STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 04-2451
KENSINGTON MANOR, INC., d/b/a KENSINGTON MANOR,	)	
Respondent.	)	

RECOMMENDED ORDER

Administrative Law Judge (ALJ) Daniel Manry conducted the administrative hearing in this proceeding on December 2, 2004, in Sarasota, Florida, on behalf of the Division of Administrative Hearings (DOAH).

APPEARANCES

For Petitioner: Gerald L. Pickett, Esquire
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For Respondent: Alfred W. Clark, Esquire
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STATEMENT OF THE ISSUES

The issues are whether Respondent committed the violations alleged in the Administrative Complaint concerning three nursing

home residents, whether Petitioner should impose a civil penalty of $2,500 for each violation, whether Petitioner should change the status of Respondent's license from standard to conditional, and whether Petitioner should recover investigative costs.

PRELIMINARY STATEMENT

Petitioner charged Respondent with the violations at issue in this proceeding in an Administrative Complaint dated May 24, 2004, containing five counts (Counts I through V). Respondent timely requested an administrative hearing. Petitioner referred the matter to DOAH to assign an ALJ to conduct the hearing.

The parties resolved some factual allegations in a Joint Prehearing Stipulation and proceeded to hearing on the remaining disputed issues of fact. At the outset of the hearing, the ALJ granted Respondent's Motion to Strike portions of Count III of the Administrative Complaint in subparagraphs 1 through 4 in paragraph 99 and paragraphs 110 through 144 concerning residents of the facility identified in the record as Residents 14, 18, 30, 31, 4, 5, and 16. The stricken portions of Count III did not allege facts that, if proven, constituted the charged violation. The ALJ provided Petitioner with an opportunity to proffer evidence relevant to the stricken allegations, but Petitioner declined to proffer any evidence.

The parties submitted evidence concerning the remaining disputed issues, including one joint exhibit. Petitioner

presented the testimony of one witness and submitted eight exhibits for admission into evidence. Petitioner stipulated that those portions of the admitted exhibits consisting of a preliminary charging document identified in the record as CMS Form 2567L, were not offered for the truth of the facts asserted therein. Respondent presented the testimony of three witnesses and submitted three exhibits for admission into evidence. Pursuant to the agreement of the parties during the hearing, Petitioner filed the deposition testimony of one witness on January 19, 2005, and Respondent filed the deposition testimony of two witnesses on January 12, 2005.

The identity of the witnesses and exhibits and the rulings regarding each are reported in the one-volume Transcript of the hearing filed with DOAH on December 13, 2004. Petitioner and Respondent timely filed their respective Proposed Recommended Orders (PROs) on January 18 and 14, 2005.

FINDINGS OF FACT

1. Petitioner is the state agency responsible for licensing and regulating nursing homes in Florida. Respondent is licensed to operate an 87-bed nursing home located at 3250 12th Street, Sarasota, Florida (the facility).

2. From February 9 through 11, 2004, Petitioner's staff inspected the facility pursuant to regulatory requirements for an annual survey of such facilities (the survey). At the

conclusion of the survey, Petitioner issued a document identified in the record as CMS Form 2567L (the 2567 form). The 2567 form alleges violations of federal nursing home regulations that Petitioner has adopted by rule.

3. The Administrative Complaint incorporates the factual allegations from the 2567 form and charges Respondent with committing four violations alleged to be Class II violations defined in Subsection 400.23(8)(b), Florida Statutes (2003). Counts I through III in the Administrative Complaint allege that facility staff committed acts involving residents identified in the record as Residents 14, 7, and 8. Count IV alleges that the allegations in Counts I through III show that Respondent administered the facility in a manner that violated relevant regulatory provisions. Counts I through IV propose an administrative fine of $2,500 for each alleged violation and the recovery of unspecified investigative costs. Count V alleges that the allegations in Counts I through III require Petitioner to change Respondent's license rating from standard to conditional while the alleged deficiencies remained uncorrected.

