STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 03-1969
KEY WEST CONVALESCENT CENTER, INC., d/b/a KEY WEST CONVALESCENT CENTER,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a final hearing was conducted in this case on December 10, 2003, in Key West, Florida, before Administrative Law Judge Claude B. Arrington of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Nelson E. Rodney, Esquire
Agency for Health Care Administration
Spokane Building, Suite 103
8350 Northwest 52nd Terrace
Miami, Florida 33166

For Respondent: Alex Finch, Esquire
Goldsmith, Grout & Lewis, P.A.
2180 North Park Avenue, Suite 100
Post Office Box 2011
Winter Park, Florida 32790-2011

STATEMENT OF THE ISSUES

Whether Respondent is guilty of the deficiencies alleged in the Administrative Complaint and the penalties, if any, that should be imposed.

PRELIMINARY STATEMENT

On April 23, 2003, Petitioner filed an Administrative Complaint that alleged certain facts and, based on those facts, alleged in two separate counts that Respondent was guilty of two Class II deficiencies. Petitioner contended that Respondent should be fined $2,500.00 for each deficiency and that the status of its licensure should be downgraded from standard to conditional.

Count I pertained to Respondent's care of a patient who will be referred to as A.V. Based on the factual allegations pertaining to A.V.'s care, Petitioner alleged that Respondent:

> . . . violated Section 483.25(c), Code of Federal Regulations as incorporated by Rules 59A-4.1288 and 59A-4.106(2), Florida Administrative Code, [which is] ... classified as a Class II deficiency pursuant to Section 400.23(8)(b), Florida Statutes, [and] carries, in this case, a fine of $2,500.00 and gives rise to a conditional rating pursuant to Section 400.23(7), Florida Statutes.[1]

Count II alleged that on certain dates Respondent failed to provide the required amount of direct care staff for a 24-hour period. Count II further alleged that the failure to provide

the required amount of direct care staff compromised the residents' ability to maintain or reach his or her highest practicable physical, mental, and psychosocial wellbeing. Based on the factual allegations set forth in Count II, Petitioner alleged that Respondent:

> ... violated Section 400.23(3)(a), Florida Statutes, and/or Section 483.23(3)(a), Code of Federal Regulations as incorporated by Rules 59A-4.1288 and 59A-4.108, Florida Administrative Code, [which is] ... classified as a Class II deficiency pursuant to Section 400.23(8)(b), Florida Statutes, [and] carries, in this case, a fine of $2,500.00 and gives rise to a conditional rating pursuant to Section 400.23(7), Florida Statutes.

Respondent denied the material allegations of the Administrative Complaint, the matter was referred to the Division of Administrative Hearings, and this proceeding followed.

In response to the prehearing order entered in this proceeding, the parties filed a Joint Prehearing Stipulation, which contained certain factual stipulations. The stipulated facts found to be relevant are included in this Recommended Order.

At the final hearing, Petitioner presented the testimony of Arlene Schweitzer, a registered nurse who conducted the survey of Respondent's facility. Petitioner presented four composite exhibits, each of which was admitted into evidence. Respondent

presented the testimony of Michael Derouin, D.P.M. (a podiatric physician); Christina Romine (Respondent's director of social services); Donna Rosado (a certified nursing assistant and Respondent's director of admissions); Jane Monti (a registered nurse); and Robin Blier (a registered nurse and, as of January 6, 2003, Respondent's acting administrator). Respondent offered 11 sequentially numbered exhibits, each of which was admitted into evidence.

A Transcript of the proceedings was filed on January 16, 2004. Each party filed a Proposed Recommended Order, which has been duly-considered by the undersigned in the preparation of this Recommended Order.

FINDINGS OF FACT

1. Respondent is a licensed, skilled nursing home facility located in Key West, Florida. Respondent was at all times pertinent hereto a long-term Medicare provider; was licensed by Petitioner; and was required to comply with Chapter 400 Part II, Florida Statutes, Chapter 59A-4, Florida Administrative Code, and Title 42, Section 483, Code of Federal Regulations.

2. Petitioner is the agency of the State of Florida with the responsibility to regulate skilled nursing homes and to administer the federal Medicaid and Medicare programs in Florida.

