STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

HARBOUR HEALTH CENTER, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 04-4498
AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. HARBOUR HEALTH SYSTEMS, LLC, d/b/a HARBOUR HEALTH CENTER, Respondent.	)	Case No. 04-4635

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its duly-designated Administrative Law Judge, Jeff B. Clark, held a final administrative hearing in this case on March 2, 2005, in Port Charlotte, Florida.

APPEARANCES

For Petitioner/Respondent Harbour Health Center:

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

For Respondent/Petitioner Agency for Health Care Administration:

Eric Bredemeyer, Esquire
Agency for Health Care Administration
2295 Victoria Avenue, Room 346C
Fort Myers, Florida 33901

STATEMENT OF THE ISSUES

Whether, based upon a preponderance of the evidence, the Agency for Health Care Administration (AHCA) lawfully assigned conditional licensure status to Harbour Health Center for the period June 17, 2004, to June 29, 2004; whether, based upon clear and convincing evidence, Harbour Health Center violated 42 Code of Federal Regulations (C.F.R.) Section 483.25, as alleged by AHCA; and, if so, the amount of any fine based upon the determination of the scope and severity of the violation, as required by Subsection 400.23(8), Florida Statutes (2004).

PRELIMINARY STATEMENT

On November 3, 2004, Harbour Health Systems, LLC, d/b/a Harbour Health Center (the facility), filed its Petition for Formal Administrative Hearing contesting the imposition of a conditional license from June 17, 2004, to June 29, 2004, based

on alleged deficiencies noted on a survey conducted on June 14 through 17, 2004. This petition was amended on November 24, 2004, by the filing of an Amended Petition for Formal Administrative Hearing. In the Notice of Assignment of Conditional Licensure Status, AHCA alleged that, at the time of the survey, the facility was not in compliance with Chapter 400, Part II, Florida Statutes (2004), based on facts set forth in the survey report. The survey report states that:

> Based upon interview, observation, and record review it was determined the facility failed to assure that 1 (Resident #16) of 21 active sampled residents received the necessary care and service to prevent and/or treat pain in order for the resident to attain and maintain her highest practicable physical and mental well being; and the facility failed to ensure communication between the facility and outside agencies providing services for 1 residents [sic] (Resident #10) to attain and maintain their [sic] highest practicable physical and mental well being; 3) Facility staff failed to identify [a] sore in 1 (Resident #8). This is evidenced by; 1) Resident #16 demonstrating pain during a treatment and not receiving pain medication as ordered; 2) No interdisciplinary care plan between Hospice and the facility, and a delay in receiving treatment for an eye infection resulted due to lack of communication between Hospice and the nursing department for Resident #10. 3) Resident #8 injuring foot by cast friction and facility did not implement interventions to prevent re-injury.

This case was designated DOAH Case No. 04-4498 by the Division of Administrative Hearings.

On November 17, 2004, AHCA filed its Administrative Complaint seeking to impose a $2,500 administrative fine for the deficiencies alleged as a result of the June 14 through 17, 2004, survey. On November 24, 2004, the facility requested an administrative hearing contesting the proposed fine. This case was designated DOAH Case Number 04-4635 by the Division of Administrative Hearings.

An Initial Order was sent to the parties in both cases. On January 14, 2005, an Order of Consolidation was entered. On that same day, the cases were scheduled for final hearing on February 17, 2005, in Port Charlotte, Florida. On February 1, 2005, an Order Granting Continuance and Rescheduling Hearing was entered, granting the facility's Motion for Continuance and rescheduling the final hearing for March 2, 2005.

