STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. LAKELAND MANOR HEALTH CARE ASSOCIATES, LLC, d/b/a WEDGEWOOD HEALTHCARE CENTER, Respondent.	)	Case No. 05-0121

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case before Daniel M. Kilbride, Administrative Law Judge of the Division of Administrative Hearings, on April 27, 2005, in Lakeland, Florida.

APPEARANCES

For Petitioner: Kim M. Murray, Esquire
Agency for Health Care Administration
525 Mirror Lake Drive, Suite 330D
St. Petersburg, Florida 33701

For Respondent: Donna Holshouser Stinson, Esquire
R. Davis Thomas, Qualified Representative
Broad and Cassel
Post Office Drawer 11300
Tallahassee, Florida 32302-1300

STATEMENT OF THE ISSUES

Whether Respondent, Lakeland Manor Health Care Associates, LLC, d/b/a Wedgewood Healthcare Center, committed a Class I

deficiency at the time of a survey conducted on October 29, 2004, so as to justify the issuance of a "conditional" license; and whether to impose an administrative fine of $10,000 under Section 400.23, Florida Statutes (2004), and an additional fine of $6,000 under Section 400.19, Florida Statutes (2004).

PRELIMINARY STATEMENT

An Administrative Complaint dated December 22, 2004, was filed by Petitioner, Agency for Health Care Administration ("Petitioner"), against Respondent, Lakeland Manor Health Care Associates, LLC, d/b/a Wedgewood Healthcare Center ("Respondent"), alleging a Class I deficiency, changing its license rating from "standard" to "conditional," and imposing a fine against Respondent. Respondent denied the allegations and timely requested a formal hearing. The matter was forwarded to the Division of Administrative Hearings ("DOAH") for hearing on January 13, 2005, and discovery ensued. An Amended Administrative Complaint was approved for filing on January 27, 2005.

At hearing, Petitioner presented the testimony of five witnesses: Thomas Gill, Health Facility Evaluator II; Leslie Bower, fire protection specialist; Margaret Messenger, registered nurse specialist; Karen Allen, registered nurse specialist; and Kay Sannella, registered nurse specialist and recognized as an expert in general nursing practices.

Petitioner submitted nine exhibits into evidence. Respondent presented the testimony of four witnesses: Mark Mulligan, Respondent's maintenance director; Kelly Riehn, licensed practical nurse (LPN); Clark Evans, Respondent's administrator; and Sharon White, certified nursing assistant (CNA). Respondent submitted four exhibits into evidence. Respondent's Exhibit 1 is the deposition testimony of an additional witness, Bobbie Tyler, a CNA.

A Transcript of the hearing was filed with DOAH on May 24, 2005. Following the granting of a motion for extension of time to file proposed recommended orders, the parties timely submitted Proposed Recommended Orders on June 13, 2004. Both parties' proposals have been given careful consideration in the preparation of this Recommended Order.

FINDINGS OF FACT

Based upon the evidence presented at the final hearing, the following relevant findings of fact are made:

1. At all times material hereto, Petitioner is the state agency charged with licensing of nursing homes in Florida under Subsection 400.021(2), Florida Statutes (2004), and the assignment of a license status pursuant to Subsection 400.23(7), Florida Statutes (2004). Petitioner is charged with evaluating nursing home facilities to determine their degree of compliance

with established rules as a basis for making the required licensure assignment.

2. Pursuant to Subsection 400.23(8), Florida Statutes (2004), Petitioner 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 determines whether the licensure status of a nursing home is "standard" or "conditional" and the amount of the administrative fine that may be imposed, if any.

3. Surveyors note their findings on a standard prescribed Center for Medicare and Medicaid Services (CMS) Form 2567, entitled, "Statement of Deficiencies and Plan of Correction," which is commonly referred to as "Form 2567." 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, and sets forth specific factual allegations that they believe support the violation. Insofar as relevant to this proceeding, Form 2567 identifies Tag F323, which is the basis of Petitioner's charging document.

4. Respondent is a licensed nursing facility located at 1010 Carpenter's Way, Lakeland, Florida 33809.

5. Based on the state requirements of Subsections 400.23(7) and (8), Florida Statutes (2004), and pursuant to Florida Administrative Code Rule 59A-4.133(16)(d), Petitioner determined that Respondent failed to comply with state requirements and under the Florida classification system, classified the noncompliance as an isolated state Class I deficiency which required immediate corrective action because Respondent's noncompliance was likely to cause serious injury, harm, impairment, or death to residents receiving care at Respondent.

