STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. ENGLEWOOD HEALTH CARE ASSOCIATES, LLC, d/b/a ENGLEWOOD HEALTHCARE AND REHABILITATION CENTER, Respondent.	)	Case Nos. 03-0192 03-0193

RECOMMENDED ORDER

On April 3 and 4, 2003, a formal administrative hearing in these cases was held in Punta Gorda, Florida, before William F. Quattlebaum, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: Joanna Daniels, Esquire
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For Respondent: R. Davis Thomas, Jr.
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STATEMENT OF THE ISSUE

The issue in these cases is whether the allegations of the Administrative Complaints filed by the Petitioner against the Respondent are correct, and if so, what penalty should be imposed.

PRELIMINARY STATEMENT

By Administrative Complaints filed on December 30, 2002, the Agency for Health Care Administration (Petitioner) alleged that Englewood Health Care Associates, LLC, d/b/a Englewood Healthcare and Rehabilitation Center (Respondent) failed to ensure the safety of three residents who smoke cigarettes. In DOAH Case No. 03-0192 (AHCA Case No. 2002045948), the Petitioner seeks to impose administrative fines and fees totaling $26,000. In DOAH Case No. 03-0193 (AHCA Case No. 2002046867), the Petitioner seeks to impose a conditional license status on the Respondent. (Based on a settlement agreement between the parties reached shortly prior to commencement of the formal hearing, jurisdiction in previously consolidated DOAH Case No. 03-0191 has been relinquished by separate order to the Petitioner for such further activity as is warranted.)

At the hearing, the Petitioner presented the testimony of two witnesses and had exhibits numbered 1-9, 11-17 (including 17A), 18-21 and 24 admitted into evidence. The Respondent

presented the testimony of three witnesses and had exhibits numbered 1-10 admitted into evidence.

A Transcript of the hearing was filed on July 11, 2003. By agreement, both parties filed Proposed Recommended Orders on July 28, 2003, that were considered in the preparation of this Recommended Order.

All citations are to Florida Statutes (2002) unless otherwise indicated.

FINDINGS OF FACT

1. The Petitioner is the state agency responsible for licensure and regulation of nursing homes operating in the State of Florida.

2. The Respondent operates a licensed skilled nursing facility in Englewood, Florida.

3. The Petitioner surveyed the facility on July 26, 2002. Based on the surveyor's observations, the facility was charged with failure to ensure the safety of three residents who smoke tobacco. For purposes of maintaining the residents' privacy, the residents are identified in the survey and in this Recommended Order as Residents 4, 6 and 7.

4. The Petitioner imposed a "conditional" license rating on the facility and imposed an administrative fine and survey fee forming the basis for this proceeding.

5. The Respondent was resurveyed on August 5, 2002, and Petitioner determined that the deficiency had been remedied. As of August 26, 2002, the Respondent's license returned to "standard" rating.

6. The facility has a smoking area in a courtyard, which lies in the center of the building and which is surrounded by the facility. The courtyard is visible from inside the facility. The Respondent's employees who smoke do so in the courtyard along with the facility's residents.

7. Generally at the time of admission, incoming residents who smoke are assessed as to their ability to do so safely.

8. The Petitioner asserts that the alleged failure of the facility to assess or to reassess the ability of smoking residents constitutes neglect of the residents.

9. The parties do not dispute that facility residents have the "right" to smoke cigarettes if they chose to do so.

10. There is no requirement that smokers wear protective clothing while smoking. Such clothing (such as a "smoker's apron") may be offered to smokers but the facility may not require that a resident use the clothing. The evidence establishes that two of the three residents (4 and 6) discussed herein had been offered smoking aprons and declined to use them.

11. The facility may encourage residents to smoke during "group" smoking situations, but the facility may not require a

resident to participate and may not limit a resident's smoking to such events.

12. There is no legal requirement that cigarette smokers be supervised on a one-to-one basis.

13. The evidence fails to establish that the observations of the Petitioner's surveyor caused, or were likely to cause, serious injury to the residents addressed herein. There is no credible evidence of any injury to any resident. Given the apparent frequency of smoking behavior by residents, it is reasonable to expect that there would be evidence of at least a minor injury to a smoker if such activity posed a credible threat of injury.