3. Petitioner surveys nursing home facilities to evaluate their compliance with established rules and conducts federally mandated surveys of long-term care facilities receiving Medicare and Medicaid to ensure compliance with federal statutory and rule requirements. Petitioner classifies any deficiency noted by a survey according to the nature and scope of the deficiency. The severity of the deficiency determines the amount of any administrative fine and whether the licensure status of the facility should be "standard" or "conditional."

4. A licensee’s failure to comply with an applicable statute or rule is a deficiency. A survey results in a report, commonly called a Form 2567, which lists each deficiency that is found, identifies the applicable regulatory standard that the surveyor believes has been violated, provides a factual basis for the alleged violation, and indicates the scope and severity of the deficiency.

5. Petitioner conducted a survey of Respondent during the period January 20-24, 2003. Arlene Schweitzer, who is a registered nurse and an experienced surveyor, conducted the survey on behalf of Petitioner. The survey included a review of the facility’s records, observation of residents, and interviews of residents, their family members, and members of the facility’s staff.

6. As a result of Nurse Schweitzer's survey, Petitioner filed the Administrative Complaint containing the allegations at issue in this proceeding.

7. At the times material to this proceeding, A.V. was a 39-year-old female who was afflicted with cancer that had metastasized to multiple organs. A.V. was bedfast and her condition was terminal. A.V.'s bed included an air mattress to make her more comfortable and to protect against pressure sores.

8. At the times material to this proceeding, Dr. Michael R. Derouin, Dr. Michael G. Simmons, and Dr. John J. Schoppe, Jr., were physicians practicing in the same practice group in the specialty of podiatric medicine. All examinations conducted by these doctors on A.V. were in her room at Respondent's facility.

9. In response to a request from Respondent's staff, Dr. Derouin examined A.V. on January 3, 2003. On that date, Dr. Derouin observed that A.V. had a pressure sore on her left heel.[2] Based on his observation, Dr. Derouin described the pressure sore as being approximately one centimeter by one centimeter (at hearing Dr. Derouin testified that the pressure sore was about the size of a dime). Dr. Derouin further described the pressure sore as being superficial with no clinical signs of infection.

10. On January 3, 2003, Dr. Derouin treated A.V. by applying to the pressure sore antibiotic ointment followed a normal saline wet to dry dressing. Dr. Derouin ordered Respondent's staff to continue that treatment on a daily basis. In addition, Dr. Derouin ordered that a protective and pressure relieving apparatus referred to as a waffle boot be applied to A.V.'s left foot. He further ordered that Respondent's staff continue to elevate A.V.'s left foot off of her bedding.

11. In addition to the examination discussed above, Dr. Derouin examined A.V. on January 6, 13, 20, and 27, and February 3, 2003. Dr. Simmons examined A.V. on January 10 and 24 and February 7, 2003. Dr. Schoppe examined A.V. on January 30, 2003.

12. Each of these doctors generated a report following his examination of A.V. None of the reports describe the pressure sore as being anything other than superficial, and none note the presence of infection. On February 3, Dr. Derouin considered the pressure sore to be healed.

13. Petitioner established that Respondent was dilatory in obtaining a waffle boot for A.V. Although Respondent does not stock waffle boots as part of its inventory, waffle boots were readily available from a hospital that is adjacent to Respondent's facility.

14. Dr. Derouin was aware that Respondent did not stock waffle boots as part of its inventory. He noted on January 6, 13, and 20, that a waffle boot had been ordered and would be applied when available. On January 27, Dr. Derouin noted that the waffle boot had arrived and had been applied to A.V.'s left foot. Dr. Derouin testified that he found it acceptable for Respondent's staff to elevate A.V.'s left foot by using a pillow until the waffle boot arrived.

15. The facility failed to document that it complied with Dr. Derouin's order to treat A.V.'s pressure sore by applying antibiotic ointment followed by a normal saline wet to dry dressing on January 4, 5, 6, 12, and 15. On all other dates, Respondent's staff documented that the wet to dry treatment was administered. Dr. Derouin administered the wet to dry treatment during his examination on January 6, which relieved Respondent's staff of that responsibility on that date. Petitioner established that Respondent's staff failed to comply with Dr. Derouin's treatment order on January 4, 5, 12, and 15.

