STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

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| DEPARTMENT OF HEALTH, BOARD OF NURSING, | ) | |
| Petitioner, | ) | |
| vs. | ) | Case No. 04-3796PL |
| LOGAN T. LANHAM, R.N., | ) | |
| Respondent. | ) | |

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case before Larry J. Sartin, an Administrative Law Judge of the Division of Administrative Hearings, on January 13, 2005, in Vero Beach, Florida.

APPEARANCES

For Petitioner: J. Blake Hunter, Esquire
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## STATEMENT OF THE ISSUE

The issue in this case is whether Respondent, Logan T. Lanham, R.N., committed the violations alleged in an Administrative Complaint issued by Petitioner, the Department of Health, and, if so, what disciplinary action should be taken against him.

## PRELIMINARY STATEMENT

In a two-count Administrative Complaint dated January 27, 2003, the Department of Health (hereinafter referred to as the "Department") charged Logan T. Lanham, R.N., with having violated statutory provisions governing the conduct of nurses in Florida. Mr. Lanham disputed the factual allegations in the Administrative Complaint by executing an Election of Rights form in which he requested a formal administrative hearing before the Division of Administrative Hearings.

Mr. Lanham's request for hearing was filed with the Division of Administrative Hearings on October 18, 2004, for the assignment of an administrative law judge to conduct an evidentiary hearing. The matter was designated DOAH Case No. 04-3796PL and was assigned to the undersigned.

On October 25, 2004, Petitioner filed Petitioner's Motion for Consolidation requesting that this case be consolidated with Department of Health, Board of Nursing v. Patti Jo Rossi, L.P.N, DOAH Case No. 04-3795PL (hereinafter referred to as the "Rossi

Case"), an action against Patti Jo Rossi's license to practice nursing. Ms. Rossi worked at the same facility as Mr. Lanham and was alleged to have committed very similar violations to those Mr. Lanham is alleged to have committed. The events, however, occurred on separate occasions. On November 2, 2004, an Order Denying Motion for Consolidation was entered.

By Notice of Hearing entered November 8, 2004, the final hearing of this case was scheduled to commence January 13 and 14, 2005, in Vero Beach, Florida.

On December 13, 2004, Petitioner filed Petitioner's Motion for Official Recognition. That Motion was granted by Order entered January 4, 2005.

On December 22, 2004, the parties filed a Joint Prehearing Stipulation. Among other things, the parties included in the Stipulation a Statement of Those Facts That Are Admitted. Those facts have been included in this Recommended Order.

At the final hearing the Department presented the testimony of Sharon Sullivan, L.P.N., Carrie Duprey, L.P.N, Verlecia Toussaint, C.N.A., Scott Eckert, and Rosemary Nunn-Hill, R.N. (accepted as an expert in nursing care). The Department also had admitted 13 exhibits. Mr. Lanham testified on his own behalf.

The final hearing was conducted immediately after the hearing in the Rossi Case. Much of the evidence presented in

that hearing was relevant to the issues presented in the hearing of this case. Therefore, the parties stipulated that the evidence presented in the Rossi Case, except to the extent that it related to specific actions of Ms. Rossi, would constitute part of the record evidence in this case.

By Notice of Filing of Transcript issued February 4, 2005, the parties were informed that the one-volume Transcript of the final hearing had been filed. The parties were also informed that they had until February 23, 2005, to file proposed recommended orders. Both parties filed post-hearing argument, which has been fully considered in entering this Recommended Order.

## FINDINGS OF FACT

A. The Parties.

1. The Department is the agency in Florida responsible for regulating the practice of nurses pursuant to Chapters 20, 456, and 464, Florida Statutes (2004).[1]

2. Mr. Lanham is and has been at all times material hereto a licensed registered nurse in the State of Florida, having been issued license number 3221312.

3. Mr. Lanham, at the times pertinent, was employed in his capacity as a registered nurse by Palm Gardens of Vero Beach (hereinafter referred to as "Palm Gardens"). Mr. Lanham was

employed by Palm Gardens from approximately October 1998 until January 3, 2002.

B. Palm Gardens.

4. Palm Gardens was, at the times pertinent, a Florida licensed residential nursing home facility as defined in Section 400.021(13), Florida Statutes.

5. Palm Gardens' facility included a wing, "A-Wing," which was devoted to the care of residents suffering from various forms of dementia, including Alzheimer's disease. While employed at Palm Gardens, Mr. Lanham was assigned to A-Wing.

6. Due to the tendency of some patients on A-Wing to "wander," A-Wing doors leading to the outside were equipped with alarms which sounded whenever a patient attempted to open them. Whenever an alarm was triggered, employees, including nurses, had to check to ensure that a resident was not leaving the unit.