The final hearing took place as rescheduled on March 2, 2005. AHCA presented four witnesses: Donna Houk, registered nurse specialist, qualified as an expert in nursing; Barbara Pescatore, registered nurse specialist, qualified as an expert in nursing; Ann Sarantos, Bachelor of Science in Nursing, qualified as an expert in nursing; and Marilyn Steiner, a nursing home evaluator. AHCA introduced five composite exhibits, which were accepted into evidence and marked Petitioner's Exhibits 1 through 5. Documentary exhibits of both parties were accepted into evidence subject to appropriate

consideration of any possible hearsay objections. The facility presented eight witnesses: Katherine Warden, registered nurse; Alicia Lawrence, registered nurse; Lynn Ann Lima, Bachelor of Science in Nursing; Gloria Ramirez, Bachelor of Science in Nursing, qualified as an expert in long-term care nursing; Cheryl Cobb-Tellos, qualified as an expert in long-term care nursing; William Lucky, M.D., board certified in wound care; Cheryl Knott, certified nursing assistant; and Catherine Rollins, licensed practical nurse. The facility introduced four composite exhibits which were received into evidence and marked Respondent's Exhibits 1 through 4. By agreement of the parties, the deposition of Dr. Michael Brinson taken on March 16, 2005, was filed with the Clerk of the Division of Administrative Hearings, on April 13, 2005, and considered as final hearing testimony.

The two-volume Transcript of Proceedings was filed with the Clerk of the Division of Administrative Hearings on April 12, 2005. Both parties timely filed Proposed Recommended Orders.

FINDINGS OF FACT

Based upon stipulations, deposition, oral and documentary evidence presented at the final hearing, and the entire record of the proceeding, the following relevant findings of fact are made:

1. At all times material hereto, AHCA was the state agency charged with licensing of nursing homes in Florida under Subsection 400.021(2), Florida Statutes (2004), and the assignment of a licensure status pursuant to Subsection 400.23(7), Florida Statutes (2004). AHCA is charged with the responsibility of evaluating nursing home facilities to determine their degree of compliance with established rules as a basis for making the required licensure assignment. Additionally, AHCA is responsible for conducting federally mandated surveys of those long-term care facilities receiving Medicare and Medicaid funds for compliance with federal statutory and rule requirements. These federal requirements are made applicable to Florida nursing home facilities pursuant to Florida Administrative Code Rule 59A-4.1288, which states that "[n]ursing homes that participate in Title XVIII or XIX must follow certification rules and regulations found in 42 C.F.R. §483, Requirements for Long Term Care Facilities, September 26, 1991, which is incorporated by reference."

2. The facility is a licensed nursing facility located in Port Charlotte, Charlotte County, Florida.

3. Pursuant to Subsection 400.23(8), Florida Statutes (2004), AHCA must classify deficiencies according to the nature and scope of the deficiency when the criteria established under Subsection 400.23(2), Florida Statutes (2004), are not met. The

classification of any deficiencies discovered is, also, determinative of whether the licensure status of a nursing home is "standard" or "conditional" and the amount of administrative fine that may be imposed, if any.

4. Surveyors note their findings on a standard prescribed Center for Medicare and Medicaid Services (CMS) Form 2567, titled "Statement Deficiencies and Plan of Correction" and which is commonly referred to as a "2567" form. During the survey of a facility, if violations of regulations are found, the violations are noted and referred to as "Tags." A "Tag" identifies the applicable regulatory standard that the surveyors believe has been violated, provides a summary of the violation, sets forth specific factual allegations that they believe support the violation, and indicates the federal scope and severity of the noncompliance. To assist in identifying and interpreting deficient practices, surveyors use Guides for Information Analysis Deficiency Determination/Categorization Maps and Matrices.

5. On, or about, June 14 through 17, 2004, AHCA conducted an annual recertification survey of the facility. As to federal compliance requirements, AHCA alleged, as a result of this survey, that the facility was not in compliance with 42 C.F.R. Section 483.25 (Tag F309) for failing to provide necessary care and services for three of 21 sampled residents to attain or

maintain their respective highest practicable physical, mental, and psychosocial well-being.