4. Count I alleges that a staff nurse at the facility abused Resident 14, an elderly female. The substance of the allegation is that the nurse "intentionally caused pain" to Resident 14 by raising the resident's left hand above her head

so the resident would open her mouth and allow the nurse to ensure the resident had swallowed her medication.

5. Respondent admitted Resident 14 to the facility on January 31, 2000, with multiple health problems, including anxiety, paranoia, psychosis, delusions, and disorientation due to dementia. Resident 14 was not ambulatory and suffered poor wheel chair positioning for which she had been evaluated and received therapy. Resident 14 was non-verbal, angry, aggressive, combative with staff and other residents, displayed territorial aggression, and a tendency to strike out at others. Prior to admission, Resident 14 had suffered a fracture of the left arm resulting in a limited range of motion in her left shoulder of 60 degrees. At the time of the survey, Resident 14 was approximately 93 years old.

6. Two surveyors observed a staff nurse administering medication to Resident 14 while the resident was sitting in her wheel chair in her room. Resident 14 did not respond to repeated cues from the nurse to open her mouth so the nurse could ensure the resident had swallowed her medication. The nurse continued to observe Resident 14 for some indication the resident had not swallowed her medication and offered pudding to the resident. Resident 14 remained unresponsive. The nurse directed a certified nurse assistant (CNA) to give Resident 14 breakfast and left to care for other residents.

7. The surveyors asked the nurse to return to the room to ensure that Resident 14 had swallowed her medication. Resident 14 did not respond to additional cues from the staff nurse to open her mouth because the resident was distracted by the surveyors. The staff nurse attempted to redirect the attention of the resident to the nurse's cues to open her mouth by holding the resident's left hand and raising her hand and arm. Resident 14 opened her mouth, and the staff nurse observed no medication in the resident's mouth.

8. The disputed factual issues call into question how quickly and how high the staff nurse raised the left hand of Resident 14, whether the resident suffered pain, and whether the staff nurse knew the action would cause pain. Although Resident 14 was non-verbal, Count I alleges, in relevant part, that Resident 14 cried "OW" when the staff nurse, without warning, raised the resident's hand over her head.

9. A preponderance of evidence does not show that the staff nurse lifted the hand of Resident 14 in an abrupt manner. During cross-examination of the surveyor, counsel for Respondent conducted a reenactment of the alleged incident. The witness verified the manner in which the person acting as the staff nurse in the reenactment raised the left hand and arm of the person acting as Resident 14. The demonstration did not show the staff nurse acted abruptly.

10. The reenactment showed that the description of the incident by the surveyor was less than persuasive. Petitioner admits in its PRO that a determination of whether the staff nurse raised the resident's hand gently or abruptly is a "matter of perspective." Petitioner argues unpersuasively at page 14 in its PRO that the surveyor's perception should be accepted because:

> Clearly, the surveyor would not have made comment if the resident had been treated in a gentle manner.

11. Petitioner cites no evidence or law that precludes the written statement provided by the staff nurse during the facility's investigation of the incident from enjoying a presumption of credibility equivalent to that Petitioner claims for the report of the surveyor. The staff nurse had been a nurse at the facility for 19 years without any previous complaints or discipline and had ample experience with residents that suffered from dementia. The nurse had cared for Resident 14 for most of the four years that Resident 14 had been a resident at the facility.

12. Irrespective of how fast and high the staff nurse raised the hand of Resident 14, a preponderance of evidence does not show that Resident 14 suffered an injury or harm that is essential to a finding of abuse. The surveyor asked Resident 14 if the resident had been in pain prior to the incident.

Resident 14 was "unable to speak," according to the surveyor, but nodded affirmatively. Resident 14 did not indicate the source or location of any pain, and there is no evidence that the surveyor asked Resident 14 to indicate to the surveyor where the resident was experiencing pain.

13. After the incident, the surveyors undertook no further inquiry or investigation, did not question the nurse or the resident further, and refused a request by facility administrators for a written statement describing the incident. The surveyors at the facility did not make a determination of whether the incident resulted in "harm" to Resident 14. Rather, the allegation of harm arises from Petitioner's employees who did not testify at the hearing. The determination of harm is uncorroborated hearsay, and the trier of fact has not relied on that determination for any finding of fact.