7. Part of A-Wing consisted of a room which was used as a dining room and day room (hereinafter referred to as the "Day Room"). There were four, floor-to-ceiling, windows at one corner of the Day Room located near an open area of A-Wing, which included a nurses' station.

8. There was a single, heavy, self-closing door providing access to the Day Room. This door was normally propped open. During the pertinent period of time involved in this case, the door to the Day Room was slightly larger at the one corner than

the door jam, which caused the door to stick if closed. Although the door could be opened, it took some strength to do so. The condition of the door was known to employees of A-Wing, including Mr. Lanham.

C. Patients M.S. and G.K.

9. Among the patients on A-Wing were M.S. and G.K., both female residents. Both were elderly, suffered from dementia and Alzheimer's disease, and were in relatively poor physical and mental health.

10. M.S., whose date of birth was February 3, 1920, and G.K., whose date of birth was March 21, 1915, were both totally dependant on the facility and employees of Palm Gardens for their care.

11. Both residents were ambulatory, but not capable of providing the daily necessities of life, such as cleaning themselves or dressing. Neither resident was oriented as to time or place, and both lacked the capacity to consent.

12. Both residents, but especially M.S., had a habit of wandering the halls of A-Wing and touching doors equipped with alarms, which would cause the alarms to sound.

D. The Events of December 13, 2001.

13. On December 13, 2001, Mr. Lanham was working the "swing shift" (from 3:00 p.m. to 11:00 p.m.) on A-Wing.

14. During Mr. Lanham's shift, both M.S. and G.K. were wandering the wing, sometimes setting off door alarms. G.K. was agitated and had been found by Mr. Lanham in another resident's room eating food that had been left in the room.

15. Neither M.S. nor G.K. was harming any other residents or causing any harm to themselves.

16. Out of frustration over having to respond every time that M.S. or G.K. set off an alarm, Mr. Lanham took both residents and directed them into the Day Room, closing the door as he left. By closing the door to the Day Room, Mr. Lanham effectively locked M.S. and G.K. into the room.

17. Mr. Lanham left both residents in the Day Room without any supervision; no one was in the Day Room with them and no one was watching them through the windows between the room and the hall. M.S. and G.K., for most of the time they were in the Day Room, were unsupervised by any employee of Palm Gardens.

18. M.S., crying, attempted unsuccessfully to open the door of the Day Room. M.S. and G.K., however, were too weak to open the door. M.S. began to hit on the door when she couldn't open it. M.S. and G.K. were involuntarily confined to the Day Room.

19. At some point after M.S. and G.K. had been placed in the Day Room, Sharon Sullivan, L.P.N., told Mr. Lanham that M.S. and G.K. had to be let out. He was reminded that the door was

too difficult for them to open when fully closed, which he already knew. Mr. Lanham, after admitting that he had placed M.S. and G.K. in the Day Room and why, indicated that it was okay to leave them in there as long as he could see them. When Ms. Sullivan told Mr. Lanham that she disagreed, he left the unit.

20. Mr. Lanham left A-Wing to go see Carrie Duprey, L.P.N., the House Supervisor. Mr. Lanham indicated to Ms. Duprey that he had a "hypothetical" question. He then asked Ms. Duprey whether it would be considered abuse if, in order to keep a resident occupied, he placed the resident in the Day Room, with the door closed but not locked, as long as a C.N.A. stayed with the resident.[2] Ms. Duprey indicated she did not think that his hypothetical action would constitute abuse.[3]

21. Ms. Duprey's answer to Mr. Lanham's hypothetical question did not constitute, in any way, permission for him to either place M.S. and G.K. in the Day Room or to leave them there. Ms. Duprey was unaware that Mr. Lanham had already placed the residents in the Day Room or that he had placed them there unattended and unable to leave on their own.

22. After speaking with Ms. Duprey, Mr. Lanham returned to A-Wing where he spoke to Ms. Sullivan again. Mr. Lanham again told Ms. Sullivan that placing M.S. and G.K. in the Day Room was okay. Ms. Sullivan continued to disagree. When Ms. Sullivan

persisted, Mr. Lanham opened the door to the Day Room and allowed the residents to leave.

23. M.S. and G.K. had been left in the Day Room with the door closed, unable to leave on their own and with no one else present in the room for somewhere between more than 20 minutes and less than an hour.[4] While they were not actually injured, M.S. and G.K. could have been because they were unsupervised.

E. Unprofessional Conduct.

24. Mr. Lanham's conduct fell below the minimum standards of acceptable and prevailing nursing practice. By placing M.S. and G.K. in the Day Room, unsupervised and unable to leave without assistance, Mr. Lanham failed to protect the welfare and safety of those residents.