16. Petitioner did not establish that A.V. suffered an ill effect from either the missed treatments or Respondent's delay in obtaining a waffle boot.[3] Respondent's delay in obtaining a waffle boot for A.V. and the fact that some treatments were undocumented (and therefore found by the undersigned not to have been performed) did not cause A.V.'s pressure sore to worsen.[4]

17. Prior to January 1, 2003, each long-term care facility, including Respondent, was required to have sufficient certified nursing assistant staffing to provide 2.3 hours of direct care per resident per day. Pursuant to Section 400.23(3)(a), Florida Statutes (2002),[5] the minimum direct care staffing requirement increased from 2.3 hours per day to 2.6 hours per day on January 1, 2003.

18. At all times pertinent to this proceeding, a shortage of certified nursing assistants existed in Key West. Since approximately 1997, Respondent has used certified nursing assistants plus registered nurses to meet the minimum direct care staffing requirement.[6]

19. For each of the four units in the facility, Respondent's staff posted an assignment list naming the individuals who were responsible during a particular shift for the direct care of the residents of the unit. Because there was no requirement that such lists be retained, the lists were not retained and were not available for Petitioner's review.

20. There is no rule as to the type of records a facility must keep to document the direct care staffing requirements set forth in Section 400.23(3)(a), Florida Statutes.[7]

21. At the times pertinent to this proceeding, Respondent's payroll records reflected that an employee had worked a particular shift, but they did not reflect whether a

registered nurse or a salaried employee had performed direct care to residents during that shift. Respondent pays a registered nurse at his or her regular hourly rate (plus any overtime) whether the registered nurse worked as a registered nurse or as a direct care provider. Moreover, Respondent's payroll records do not document what duties a salaried employee performed during a particular shift.

22. Based on the documentation submitted during her survey, Nurse Schweitzer calculated that Respondent had not met the minimum direct care requirement on January 2, 4, 5, 6, 7, 9, 11, 12, and 15. Nurse Schweitzer testified that she did not receive payroll information for January 1 or January 8 and, consequently, made no determination as to those two dates.

23. In making her calculations, Nurse Schweitzer disallowed certain hours of direct care Respondent claimed were performed by salaried employees or registered nurses. In the absence of definitive documentation and after talking with certain members of Respondent's staff, Nurse Schweitzer concluded that the documentation was a sham. She believed that the salaried employees Respondent claimed were performing direct care for patients were actually performing their usual non-nursing duties. She also believed that the registered nurses Respondent claimed were performing direct care for patients were actually performing traditional nursing services.

24. Respondent's witnesses established that the facility had used registered nurses and salaried employees to meet the direct care staffing requirements found in Section 400.23(3)(a), Florida Statutes. Consequently, it is found that Nurse Schweitzer should not have deleted the hours of direct care provided by registered nurses and salaried employees.

25. Petitioner established that the records submitted to Petitioner in response to the survey failed to document compliance with the direct care staffing requirements. Respondent established at the formal hearing that notwithstanding its inadequate documentation, it had met or exceeded those minimum direct care staffing requirements by using registered nurses and salaried employees as direct care providers.

CONCLUSIONS OF LAW

26. The Division of Administrative Hearings has jurisdiction over the subject matter of and the parties to this proceeding pursuant to Sections 120.569 and 120.57(1), Florida Statutes.

27. The burden of proof in this case is on Petitioner. See Beverly Enterprises - Florida v. Agency for Health Care Administration, 745 So. 2d 1133 (Fla. 1st DCA 1999). The burden of proof for the assignment of a licensure status is by a preponderance of the evidence. See 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). The burden of proof to impose an administrative fine is by clear and convincing evidence. See Department of Banking and Finance v. Osborne Stern and Company, 670 So. 2d 932 (Fla. 1996).