6. Should Respondent be found to have committed the alleged deficient practice, the period of the "conditional" licensure status would extend from October 29, 2004, through December 7, 2004, the date of Petitioner's follow-up survey in which the cited violations were found to have been corrected.

7. On October 26, 2004, through October 29, 2004, Petitioner conducted an annual health and life safety survey of Respondent. On the morning of October 26, 2004, Thomas Gill, Petitioner's surveyor, who was the team leader of the survey team, toured the 800 hall of Respondent's facility. Gill was accompanied during his tour of the 800 hall with one of Respondent's employees, Kelly Riehn, an LPN.

8. The survey procedure involved, inter alia, sampling rooms on the hall to determine if the hot water was felt to be

within accepted temperature ranges. After the hot water in the lavatories in Rooms 800 through 803 had been turned on for more than 30 seconds, Gill noted that the skin on his hands turned a reddish color after holding his hands under the water for one to two seconds. He believed the water to be hotter than it should be. Gill proceeded to check the hot water by hand-inspection in the remainder of the rooms on the 800 hall. He found that the other rooms appeared to have hot water within the accepted range, including the bathing areas. The bathrooms in the residents' rooms contain only a toilet and sink.

9. Gill then determined that he needed the maintenance director to come to the 800 hall to test the water temperatures with a thermometer. Gill informed Riehn that he needed the maintenance director. After some delay, Gill reported his findings to the survey team. He then located the life safety surveyor, who conducts an independent survey, and requested that he locate the facility maintenance director and assist him in measuring the water temperature in the four rooms and throughout the facility.

10. After some delay in locating Respondent's employee, Leslie Bower, the life safety surveyor, accompanied the maintenance director, Mark Mulligan, to the maintenance office to review the blueprints for the facility and then proceeded to the room where the hot water heater was located to inspect the

water heating devices and system. Bower then observed Mulligan test the water with a thermometer in three of the resident rooms. The temperature of the hot water coming out of the lavatory faucets in the residents' rooms registered 140 degrees Fahrenheit. To check the water temperatures, the water was allowed to run for 30 to 40 seconds, in order for it to get hot. Bower informed Gill that the hot water in the four affected rooms registered 140 degrees Fahrenheit.

11. Gill reported his findings to the survey team. The survey team determined that because the hot water coming out of the tap was 140 degrees Fahrenheit, there was a likelihood of harm, injury, or death to residents and action need to be taken quickly. The survey team did not suggest that any resident was at risk of receiving extensive burns from immersion in a tub or placement under a shower. The only allegation of likelihood of harm to residents pertained to the sinks in Rooms 800 to 803.

12. Gill informed Respondent's administrator, Clark Evans, at approximately 2:00 p.m., that the hot water in the four residents' rooms was 140 degrees Fahrenheit. Evans immediately proceeded to the four rooms (Rooms 800 through 803), where he tested the hot water with his hands in one of the affected rooms. After approximately 30 seconds, the water became "uncomfortable," and he had to remove his hands. Evans then turned the hot water off under the sink. He instructed Mulligan

to turn off the hot water to the other three sinks, which was done.

13. The evidence clearly reflects that the hot water temperature in the sinks of the four rooms was 140 degrees Fahrenheit on October 24, 2004, if the water was allowed to run for 30 to 40 seconds.

14. During the time of Petitioner's survey, Riehn was a floor nurse on the 700 and 800 halls working the 7:00 a.m. to 3:00 p.m. shift. Riehn presented testimony that she washed her hands after giving medications to residents who resided in Rooms 800 through 803 prior to Petitioner's tour of the 800 hall. She typically washes her hands for 45 seconds. Then, she passes medications out to 30 residents each morning over a period of "about an hour and a half."

15. Riehn testified that she "sometimes" turn on both the hot and cold water faucets when washing her hands. She did not recall anything "exceptional" about the water and that it "seemed normal." Riehn also administered medications at 12:00 noon and 2:00 p.m. on her unit, however, she presented no testimony concerning the water temperature at those times.

16. Respondent had a system in place to check water temperatures on a weekly basis. The maintenance director checked one room on each hall, selected randomly, and checked all bathing areas each week. The reports were written in a log

book, though the room number was not written down. Respondent also had a system for reporting maintenance and safety issues and kept a log for those purposes, as well. Staff received training on how to report safety issues. There was no record of any complaints of the water being excessively hot. There were also no incidents involving hot water in the facility's incident and accident reporting logs.