6. As to the state requirements of Subsections 400.23(7) and (8), Florida Statutes (2004), and by operation of Florida Administrative Code Rule 59A-4.1288, AHCA determined that the facility had failed to comply with state requirements and, under the Florida classification system, classified the Federal Tag F309 non-compliance as a state Class II deficiency.

7. Should the facility be found to have committed any of the alleged deficient practices, the period of the conditional licensure status would extend from June 17, 2004, to June 29, 2004.

Resident 8

8. Resident 8's attending physician ordered a protective device to protect the uninjured left ankle and lower leg from injury caused by abrasive contact with the casted right ankle and leg.

9. Resident 8 repeatedly kicked off the protective device, leaving her uninjured ankle and leg exposed. A 2.5 cm abrasion was noted on the unprotected ankle. The surveyors noted finding the protective device in Resident 8's bed but removed from her ankle and leg.

10. Resident 8 was an active patient and had unsupervised visits with her husband who resided in the same facility but who

did not suffer from dementia. No direct evidence was received on the cause of the abrasion noted on Resident 8's ankle.

11. Given Resident 8's demonstrated propensity to kick off the protective device, the facility should have utilized a method of affixing the protective device, which would have defeated Resident 8's inclination to remove it.

12. The facility's failure to ensure that Resident 8 could not remove a protective device hardly rises to the level of a failure to maintain a standard of care which compromises the resident's ability to maintain or reach her highest practicable physical, mental or psychosocial well-being. The failure to ensure that the protective device could not be removed would result in no more than minimal discomfort.

Resident 10

13. Resident 10 has terminal diagnoses which include end-stage coronary artery disease and progressive dementia and receives hospice services from a local Hospice and its staff. In the Hospice nurse's notes for Resident 10, on her weekly visit, on May 17, 2004, was the observation that the right eye has drainage consistent with a cold. On May 26, 2004, the same Hospice nurse saw Resident 10 and noted that the cold was gone. No eye drainage was noted. No eye drainage was noted between that date and June 2, 2004.

14. On June 3, 2004, eye drainage was noted and, on June 4, 2004, a culture of the drainage was ordered. On June 7, 2004, the lab report was received and showed that Resident 10 had a bacterial eye infection with Methicillin Resistant Staphylococcus Aureus (MRSA) bacteria. On June 8, 2004, the attending physician, Dr. Brinson, referred the matter to a physician specializing in infectious disease, and Resident 10 was placed in contact isolation. The infectious disease specialist to whom Resident 10 was initially referred was not available, and, as a result, no treatment was undertaken until a second specialist prescribed Bactrim on June 14, 2004.

15. From June 8, 2004, until June 14, 2004, Resident 10 did not demonstrate any outward manifestations of the diagnosed eye infection. A June 9, 2004, quarterly pain assessment failed to note any discomfort, eye drainage or discoloration. In addition to noting that neither infectious control specialist had seen Resident 10, the nurses notes for this period note an absence of symptoms of eye infection.

16. Colonized MRSA is not uncommon in nursing homes. A significant percentage of nursing home employees test positive for MRSA. The lab results for Resident 10 noted "NO WBC'S SEEN," indicating that the infection was colonized or inactive.

17. By placing Resident 10 in contact isolation on June 8, 2004, risk of the spread of the infection was reduced, in fact,

no other reports of eye infection were noted during the relevant period.

18. According to Dr. Brinson, Resident 10's attending physician, not treating Resident 10 for MRSA would have been appropriate. The infectious disease specialist, however, treated her with a bacterial static antibiotic. That is, an antibiotic which inhibits further growth, not a bactericide, which actively destroys bacteria. Had this been an active infectious process, a more aggressive treatment regimen would have been appropriate.