28. When Petitioner seeks to take punitive action against a licensee, such action may be based only upon those offenses specifically alleged in the administrative complaint. See Cottrill v. Department of Insurance, 685 So. 2d 1371, 1372 (Fla. 1st DCA 1996); Chrysler v. Department of Professional Regulation, 627 So. 2d 31 (Fla. 1st DCA 1993); Klein v. Department of Business and Professional Regulation, 625 So. 2d 1237, 1238-39 (Fla. 2d DCA 1993); Arpayoglou v. Department of Professional Regulation, 603 So. 2d 8 (Fla. 1st DCA 1992); Willner v. Department of Professional Regulation, Board of Medicine, 563 So. 2d 805, 806 (Fla. 1st DCA 1992); Celaya v. Department of Professional Regulation, Board of Medicine, 560 So. 2d 383, 384 (Fla. 3d DCA 1990); Kinney v. Department of State, 501 So. 2d 129, 133 (Fla. 5th DCA 1987); Sternberg v. Department of Professional Regulation, 465 So. 2d 1324, 1325 (Fla. 1st DCA 1985); Hunter v. Department of Professional Regulation, 458 So. 2d 842, 844 (Fla. 2d DCA 1984).

29. Section 400.23(8), Florida Statutes, states in relevant part:

> (8) . . . deficiencies shall be classified according to the nature and the scope of the deficiency. The scope shall be cited as isolated, patterned, or widespread. An isolated deficiency is a deficiency affecting one or a very limited number of residents, or involving one or a very limited number of staff, or a situation that occurred only occasionally or in a very limited number of locations. A patterned deficiency is a deficiency where more than a very limited number of residents are affected, or more than a very limited number of staff are involved, or the situation has occurred in several locations, or the same resident or residents have been affected by repeated occurrences of the same deficient practice but the effect of the deficient practice is not found to be pervasive throughout the facility. A widespread deficiency is a deficiency in which the problems causing the deficiency are pervasive in the facility or represent systemic failure that has affected or has the potential to affect a large portion of the facility's residents. The agency shall indicate the classification on the face of the notice of deficiencies 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. . . .
>
> (b) 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. A class II deficiency is subject to a civil penalty of $2,500 for an isolated deficiency, $5,000 for a patterned deficiency, and $7,500 for a widespread deficiency. . . .
>
> (c) 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 practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. A class III deficiency is subject to a civil penalty of $1,000 for an isolated deficiency, $2,000 for a patterned deficiency, and $3,000 for a widespread deficiency. . . . If a class III deficiency is corrected within the time specified, no civil penalty shall be imposed.
>
> (d) 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. If the class IV deficiency is isolated, no plan of correction is required.

30. Section 400.23(7), Florida Statutes, provides, in pertinent part, as follows:

> (7) . . . The agency shall assign a licensure status of standard or conditional to each nursing home.

> (a) A standard licensure status means that a facility has no class I or class II deficiencies and has corrected all class III deficiencies within the time established by the agency.
> (b) A conditional licensure status means that a facility, due to the presence of one or more class I or class II deficiencies, or class III deficiencies not corrected within the time established by the agency, is not in substantial compliance at the time of the survey with criteria established under this part or with rules adopted by the agency. If the facility has no class I, class II, or class III deficiencies at the time of the follow-up survey, a standard licensure status may be assigned.

31. Petitioner established that Respondent's staff failed to comply with Dr. Derouin's treatment orders for A.V. on January 4, 5, 12, and 15, 2003, as alleged in Count I of the Administrative Complaint. However, Petitioner failed to establish that Respondent's treatment of A.V. constituted a Class II deficiency as defined by Section 400.23(8)(b), Florida Statutes, because there was no harm to the patient and the resident's ability to maintain or reach her highest practicable physical, mental, and psychosocial well-being was not compromised.

32. Although no harm was caused to A.V. by Respondent's failure to follow Dr. Derouin's treatment orders for A.V., the failure had the potential to cause harm to the patient and should be viewed as an isolated, Class III deficiency pursuant to Section 400.23(8), Florida Statutes.

33. Petitioner charged in Count II of the Administrative Complaint that Respondent failed to provide the required amount of direct care staffing required by Section 400.23(3)(a), Florida Statutes, for certain dates in January. Count II further charged that the failure to provide the required amount of direct care staff compromised the residents' ability to maintain or reach his or her highest practicable physical, mental, and psychosocial wellbeing. Petitioner failed to establish the alleged violation since Respondent proved that it had met or exceeded the minimum direct care staffing requirement by using registered nurses and salaried employees as direct care providers.