14. Upon learning of the incident, Respondent's nursing staff immediately examined Resident 14 for injuries, had Resident 14 examined by her physician, and had Resident 14 x-rayed for possible injuries. No injury was found. Resident 14 did not complain of pain when her physician performed a range of motion examination on the suspect arm.

15. Resident 14 was able to move both of her arms without pain. The medical records for Resident 14 and the testimony of her occupational therapist show that the resident had use of her

left arm. Resident 14 frequently flailed both arms in an effort to strike others. Notes in the medical records show that Resident 14 "lashes out," "swings her arms," was "physically abusive to staff when attempting to provide care," and "refused to open mouth and became agitated and combative."

16. The limited range of motion in the left shoulder of Resident 14 did not prevent Resident 14 from raising her left hand above her head while seated in a wheel chair. Resident 14 sat in a wheel chair with a forward pelvic thrust, causing her to slump with a lateral lean to the left. The wheel chair position effectively lowered the resident's head, reduced the distance between her head and left hand, and enabled the resident to raise her left hand above her head without pain.

17. Count II alleges that Respondent failed to assist Resident 7 in "coping with changes in her living arrangements in a timely manner" after Resident 7 became upset that her guardian was selling her home. The allegation is not supported by a preponderance of evidence.

18. Respondent admitted Resident 7 to the facility in September of 2003. Prior to admission, the circuit court for Sarasota County, Florida, entered an order appointing a guardian for Resident 7. In relevant part, the court order authorized the guardian to determine residency of Resident 7 and to manage her property.

19. Prior to December 28, 2003, Resident 7 was reasonably content. Social service's notes in October 2003, show that Resident 7 was "alert with no mood or behaviors." Nurses notes in November 2003, show Resident 7 to be "pleasant" with a "sense of humor."

20. On December 28, 2003, Resident 7 became angry when her guardian revealed plans to sell the resident's home. Resident 7 continued to exhibit anger for several weeks.

21. On January 6, 2004, Respondent conducted a care plan conference with the guardian for Resident 7, discussed Resident 7's emotional state, and obtained the guardian's consent for counseling. Pursuant to the care plan, Respondent's social services staff met with Resident 7 regularly and provided psychological counseling twice a week.

22. Facility staff did not undertake discharge planning for Resident 7. Staff provided other assistance to the resident, but that assistance was minimal and consisted mainly of giving Resident 7 telephone numbers to contact the Long Term Care Ombudsman in the area and the attorney for the guardian.

23. The sufficiency of the other assistance provided by Respondent is not material because the court convened a second hearing to consider the objections of Resident 7 to her guardian and to consider a competency examination by another physician. On February 6, 2004, the court entered an order denying the

resident's suggestion of capacity and authorizing the guardian to sell the residence.

24. The allegation that Respondent should have undertaken discharge planning is not supported by a preponderance of the evidence. Pursuant to two court orders, Resident 7 continued to be in need of a nursing home level of care, and her expectations for discharge to a lower level of care were unrealistic.

25. Count III alleges that a facility staff nurse failed to administer analgesic medication to Resident 8 causing "continued pain and emotional stress to the resident." Resident 8 experienced chronic pain from a joint disorder. A care plan for pain management, in relevant part, authorized Tylenol as needed. A preponderance of evidence does not show that Respondent failed to provide Tylenol to Resident 8 in accordance with the care plan.

26. During the survey, a surveyor observed staff at the facility reinserting a catheter into a vein of Resident 8. The witness for Petitioner testified that the procedure did not cause Resident 8 to experience pain. It is undisputed that Resident 8 did not request pain medication and that no pain medication was medically required prior to the procedure. Respondent did provide Resident 8 with a prescription medication to calm the resident.

27. The preponderance of evidence does not show that Respondent failed to ensure that Resident 8 obtained optimal improvement or that Resident 8 deteriorated. Petitioner submitted no evidence that Resident 8 experienced any lack of improvement or decline in functioning or well-being.