14. The Respondent's submission of a required plan of correction does not establish that a cited deficiency existed at the time of the survey.

Resident 4

15. Resident 4 was afflicted with "Fredereich's Ataxia" a degenerative condition which results in diminution of fine motor skills. She spoke and moved in a slow manner. Her head would "bob" in a manner that could suggest she was dozing off.

16. Despite her condition, Resident 4's cognitive abilities were undiminished. She used a motorized wheelchair and was able to leave the facility on her own volition. She used a computer and could operate a television remote control

without assistance. She could handle coins and obtain snacks from a vending machine.

17. Resident 4's care plan provided that the resident could smoke cigarettes independently.

18. Based on review of a nurse's notes, the Petitioner asserts that the Resident 4's smoking ability should have been reassessed following an incident on July 4, 2002, during which a "bib" lying on the floor nearby Resident 4 was discovered smoldering after ash from Resident 4's cigarette landed on it. The "bib" was extinguished, and there were no injuries.

19. Although there is evidence that following the burning "bib" incident the staff was advised to monitor Resident 4's smoking more closely, there is no evidence that a formal smoking reassessment was completed for Resident 4. The evidence further establishes that the staff determining that Resident 4's smoking assessment did not need to be re-addressed was unaware of the "bib" incident. The monitoring advisory was not documented in Resident 4's care plan. The written care plan is the document which all facility staff access to determine the current status and condition of a resident.

20. The Petitioner further asserts that the Respondent should have reassessed Resident's 4's ability to smoke cigarettes safely based on burn holes in her clothing and the

appearance of an alleged burn mark on a leg brace used by Resident 4.

21. The evidence establishes that Resident 4 wore clothing with burn holes, allegedly caused by the dropping of burning ashes on the clothing. There is no evidence as to the age of the clothing or the frequency with which such burn holes occurred.

22. The evidence establishes that the Respondent's surveyor observed what she believed to be a burn mark on a leg brace worn by Resident 4. The evidence fails to establish that a burning cigarette caused the mark observed by the surveyor. The mark, located on a leather portion of a brace, exhibited no visible charring. No credible analysis of the mark was performed.

23. The evidence establishes that Resident 4 reported to the Respondent's surveyor that she burned her thumb while smoking. The evidence fails to establish that a mark visible on Resident 4's thumb was the result of a cigarette burn.

24. At the time of the survey, the Resident 4 was observed smoking in the courtyard area. The Respondent was wearing a cloth respiratory mask that was hanging freely from one ear. For reasons related to either physical condition or medication, the Respondent appeared to be periodically dozing as she was smoking. The evidence fails to establish whether Resident 4 was

actually "nodding off" or whether the appearance was related to the head "bob" resulting from her diagnosis.

25. The evidence fails to establish that additional smoking restrictions for Resident 4 were necessary. The evidence fails to establish that Resident 4, who apparently strongly valued her independence, would have accepted smoking restrictions or additional supervision.

Resident 6

26. Resident 6 was admitted to the facility subsequent to suffering a stroke. His cognitive abilities were not impaired. Resident 6's care plan provided that he could smoke with minimal supervision.

27. The Respondent's surveyor observed Resident 6 smoking in the facility's courtyard. A staff person was present, as was another resident. Resident 6 had cigarette ashes on his clothing.

28. Articles of clothing in Resident 6's closet had burn holes in them. There is no evidence as to the age of the clothing or the frequency with which such burn holes occurred.

29. The evidence fails to establish that Resident 6's plan of care was violated or that the Respondent was negligent in supervising the Resident 6's cigarette smoking.

Resident 7

30. Resident 7 was admitted to the facility on July 17, 2002, with a diagnosis of organic brain syndrome. Although Resident 7's cognition was moderately impaired, he was permitted to move freely about the facility and smoked in the smoking area.

31. At the time of the survey, Resident 7's care plan did not address his cigarette smoking. On July 25, 2002, a smoking evaluation was completed and included in Resident 7's written care plan. His cigarettes were stored for him and supplied to him upon request. He was to be accompanied by staff when he smoked.