17. When told that the water temperature in the four rooms was 140 degrees Fahrenheit, Evans attempted to determine the cause of the problem. He and the maintenance director pulled blueprints of the building and determined that those rooms were on a separate water heater from the remainder of the hall. This was an unusual system.

18. As he had experience running a small nursing home, where he also had maintenance director duties, Evans, along with the maintenance director, also inspected the water heater and tried to adjust the mixing valve, which mixes hot and cold water to the appropriate temperature. Instead of resulting in an adjustment, the temperatures changed inconsistently, demonstrating that there was a problem with the valve.

19. The circulating pumps that keep the water flowing through the hot water pipes, which provide hot water to the four affected rooms, were not working. The hot water pipes were on a loop system. Because the circulating pumps were not working,

the hot water, once turned off at the sink, would just sit in the pipes instead of circulating back to the hot water heater. When the hot water was turned on at the sinks, it could come out hot or cold depending on how long it had been since the hot water was last turned off.

20. A plumber was called immediately, and the problem was corrected before the end of the survey.

21. While there was some hearsay evidence that some staff, upon questioning by the surveyors, indicated the water in the affected rooms was overly hot, this evidence was not reliable, as it was not known what questions were asked by the surveyors or in what context, and some of this hearsay was refuted by testimony.

22. The greater weight of the evidence was that facility management had no reason to be aware of a problem with the hot water in those rooms and that as soon as they became aware of the problem, they responded quickly and thoroughly.

23. Resident No. 27, who resides in one of the subject rooms, had dementia, resulting in poor safety awareness; and as a consequence, was at risk for falls. She was in a wheelchair, but would sometimes attempt to stand. Because of these concerns, she had a wheelchair alarm and a bed alarm which would sound if she attempted to get up. Additionally, she was positioned in her chair in front of the nurses' station so she

could be monitored. She was closely observed, and this is reflected in the nursing notes. Staff was required to help Resident No. 27 ambulate. The resident was sufficiently alert to know when she had to go to the bathroom and would request staff assistance. The routine was that staff would take her to the bathroom, place her on the toilet, get her up, and then turn on the water to help her wash. CNAs check water temperatures before wetting a cloth to give to the resident.

24. On one occasion, on September 24, 2004, Resident No. 27 was found in the bathroom by herself. Her bed alarm was going off, and Riehn, who found her, recorded the incident in the nursing notes. Though the water was running, there was apparently no problem with the temperature. This was the only known occasion when the resident tried to use the bathroom without assistance, as she was not allowed to use the bathroom without assistance. Resident No. 27 had no medical problems which would affect feeling in her extremities, and she was capable of feeling pain and reacting to it. She would not leave her hand in water hot enough to cause pain.

25. Resident No. 29, who resides in one of the subject rooms, was more cognitively impaired than Resident No. 27. She required staff assistance for all her activities. She was in a Broda chair, which is a chair positioned to lean back so that a resident will not fall out. While the chair was mobile,

Resident No. 29 did not have the cognitive capability to negotiate it through doorways to reach the bathroom and had never been known to do so. Resident No. 29 also did not have any condition which would cause her to lose feeling in her extremities or prevent her from withdrawing from pain.

26. Resident No. 29 was not capable of getting herself into the bathroom. Resident No. 29 was under close and careful supervision, not because of fear of burns, but because she had a tendency to try to walk and fall. Even if she managed to get into the bathroom without staff observation, even if she turned on the hot water, even if the mixing valve was malfunctioning at that time, even if the water in the pipes was still excessively hot, and even if the facility had not detected and corrected the problem by then, she would have to defy pain while holding some part of her body under the faucet for several seconds. This occurrence was highly unlikely.

27. There did not appear to be a sufficiently significant risk of harm to residents for the lead surveyor to notify facility staff when he checked the water temperature on the initial tour. Instead, he waited to report it at the team meeting, and the team thought it appropriate to wait for the maintenance director to return from lunch to check the temperatures, even though their protocol requires that the survey staff measure with their own equipment.