25. Mr. Lanham's conduct constituted unprofessional conduct for a nurse.

F. Involuntary Seclusion.

26. Placing M.S. and G.K. in the Day Room, unsupervised and unable to leave without assistance, constituted involuntary seclusion.

27. Based upon the length of time that Mr. Lanham left M.S. and G.K. in the Day Room constituted an "extended" involuntary seclusion.

G. Mr. Lanham's Explanation.

28. Mr. Lanham testified at hearing that he had directed a C.N.A. to stay with M.S. and G.K. when he left them in the Day Room. This testimony is not been credited.

29. Mr. Lanham's version of events is inconsistent with other, more credible witnesses. Additionally, when first asked to give a written statement, Mr. Lanham failed to indicate that he had left anyone in the Day Room with the residents. It was not until he added an addendum to his statement a few days later that he first suggested that others were in the Day Room.

30. Mr. Lanham's testimony at hearing as to whether he placed M.S. and/or G.K. in the Day Room, while not clear, is not credited to the extent that he stated that the did not place them in the Day Room. This testimony conflicts with his admission to Ms. Sullivan and his written statement.

## CONCLUSIONS OF LAW

A. Jurisdiction.

31. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to Sections 120.569 and 120.57(1), Florida Statutes (2004).

B. The Burden and Standard of Proof.

32. In the Administrative Complaint, the Department is seeking the imposition of, among other penalties, the revocation

or suspension of Mr. Lanham's license to practice nursing in Florida. Therefore, the Department has the burden of proving the allegations in the Administrative Complaint by clear and convincing evidence. See Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); and McKinney v. Castor, 667 So. 2d 387 (Fla. 1st DCA 1995).

33. Clear and Convincing evidence has been defined as evidence which:

> 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.

Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

C. The Charges Against Mr. Lanham; Sections 456.072(1) and 464.018, Florida Statutes.

34. The grounds proven in support of the Department's assertion that Mr. Lanham's license should be disciplined must be those specifically alleged in the Administrative Complaint. See, e.g., Cottrill v. Department of Insurance, 685 So. 2d 1371 (Fla. 1st DCA 1996); Kinney v. Department of State, 501 So. 2d

129 (Fla. 5th DCA 1987); and Hunter v. Department of Professional Regulation, 458 So. 2d 842 (Fla. 2nd DCA 1984). Due process prohibits the Department from taking disciplinary action against a licensee based on matters not specifically alleged in the charging instrument, unless those matters have been tried by consent. See Shore Village Property Owners' Association, Inc. v. Department of Environmental Protection, 824 So. 2d 208, 210 (Fla. 4th DCA 2002); and Delk v. Department of Professional Regulation, 595 So. 2d 966, 967 (Fla. 5th DCA 1992).

35. The specific charges contained in the Administrative Complaint are based upon alleged violations of Section 456.072(1), Florida Statutes (Count I), and Section 464.018(1), Florida Statutes (Count II). Both provisions provide authority for the Department to take disciplinary action against the nursing license of any person who commits any of a number of proscribed acts.

36. In Count I, the specific violation alleged is found in Section 456.072(1)(k), Florida Statutes, which authorizes disciplinary action for the following act:

> (k) Failing to perform any statutory or legal obligation placed upon a licensee. [Emphasis added].

37. In support of this violation, the Department alleged in Count I of the Administrative Complaint that Mr. Lanham

violated Section 400.022(1)(o), Florida Statutes, by failing to "respect the right of residents at Palm Garden to be free from mental and physical abuse and extended involuntary seclusion."

38. In Count II, the specific violation alleged is found in Section 464.018(1)(h), Florida Statutes, which authorizes disciplinary action for the following act:

> Unprofessional conduct, which shall include, but not be limited to, any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing nursing practice, in which case actual injury need not be established.

39. In Count II of the Administrative Complaint, the Department alleged that Mr. Lanham violated Section 464.018(1)(h), Florida Statutes, "by isolating patients M.S. and/or G.K. in a room in which patients M.S. and/or G.K. could not voluntarily leave without assistance."

D. Count I; Failing to Perform any Statutory or Legal Obligation Placed Upon a Licensee.

40. In support of the allegation that Mr. Lanham violated Section 456.072(1)(k), Florida Statutes, the Department has argued that Section 400.022(1)(o), Florida Statutes, imposed an obligation on him to refrain from placing M.S. and G.K. in extended involuntary seclusion and that he violated this obligation.

41. In support of the Department's argument, the Department has cited two decisions from this forum in which

Administrative Law Judges found that an obligation was imposed on certified nursing assistants by Section 400.022(1)(o), Florida Statutes. Department of Health, Board of Nursing v. Brett W. Mauch, C.N.A., 2002 WL 1592356 (Fla.Div.Admin.Hrgs. May 24, 2002); and Department of Health, Board of Nursing v. Charsee Boston, 2002 WL 1592356 (Fla.Div.Admin.Hrgs. May 28, 2002).