28. Count IV in the Administrative Complaint alleges that the allegations in Counts I through III show that Respondent failed to administer the facility in a manner that enabled the facility to use its resources effectively and efficiently to maintain the highest practical well-being of Residents 14, 7, and 8. For reasons previously stated, the preponderance of evidence does not show that Respondent committed the acts alleged in Counts I through III. Without the violations charged in Counts I, II, or III, the charges in Count IV are moot.

29. Assuming arguendo that the staff nurse abused Resident 14, a preponderance of evidence does not show that Respondent failed to take action that could have prevented such abuse. Petitioner's surveyor was unable to explain in her testimony how Respondent could have prevented the alleged abuse.

30. The surveyor did not report the incident to management at the facility for approximately 1.5 hours. Management immediately suspended the staff nurse and undertook an investigation required by law. Petitioner's surveyors refused to provide written statements describing the incident. The

staff nurse provided a written statement that Respondent included as part of its investigation and report to Petitioner.

31. Respondent maintains adequate policies and procedures for background screening and regular training for its staff relating to abuse and neglect of residents. Respondent had accomplished all background screening and abuse training requirements for the staff nurse involved in the incident. Respondent had no information in the nurse's history that would have enabled the facility to predict any potential for this staff nurse to intentionally harm a resident.

32. A preponderance of evidence does not show that Respondent failed to administer the facility in a manner that would ensure the highest practical well-being for Resident 7. Two court orders determined that Resident 7 was incompetent and authorized the guardian to sell the resident's real property. The opinion of a surveyor that Resident 7 was "clearly competent" does not eviscerate the findings of the court.

33. A preponderance of evidence does not show that Respondent failed to administer the facility in a manner that would ensure the highest practical well-being for Resident 8. Respondent maintained an adequate pain management care plan for Resident 8 that included Tylenol as needed. It is undisputed that the care plan did not require Tylenol before or after the re-insertion of the catheter into the vein of Resident 8, that

insertion of the catheter caused Resident 8 no pain, that Tylenol was not medically required before or after the procedure, and that Respondent provided Resident 8 with a stronger prescription medication for anxiety.

34. Count V of the Administrative Complaint alleges that the allegations in Counts I through IV require Petitioner to change the status of Respondent's license from standard to conditional. In the absence of the violations charged in Counts I through IV, there is no factual basis to support the proposed change in the status of Respondent's license.

CONCLUSIONS OF LAW

35. DOAH has jurisdiction over the parties and the subject matter of this proceeding. §§ 120.569 and 120.57, Fla. Stat. (2003). DOAH provided the parties with adequate notice of the administrative hearing.

36. In response to the Motion to Strike, Petitioner stipulated that the presence of "harm" is a prerequisite to a finding of a Class II violation. Count III expressly provides that the relevant allegations "are not cited at the harm level."

37. Petitioner argued at the hearing that multiple deficiencies at a level below Class II, i.e., without harm, can accumulate to a Class II violation. Petitioner cited no legal authority, either at the hearing or in its PRO, to support its argument.

38. Petitioner has the burden of proof concerning the allegations and charges other than those stricken from Count III in the Administrative Complaint. Beverly Enterprises - Florida v. Agency for Health Care Administration, 745 So. 2d 1133 (Fla. 1st DCA 1999). Petitioner must show by a preponderance of evidence that Petitioner should change the status of Respondent's license from standard to conditional and the duration of the change. Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981). Petitioner must show by clear and convincing evidence that Respondent committed the acts for which Petitioner proposes an administrative fine and the reasonableness of the proposed fine. Department of Banking and Finance v. Osborne Stern and Company, 670 So. 2d 932 (Fla. 1996); Latham v. Florida Commission on Ethics, 694 So. 2d 83 (Fla. 1st DCA 1997).

39. Petitioner did not show by even a preponderance of evidence that Respondent committed the violation charged in Count I relating to Resident 14. Petitioner agreed during the hearing that "harm" is a necessary requirement for a finding of a Class II deficiency, and a preponderance of evidence does not support a finding that Resident 14 suffered any harm.