28. A second-degree burn from water at 140 degrees Fahrenheit requires immersion for approximately five seconds. A second-degree burn damages, but does not destroy the top two layers of skin and heals in ten to 21 days. As it took approximately 30 to 40 seconds for water in the taps to reach 140 degrees Fahrenheit, a scalding burn would require that a person run the water for that period of time, and then hold his hand under the water, in spite of pain, for another five seconds.

29. The problem with the hot water was either of recent origin or very intermittent, as there were no recorded difficulties. The water had been of appropriate temperature just prior to the survey, and no problems had been discovered in the weekly random room checks.

30. Petitioner's position that water coming out of a sink at 140 degrees Fahrenheit constitutes a likelihood of serious injury or death to a resident is at odds with other regulations it enforces. Petitioner requires that hot foods be maintained at 140 degrees Fahrenheit for serving, so that a bowl of soup must be served to a resident at that temperature. It appears that there would be as much, if not more, chance of a burn from spilling a bowl of soup than from using a sink, where a resident would have to turn on the water and let it run and then voluntarily place her hand under the water.

31. The evidence is not convincing that Respondent knew or should have known that water temperatures in the lavatories of four rooms were in excess of 115 degrees Fahrenheit on the day of the survey.

32. The preponderance of evidence does not support the assertion that Residents 27 and 29 were in immediate risk of harm and were likely to be scalded by the hot water.

33. The evidence does not support the likelihood of harm, injury, or death to those residents from the hot water.

CONCLUSIONS OF LAW

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

35. The burden of proof is on Petitioner. See Beverly Enterprises - Florida Agency for Health Care Administration, 745 So. 2d 1133 (Fla. 1st DCA 1999). The burden of proof for the assignment of 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.

Department of Banking and Finance v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996).

36. The Florida Supreme Court has determined that where fines are imposed, the burden of proof must be by clear and convincing evidence, because a fine "deprives the person fined of substantial rights in property." Id. at 935. The requirement of clear and convincing evidence has also been applied to actions which affect reputation and good name. In Latham v. Florida Commission on Ethics, 694 So. 2d 83 (Fla. 1st DCA 1997), the court dismissed arguments that the lack of a fine relieved the Commission of its burden to prove its findings by clear and convincing evidence. In looking "to the nature of the proceedings and their consequences to determine the degree of proof required" (citing Osborn Stern), the court determined that loss of a good name was equally as severe as a monetary fine. Id. at 935.

37. The imposition of a "conditional" license adversely affects the reputation of a nursing facility with the public, and, thus, affects its ability to operate. Clearly, the effect of an adverse survey and the "conditional" rating emanating therefrom is penal in nature and is intended to warn consumers against doing business with the facility. It would seem that the nature of these proceedings, and the consequences from them, require Petitioner to prove its case by clear and convincing

evidence. However, that is not Petitioner's position. Petitioner holds that the rating of a nursing home, as "conditional" is a regulatory measure, not a penal sanction, and the appropriate standard of proof is the preponderance standard. Agency for Health Care Administration v. Washington Manor Nursing and Rehabilitation, Case No. 00-4035 (DOAH May 7, 2001) (Final Order, September 13, 2001).[1/]

38. The parties agree that Petitioner has the burden of proof. In this case, it is unnecessary to determine the standard of proof because Petitioner failed to prove the material allegations under the preponderance standard.

39. Subsection 400.23(7), Florida Statutes (2004), states in relevant part:

> (7) The agency shall, at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a licensure status to that facility. The agency shall base its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. 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 followup survey, a standard licensure status may be assigned. . . .

40. Section 400.23, Florida Statutes (2004), provides for classification of deficiencies as follows:

> (8) The agency shall adopt rules to provide that, when the criteria established under subsection (2) are not met, such deficiencies shall be classified according to the nature and the scope of the deficiency. . . . 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. . . .

41. Subsection 400.19(3), Florida Statutes (2004), provides in pertinent part:

> The survey shall be conducted every 6 months for the next 2-year period if the facility has been cited for a class I deficiency, has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a 6-month

> period, each resulting in at least one class I or class II deficiency. In addition to any other fees or fines in this part, the agency shall assess a fine for each facility that is subject to the 6-month survey cycle. The fine for the 2-year period shall be $6,000, one-half to be paid at the completion of each survey. . . .