42. Section 400.022(1)(o), Florida Statutes, provides the following:

> **400.022 Residents' rights.--**
>
> (1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:
>
> . . . .
>
> (o) The right to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint, and, in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter. Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.

(2) The licensee for each nursing home shall orally inform the resident of the resident's rights and provide a copy of the statement required by subsection (1) to each resident or the resident's legal representative at or before the resident's admission to a facility. The licensee shall provide a copy of the resident's rights to each staff member of the facility. Each such licensee shall prepare a written plan and provide appropriate staff training to implement the provisions of this section. The written statement of rights must include a statement that a resident may file a complaint with the agency or local ombudsman council. The statement must be in boldfaced type and shall include the name, address, and telephone numbers of the local ombudsman council and central abuse hotline where complaints may be lodged.

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

(4) Any person who submits or reports a complaint concerning a suspected violation of the resident's rights or concerning services or conditions in a facility or who testifies in any administrative or judicial proceeding arising from such complaint shall have immunity from any criminal or civil liability therefore, unless that person has

> acted in bad faith, with malicious purpose, or if the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party.

43. From the clear language of Section 400.022(1), Florida Statutes, the specific obligations created by the statute are imposed on the "licensee" of the nursing home and not its employees. That is not to say that the rights of residents specified in Section 400.022(1), Florida Statutes, need not be respected by nursing home employees; they must. But if they fail to respect their rights, the remedy must come from some other statutory provision. Section 400.022(1), Florida Statutes, while it creates rights and imposes an obligation on the facility for nursing home residents, does not give the Department the authority to impose discipline on nursing home employees.

44. Based upon the foregoing, it is concluded that the Department has failed to prove clearly and convincingly that Mr. Lanham committed the violation alleged in Count I of the Administrative Complaint.

E. Count II; Unprofessional Conduct.

45. The Department has alleged that Mr. Lanham violated Section 464.018(1)(h), Florida Statutes (displaying unprofessional conduct), by failing to conform to the minimal standards of acceptable and prevailing nursing practice, when he

placed Patients M.S. and/or G.K. in extended involuntary seclusion in violation of Section 464.018(1)(h), Florida Statutes.

46. The evidence in this case clearly and convincingly proved that Mr. Lanham's conduct in placing M.S. and G.K. in the Day Room, unsupervised and unable to leave without assistance, failed to conform to the minimal standards of acceptable and prevailing nursing practice and, therefore, constituted "unprofessional conduct."

47. Based upon the foregoing, it is concluded that the Department proved clearly and convincingly that Mr. Lanham committed the violation alleged in Count II of the Administrative Complaint.

F. Appropriate Disciplinary Action.

48. The Department is authorized, upon finding a violation of Section 456.072(2), Florida Statutes, to impose discipline upon a nurse's license to practice for any violation of Section 456.072(1) or 464.018, Florida Statutes.

49. Florida Administrative Code Rule 64B9-8.006 sets forth guidelines concerning violations of Section 456.072(1) or 464.018, Florida Statutes. For a first offense of unprofessional conduct where there is no actual injury, the guideline provided in the rule is from a minimum of a $250.00 fine to a maximum file of $500.00 and probation.

50. Consistent with the guidelines, the Department has recommended that Mr. Lanham be given a reprimand, required to pay an administrative fine of $250.00, and participate in continuing education classes, the number of and on such subjects as specified by the Board of Nursing. This suggestion is accepted as reasonable.

## RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that a final order be entered by the Department:

1. Dismissing Count I of the Administrative Complaint;

2. Finding that Logan T. Lanham, R.N., violated Section 464.018(1)(h), Florida Statutes, as alleged in Count II of the Administrative Complaint; and

3. Imposing discipline as suggested in this Recommended Order.

DONE AND ENTERED this 9th day of March, 2005, in Tallahassee, Leon County, Florida.

LARRY J. SARTIN
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 9th day of March, 2005.

## ENDNOTES

[1]/ The statutes and rules relevant to this matter are those in existence in 2001. Therefore, all further references to statutes or rules in this Recommended Order shall be to the 2001 version unless otherwise indicated.

[2]/ The evidence failed to prove that Mr. Lanham, as he suggested in his hypothetical question, actually left someone in the Day Room with M.S. and G.K.

[3]/ Ms. Duprey's response was based upon the representation from Mr. Lanham concerning his hypothetical that someone would be with the resident in the Day Room, which was not what actually happened in this case.

[4]/ In a written statement, Mr. Lanham indicated that the residents were in the room "less than 1 hr. total."

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.