40. The requirement of harm derives from analogous federal provisions that Petitioner has adopted by rule. The federal severity "Level 3" is the federal equivalent to a state Class II

deficiency. A "Level 3" severity requires noncompliance that results in a negative outcome that has compromised the resident's well-being. A "Level 3" severity does not include a deficient practice that could or has caused limited consequence to a resident.

41. The federal severity "Level 2" is the federal equivalent to a state Class III deficiency. A "Level 2" severity requires noncompliance that will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise a resident's well-being.

42. Even a Class III deficiency, therefore, requires either harm or potential for harm in the form of discomfort. For reasons stated in the Findings of Fact, a preponderance of evidence does not show that Resident 14 suffered any harm during the incident at issue.

43. Assuming arguendo that the staff nurse at the facility committed the abuse alleged in Count I of the Administrative Complaint, there is no evidence that the abuse shows that Respondent committed the violations charged in Count IV. There is no evidence that the alleged abuse was anything but an isolated episode. An isolated episode of abuse, when the facility has implemented adequate anti-abuse policies and procedures, would not violate requirements cited in Count IV of

the Administrative Complaint for Respondent to administer the facility in a manner that implements an adequate anti-neglect policy. Lifecare Center of Hendersonville v. Health Care Financing Administration, Departmental Appeals Board Decision No. CR542 (July 22, 1998); Haverhill Care Center v. Health Care Finance Administration, Departmental Appeals Board Decision No. CR522 (March 10, 1998).

44. Petitioner has determined in a previous administrative hearing that one incident of alleged neglect does not violate requirements to maintain and implement anti-neglect policies. Agency for Health Care Administration v. Beverly Health and Rehabilitation Services -- Palm Bay, DOAH Case No. 01-1605 (Final Order March 14, 2003). Pursuant to the doctrine of administrative stare decisis, Petitioner may not deviate in this case from conclusions of law in previous final orders that are not distinguishable by law or fact. Gessler v. Department of Business and Professional Regulation, 627 So. 2d 501, 504 (Fla. 4th DCA 1993) dismissed, 634 So. 2d 624 (Fla. 1994).

45. Petitioner did not show by even a preponderance of evidence that Respondent committed the violations charged in Counts II and III of the Administrative Complaint. Petitioner presented no evidence of a legal standard that required more services than the facility provided to Residents 7 and 8. Petitioner cited no legal precedent that would authorize

Respondent to provide discharge services to Resident 7 in defiance of two court orders finding Resident 7 to be incompetent and authorizing her legal guardian to determine her residence. A preponderance of evidence did not show that Resident 8 needed pain medication that she did not receive.

46. Counts IV and V are legally moot. The charge in each count depends upon facts that Petitioner did not establish by a preponderance of evidence.

47. Petitioner may have had probable cause to initiate this proceeding based on information available to the surveyors at the conclusion of the survey. However, a proceeding conducted pursuant to Subsection 120.57(1), Florida Statutes (2003), is a de novo proceeding intended to formulate final agency action, not to review agency action taken preliminarily when Petitioner issued the Administrative Complaint. Young v. Department of Community Affairs, 625 So. 2d 831, 833 (Fla. 1993); McDonald v. Department of Banking and Finance, 346 So. 2d 569, 584 (Fla. 1st DCA 1977). The ALJ does not review preliminary action taken by the agency based on evidence gathered by surveyors, but recommends final agency action based on that and other evidence of record through the date of the hearing. See McDonald, 346 So. 2d at 584 (approving admission of evidence of changed conditions and circumstances subsequent

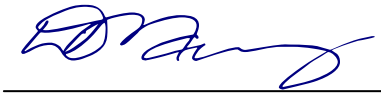
to preliminary agency action that proposed denial of application).

RECOMMENDATION

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

RECOMMENDED that Petitioner enter a final order finding Respondent not guilty of committing the violations charged in the Administrative Complaint.

DONE AND ENTERED this 4th day of February, 2005, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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this 4th day of February, 2005.

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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.