19. Ann Sarantos, who testified as an expert witness in nursing, opined that there was a lack of communication and treatment coordination between the facility and Hospice and that the delay in treatment of Resident 10's MRSA presented an unacceptable risk to Resident 10 and the entire resident population. Hospice's Lynn Ann Lima, a registered nurse, testified with specificity as to the level of communication and treatment coordination between the facility and Hospice. She indicated a high level of communication and treatment coordination. Dr. Brinson, who, in addition to being Resident 10's attending physician, was the facility's medical director, opined that Resident 10 was treated appropriately. He pointed out that Resident 10 was a terminally-ill patient, not in acute pain or distress, and that no harm was done to her.

The testimony of Hospice Nurse Lima and Dr. Brinson is more credible.

Resident 16

20. Resident 16 was readmitted from the hospital to the facility on May 24, 2004, with a terminal diagnosis of chronic obstructive pulmonary disease and was receiving Hospice care. Roxanol, a morphine pain medication, had been prescribed for Resident 16 for pain on a pro re nata (p.r.n.), or as necessary, basis, based on the judgment of the registered nurse or attending physician. Roxanol was given to Resident 16 in May and on June 1 and 2, 2004. The observations of the surveyor took place on June 17, 2004.

21. On June 17, 2004, at 9:30 a.m., Resident 16 underwent wound care treatment which required the removal of her sweater, transfer from sitting upright in a chair to the bed, and being placed on the left side for treatment. During the transfer and sweater removal, Resident 16 made noises which were variously described as "oohs and aahs" or "ows," depending on the particular witness. The noises were described as typical noises for Resident 16 or evidences of pain, depending on the observer.

22. Nursing staff familiar with Resident 16 described that she would demonstrate pain by fidgeting with a blanket or stuffed animal, or that a tear would come to her eye, and that she would not necessarily have cried out. According to facility

employees, Resident 16 did not demonstrate any of her typical behaviors indicating pain on this occasion, and she had never required pain medication for the wound cleansing procedure before.

23. An order for pain medication available "p.r.n.," requires a formalized pain assessment by a registered nurse prior to administration. While pain assessments had been done on previous occasions, no formal pain assessment was done during the wound cleansing procedure. A pain assessment was to be performed in the late afternoon of the same day; however, Resident 16 was sleeping comfortably. The testimony on whether or not inquiry was made during the wound cleansing treatment as to whether Resident 16 was "in pain," "okay," or "comfortable," differs. Resident 16 did not receive any pain medication of any sort during the period of time she was observed by the surveyor.

24. AHCA determined that Resident 16 had not received the requisite pain management, and, as a result, Resident 16’s pain went untreated, resulting in harm characterized as a State Class II deficiency. AHCA's determination is not supported by a preponderance of the evidence. In the context that the surveyor considered what she interpreted as Resident 16's apparent pain, deference should have been given to the caregivers who regularly administered to Resident 16 and were familiar with her observable indications of pain. Their interpretation of

Resident 16's conduct and their explanation for not undertaking a formal pain assessment are logical and are credible.

CONCLUSIONS OF LAW

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

26. The regulatory provisions of the Code of Federal Regulations set forth in that section under which AHCA alleges a violation exists, read as follows:

> 42 C.F.R. § 483.25 Quality of care.
>
> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care.

27. Subsection 400.23(8), Florida Statutes (2004), provides the definitions of isolated, patterned, and widespread deficiencies as follows:

> 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.

28. Subsection 400.23(8), Florida Statutes (2004), requires AHCA to classify alleged deficiencies "according to the nature and the scope of the deficiency" and to cite the scope as "isolated, patterned or widespread."

29. Subsection 400.23(8), Florida Statutes (2004), also requires AHCA to classify every alleged deficiency in terms of a class in accordance with statutory definitions of classes, which are set forth below:

> 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. . . .

A fine must be levied notwithstanding the correction of the deficiency.

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 or 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. . . . A fine must be levied notwithstanding the correction of the deficiency.

A class III 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 practicable 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. . . . A citation for a class III deficiency must specify the time within which the deficiency is required to be corrected. If a class III deficiency is corrected within the time specified, no civil penalty shall be imposed.