32. Resident 7 was also known to rummage through ashtrays looking for additional smoking material. Although the facility obtained tamper-resistant ashtrays, Resident 7 was nonetheless apparently able to obtain additional smoking material when staff was not present.

33. The Respondent's surveyor observed Resident 7 smoking in the facility's courtyard. At the time of the surveyor's observation, Resident 7 appeared to be sitting alone and unsupervised in the courtyard. It is unknown whether the smoking material was obtained from the staff (in which case he should have been accompanied by a staff member) or had been

obtained from the ashtray (in which case the staff was likely unaware that he was smoking).

34. Burn holes were present in Resident 7's clothing. There is no evidence as to the age of the clothing or the frequency with which such burn holes occurred.

35. The Respondent asserts that prior to completion of a written assessment, a smoking assessment care plan was orally communicated to all staff members working in Resident 7's unit. The evidence establishes that staff members were aware of Resident 7's smoking habits prior to completion of the written plan of care.

CONCLUSIONS OF LAW

36. The Division of Administrative Hearings has jurisdiction over the parties to and subject matter of this proceeding. Sections 120.569 and 120.57(1).

37. The Petitioner asserts that the failure of the Respondent to initially assess or subsequently reassess the smoking ability of certain residents constitutes a form of neglect.

38. The Petitioner has the burden of establishing by a preponderance of the evidence, entitlement to the relief sought, specifically the imposition of a conditional rating and fines. *Balino v. Department of Health and Rehabilitative Services*, 348 So. 2d 349 (1st DCA 1977); *Florida Department of Transportation*

v. JWC Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981). In this case, the burden has not been met.

39. The Petitioner asserts that the alleged deficiency at issue in this proceeding is a violation of Sections 400.022, 400.102(1)(a), 400.121, and 400.23(8)(b).

40. Section 400.022(1)(l) sets forth a listing of "residents' rights," which includes the "right to receive adequate and appropriate health care and protective and support services." The evidence fails to establish that the Respondent violated the residents' "right to receive adequate and appropriate health care and protective and support services" and therefore fails to establish that the Respondent has violated Section 400.022.

41. Section 400.102(1)(a) provides that an "intentional or negligent act materially affecting the health or safety of residents of the facility" is ground for disciplinary action against the facility. The evidence fails to establish that the Respondent has committed an intentional or negligent act materially affecting the health or safety of residents of the facility and therefore fails to establish that the Respondent has violated Section 400.102(1)(a).

42. Section 400.121 provides for the imposition of administrative fines. The evidence fails to establish that imposition of an administrative fine is warranted in this case.

43. The Petitioner asserts that the deficiency at issue in this proceeding is a Class I deficiency as defined at Section 400.23(8)(a), which provides as follows:

> (a) A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction. A class I deficiency is subject to a civil penalty of $10,000 for an isolated deficiency, $12,500 for a patterned deficiency, and $15,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last annual inspection or any inspection or complaint investigation since the last annual inspection. A fine must be levied notwithstanding the correction of the deficiency. (Emphasis supplied).

44. The Respondent was previously cited for a Class II citation during a survey conducted on or about December 6, 2001.

45. The evidence fails to establish that the circumstances presented by the residents addressed herein have caused, or are likely to cause, serious injury, harm, impairment, or death to a resident receiving care in the facility. In this case, the circumstances fail to establish that any resident has suffered even a minor injury related to the Respondent's policies and

procedures related to cigarette smoking. Accordingly, the evidence fails to establish the existence of the Class I deficiency as charged in the Administrative Complaints filed in these cases.

46. The Petitioner asserts that the Respondent has violated Rule 59A-4.1288, Florida Administrative Code, incorporating by reference 42 CFR Section 483.13(c), which requires that a nursing home "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." The evidence fails to establish that the Respondent has violated the cited rule.

RECOMMENDATION

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

RECOMMENDED that the Agency for Health Care Administration enter a final order dismissing the Administrative Complaints filed in these cases.

DONE AND ENTERED this 22nd day of August, 2003, in Tallahassee, Leon County, Florida.

WILLIAM F. QUATTLEBAUM
Administrative Law Judge
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Filed with the Clerk of the
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this 22nd day of August, 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.