42. Florida Administrative Code Rule 59A-4.133, under which Petitioner has charged Respondent, is entitled "Plans Submission and Review and Construction Standards." It sets forth standards for construction. Subsection (16) sets out standards for all facilities, as opposed to new facilities or those being renovated. It states, as follows, in part:

> (16) All facilities shall comply with the following standards:
>
> (a) All operable windows shall be equipped with well fitted insect screens not less than 16 mesh per inch.
>
> (b) Throw rugs or scatter rugs shall not be used in the facility. Floor mats are allowed in the facility.
>
> (c) Interior corridor doors, except for those small closets and janitors’ closets, shall not swing into corridors.
>
> (d) The temperature of hot water supplied to resident use lavatories, showers, and baths shall be between 105 degrees Fahrenheit and 115 degrees Fahrenheit. . . .

43. There is no dispute that Respondent's hot water delivery system was designed and constructed to deliver water at

the appropriate temperature to resident use areas. The problem was that a mechanical device failed.

44. Nursing home regulations do not impose strict liability on nursing homes and cannot be construed as making nursing homes guarantors of occupant safety under all circumstances. Those regulations must be construed as only imposing a duty on nursing homes to make reasonable efforts or use reasonable care to prevent an undesired event. See paragraph 59 of the Recommended Order in Washington Manor, supra; see also § 400.23(1) and (2), Fla. Stat. (2004).

45. Petitioner did not establish at hearing that staff at Respondent knew of and failed to address the faulty mixing valve or that it could have been identified and corrected sooner. To the contrary, Petitioner demonstrated that it had a system in place to monitor hot water which was consistently implemented, as well as a system for reporting problems and that staff was trained in that system. Thus, Petitioner's charge could only be sustained if Respondent is held to the acknowledged impossible standard of preventing hardware from breaking. See Washington Manor, supra.

46. Furthermore, even if there were a strict liability standard, Petitioner did not demonstrate that either Resident No. 27 or Resident No. 29 was likely to suffer serious injury, harm, impairment, or death from 140 degree Fahrenheit water in

the sink in the bathroom.[2/] In fact, that outcome appeared to be decidedly unlikely under the facts demonstrated at hearing. At most, even with a strict liability standard, the circumstances proven by Petitioner presented only a remote "potential" for harm to residents. A deficiency, which only presents a potential for harm to residents, is a Class III deficiency. See § 400.23(8)(c), Fla. Stat. (2004). A Class II deficiency cannot be the basis for a fine or a "conditional" license, unless it is not timely corrected by the nursing home. It was undisputed that Respondent immediately corrected the deficiency asserted by Petitioner. Thus, even assuming that Petitioner proved its alleged deficiency, it failed to prove that the deficiency was severe enough to support any penalties.

47. Regardless of whether Petitioner's burden of proof was the preponderance of the evidence or clear and convincing, Petitioner failed to prove that a Class I or II deficiency existed at Respondent's facility. It was, thus, inappropriate for Petitioner to issue Respondent a "conditional" rating or to impose an administrative fine.

RECOMMENDATION

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

RECOMMENDED that Petitioner, Agency for Healthcare Administration, enter a final order revising the October 24,

2004, survey report by deleting the deficiencies described under Tag F324, issuing a "standard" rating to Respondent to replace the previously-issued "conditional" rating, directing that all other records maintained by Petitioner that reflect the deficiency be revised by deleting it, and dismissing the Administrative Complaint.

DONE AND ENTERED this 29th day of June, 2005, in Tallahassee, Leon County, Florida.

S

DANIEL M. KILBRIDE
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 29th day of June, 2005.

ENDNOTES

1/ See also "Agency Discipline Proceedings: The Preponderance of Clear and Convincing Evidence," Fla. Bar Jur. January 1998. See also an Administrative Law Judge's holding that this argument was "persuasive" contained in paragraph 37 of the Recommended Order in Agency of Healthcare Administration v. Heritage Healthcare Rehabilitation Center, Case No. 98-3091 (DOAH April 6, 1999), adopted in toto by Final Order dated May 20, 1999, and paragraphs 23 to 41 of the Recommended Order in Washington Manor, supra.

2/ There was never any suggestion that anyone was actually harmed by hot water.

COPIES FURNISHED:

Donna Holshouser Stinson, Esquire
R. Davis Thomas, Qualified Representative
Broad and Cassel
Post Office Drawer 11300
Tallahassee, Florida 32302-1300

Kim M. Murray, Esquire
Agency for Health Care Administration
525 Mirror Lake Drive, 330D
St. Petersburg, Florida 33701

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
2727 Mahan Drive
Fort Knox Building, Suite 3431
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.