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. The regulatory provision of the Florida Administrative Code under which AHCA alleges a violation exists, reads as follows:

> 59A-4.106 Facility Policies.
>
> (4) Each facility shall maintain policies and procedures in the following areas:
>
> * * *
>
> (aa) Specialized rehabilitative and restorative services

31. In the conditional licensure case, AHCA has the burden of proving, by a preponderance of the evidence, the existence of the alleged violation of the referenced Quality of Care regulatory provision.

32. In the fine case, AHCA has the burden of proving, by clear and convincing evidence, the existence of a violation of the referenced Quality of Care regulatory provision, before a fine may be imposed.

33. In the fine case, AHCA has the burden of proving by clear and convincing evidence, the alleged violation. Department of Banking and Finance Division of Securities and Investor Protection v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996).

34. Clear and convincing evidence requires that the evidence

> . . . must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking confusion as to the facts in issue. The evidence must be of such a 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.

Inquiry Concerning Judge Davey, 645 So. 2d 398, 404 (Fla. 1994) (quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)).

35. AHCA must demonstrate by clear and convincing evidence both the existence of a violation and the classification of the deficiency alleged in the Administrative Complaint; Agency for Health Care Administration v. Blue Haven Retirement, Inc., Case No. 02-4170 (DOAH May 30, 2003).

36. AHCA is limited to the allegations in its Administrative Complaint, the charging document. See Tampa Health Care Center v. Agency for Health Care Administration, Case No. 01-0734 (DOAH August 22, 2001).

37. A preponderance of the evidence revealed that the facility had failed to adequately secure a protective device to protect Resident 8's non-casted ankle and lower leg. While there is no actual evidence that the abrasion that was noted on

the unprotected ankle was caused by the rough surface of the cast, it is a probable cause. The facility's failure to secure the protective device hardly rises to the level of failure to provide the necessary care and services which compromised Resident 8’s ability to maintain or reach her highest practicable physical, mental or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. The evidence demonstrates a Class III deficiency, and, as a result, AHCA has failed to prove that the facility's failure to secure the protective device is a Class II deficiency.

38. AHCA failed to demonstrate a lack of communication between the Hospice care providers and the facility or the lack of an interdisciplinary care plan. The delay in treatment of the colonized MRSA bacterial infection did not harm Resident 10. By placing Resident 10 in contact isolation when lab results revealed MRSA bacterial infection, appropriate precautionary measures were taken in the event an infectious disease specialist determined that the MRSA was non-colonized. The care and treatment provided Resident 10 did not fall below the requisite standard of care.

39. The care and treatment received by Resident 16 during her wound cleansing procedure was appropriate. The facility staff familiar with Resident 16 did not believe that she needed

pain medication. The subjective assessment of the surveyor, who was exposed to Resident 16 for only a few minutes, is not given as much credence as is the assessments of caregivers who know Resident 16. AHCA failed to prove that Resident 16's care and treatment was below the requisite standard of care.

RECOMMENDATION

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

RECOMMENDED that a final order be entered finding:

1. The facility's failure to secure the protective device to Resident 8's lower leg is not a Class II deficiency, but a Class III deficiency. The facility's care and treatment of Residents 10 and 16 did not fall below the requisite standard. The imposition of a conditional license for the period of June 17 to June 29, 2004, is unwarranted. The facility should have its standard licensure status restored for this period.

2. No administrative fine should be levied.

DONE AND ENTERED this 3rd day of June, 2005, in Tallahassee, Leon County, Florida.

S

JEFF B. CLARK
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 3rd day of June, 2005.

COPIES FURNISHED:

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

Eric Bredemeyer, Esquire
Agency for Health Care Administration
2295 Victoria Avenue, Room 346C
Fort Myers, Florida 33901

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

William Roberts, Acting General Counsel
Agency for Health Care Administration
Fort Knox Building, Suite 3431
2727 Mahan Drive
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.