34. At the final hearing, Petitioner established that Respondent failed to provide the surveyor at the time of the survey adequate documentation of its compliance with the minimum direct care standard set forth in Section 400.23(3)(a), Florida Statutes. That deficiency was not alleged by the Administrative Complaint and, consequently, no penalty may be imposed for that deficiency.

35. Petitioner failed to establish either of the Class II deficiencies alleged in the Administrative Complaint and, consequently, failed to establish that Respondent's licensure should be downgraded from standard to conditional.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner enter a final order adopting the Findings of Facts and Conclusions of Law set forth herein. It is further RECOMMENDED that Petitioner find Respondent guilty of an isolated, Class III deficiency based on Count I of the Administrative Complaint and that Petitioner find Respondent not guilty of the violation alleged in Count II of the Administrative Complaint. It is further RECOMMENDED that Petitioner assess an administrative fine against Respondent in the amount of $1,000.00 for the Class III deficiency found in Count I of the Administrative Complaint. It is further RECOMMENDED that Petitioner make no change to the status of Respondent's licensure.

DONE AND ENTERED this 11th day of March, 2004, in Tallahassee, Leon County, Florida.

CLAUDE B. ARRINGTON
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 11th day of March, 2004.

ENDNOTES

1/ Unless otherwise indicated, all statutory references are to Florida Statutes (2003).

2/ The reason the pressure sore developed was undetermined, but there was no allegation and no evidence that Respondent was deficient in permitting the pressure sore to develop.

3/ Dr. Derouin testified, credibly, that A.V. would not have had an ill effect from either the missed treatments or the delay in applying the waffle boot to her foot. It is clear that Dr. Derouin and his colleagues closely followed this patient and approved the treatment that was being provided during the healing process. It is also clear that the superficial pressure sore healed in a timely manner.

4/ In making this finding, the undersigned has considered Dr. Simmons's report dated January 10, which includes a notation that the base of the pressure sore was necrotic and Respondent's pressure sore log entry on January 10, which reflects that the pressure sore was upgraded from a Stage I to the more serious rating of Stage II. These entries were not explained at the final hearing. Dr. Simmons did not testify and it was not clear from his report the significance, if any, of the noted observation. The person who upgraded the pressure sore rating on January 10, 2003, also did not testify. The upgrading of the severity of the pressure sore is inconsistent with the reports of the treating physicians.

5/ Section 400.23(3)(a), Florida Statutes, provides in pertinent part as follows:

> (3)(a) The agency shall adopt rules providing for the minimum staffing requirements for nursing homes. These requirements shall include, for each nursing home facility, a minimum certified nursing assistant staffing of 2.3 hours of direct care per resident per day beginning January 1, 2002, increasing to 2.6 hours of direct care per resident per day beginning

> January 1, 2003. . . . Each nursing home must document compliance with staffing standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants, provided that the facility otherwise meets the minimum staffing requirements for licensed nurses and that the licensed nurses so recognized are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted towards the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and shall not also be counted towards the minimum staffing requirements for licensed nurses. . . .

6/ There is no dispute that a registered nurse can perform direct care duties of a resident in compliance with this requirement during a particular shift so long as the registered nurse is not also performing the duties typically assigned to a registered nurse.

7/ The Administrative Complaint charges Respondent with failing to meet the direct care minimum staffing standard. Respondent was not charged with failing to document that it met that standard.

COPIES FURNISHED:

Alex Finch, Esquire
Goldsmith, Grout & Lewis, P.A.
2180 North Park Avenue, Suite 100
Post Office Box 2011
Winter Park, Florida 32790-2011

Nelson E. Rodney, Esquire
Agency for Health Care Administration
Spokane Building, Suite 103
8350 Northwest 52nd Terrace
Miami, Florida 33166

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

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

Rhonda M. Medows, M.D., Secretary
Agency for Health Care Administration
2727 Mahan Drive, Suite 3116
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.