker. Because there are explanations for the falls other than poor supervision, it cannot be found by clear and convincing evidence that Rosewood failed to adequately supervise Resident 5. Therefore Count I of DOAH Case No. 02-1421 is not proven as to Resident 5. Because the bases for Count II were not proven, that count is not proven either.

74. Case No. 02-4040 alleged in Count I that the facility failed in the case of a resident's having a pressure sore, to provide necessary treatment for it, and to prevent new sores from developing. This was based on the survey of January 22-25. This allegation involved Resident 12. Resident 12 was observed with a pressure sore on December 21, 2001. She was cured of this by January 10, 2002. AHCA presented the testimony of Nurse Brown, an expert in the field of nursing, that Resident 12 acquired a Stage II pressure sore on her coccyx during the course of the survey. Nurse Hulsey, also an expert, opined that it was a skin split. The wound healed rapidly which is inconsistent with a Stage II pressure sore. Accordingly, AHCA failed to prove by clear and convincing evidence that Rosewood

failed to prevent a new sore from developing. There being no Class II deficiency, Count II also fails of proof.

75. The second Count II of the complaint alleges inadequate supervision in the case of Residents 10, 16, and 20.

76. Resident 10, a person who had no means of locomotion, was found on the floor, when she should have been in her bed. This probably occurred because of the negligence of a nursing assistant; however, no certain evidence of how Resident 10 came to be found on the floor was adduced. Accordingly, it cannot be concluded by clear and convincing evidence that Rosewood failed in its duty to supervise.

77. Resident 16 had at least three falls which staff failed to prevent, and another during which staff attempted, but failed, to catch Resident 16, who was in the process of falling. All of the discussion with regard to Resident 5, in regard to matters of one-on-one supervision, the degree of physical restraint which could be used, and the privacy of the resident apply to this resident also. Moreover, the absence of any standards by which to judge adequacy of supervision make evaluating Rosewood's efforts in this regard difficult.

78. It is a fact that Rosewood failed in its attempts to reduce seizures by failing to be adequately informed as to the requirements for administering seizure medication. This resulted in the seizure medication being rendered ineffectual.

Although this failure may have contributed to Resident 16's spills, it does not help prove a failure to supervise. In any event, AHCA failed to prove by clear and convincing evidence that Rosewood failed to adequately supervise Resident 16.

79. Resident 20 was the other party in the altercation involving Resident 1A which occurred on September 7, 2002, and which is addressed in paragraph 14, above. The facility determined that Resident 20 was very territorial and determined to address the matter by providing him with a room where he would be the sole occupant.

80. On November 10, 2002, Rosewood attempted to move another person in with Resident 20. He complained and the facility removed the roommate. On December 28, 2001, another attempt to move a roommate in with Resident 20 resulted in combat on January 2, 2002. As a result of this action, the resident was removed from the facility pursuant to the Baker Act, Section 394.451, et seq., Florida Statutes.

81. Additionally, the pleadings with regard to Resident 20 indicate that Resident 20 was a female and that his victim in the September 7, 2001, altercation was a female. The evidence of record, and AHCA's Proposed Recommended Order, address Resident 20 as a male, leaving the fact-finder nonplussed with regard to whom the pleading refers. For that reason, and the reasons discussed in detail above, AHCA did not prove by clear

and convincing evidence that the facility failed to adequately supervise Resident 20. Accordingly, Count II of Case No. 02-4040 is not proven.

82. DOAH Case No. 02-1905 seeks to impose a conditional license based on the survey of January 22-25, 2002. This is based on the same evidence adduced in DOAH Case No. 02-4040. The standard of proof in this case is proof by a preponderance of the evidence, as noted above.

83. A review of the evidence developed with regard to Residents 10, 12, 16, and 20, using the lesser standard of proof, results in the same conclusion.

RECOMMENDATION

Based upon the Findings of Fact and Conclusions of Law, it is

RECOMMENDED: That a final order be entered dismissing, DOAH Case Nos. 02-1421, 02-1905, and 02-4040.

DONE AND ENTERED this 8th day of January, 2003, in Tallahassee, Leon County, Florida.

HARRY L. HOOPER
Administrative Law Judge
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Filed with the Clerk of the
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this 8th day of January, 2003.

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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.