STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 06-4755
HEALTH CARE DISTRICT OF PALM BEACH COUNTY, d/b/a EDWARD J. HEALEY REHABILITATION AND NURSING CENTER,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on January 30, 2007, by video teleconference with connecting sites in West Palm Beach and Tallahassee, Florida, before Errol H. Powell, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Tria Lawton-Russell, Esquire
Agency for Health Care Administration
Spokane Building, Suite 103
8350 Northwest 52nd Terrace
Miami, Florida 33166

For Respondent: Lori C. Desnick, Esquire
Zumpano Patricios & Winker, P.A.
999 Ponce de Leon Boulevard
Penthouse 1110
Coral Gables, Florida 33134

STATEMENT OF THE ISSUE

The issue for determination is whether Respondent committed the offense set forth in the Administrative Complaint and, if so, what action should be taken.

PRELIMINARY STATEMENT

The Agency for Health Care Administration, hereinafter AHCA, issued a one-count Administrative Complaint against Health Care District of Palm Beach County, d/b/a Edward J. Healey Rehabilitation and Nursing Center, hereinafter Healey Center, dated October 24, 2006. AHCA charged Healey Center with violating Section 400.022(1)(l), Florida Statutes (2005), by committing an isolated Class II deficiency and imposed an administrative fine of $2,500 and a conditional license. Healey Center disputed the material allegations of fact and filed a Petition for Formal Administrative Hearing. On November 20, 2006, this matter was referred to the Division of Administrative Hearings.

Prior to hearing, on January 25, 2006, AHCA filed a Motion to Relinquish Jurisdiction. Subsequently, on January 29, 2006, AHCA filed an Amended Motion to Relinquish Jurisdiction, which was heard at hearing and was denied. Also, prior to hearing, the parties filed a Joint Pre-Hearing Stipulation.

At hearing, AHCA presented the testimony of one witness and entered ten exhibits (Petitioner’s Exhibits numbered 1 through

10) into evidence.[1] Healey Center presented the testimony of five witnesses and entered 25 exhibits (Respondent's Exhibits numbered 2-26) into evidence.

A transcript of the hearing was ordered. At the request of the parties, the time for filing post-hearing submissions was set for ten days following the filing of the transcript. The Transcript, consisting of one volume, was filed on February 7, 2007. Healey Center timely filed its post-hearing submission. AHCA requested an extension of time, by one day, to file its post-hearing submission to which Healey Center objected; the extension of time was granted. The parties' post-hearing submissions have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. At all times material hereto, Healey Center was a 198-bed skilled nursing facility operating at 1200 45th Street, West Palm Beach, Florida, and was licensed under Chapter 400, Florida Statutes.

2. On April 17, 2006, AHCA conducted a complaint survey of Healey Center. AHCA's surveyor was Nina Ashton.

3. At the time of the survey, Healey Center's licensure status was standard.

4. As a result of her survey on April 17, 2007, Ms. Ashton determined that an isolated Class III deficiency had been

committed by Healey Center, citing Tag N201, a violation of Section 400.022(1)(l), Florida Statutes, failure to adequately identify residents whose history render them at risk for abusing other residents. Healey Center was given until May 17, 2006, to correct the deficiency.

5. By letter dated May 4, 2006, Healey Center was notified, among other things, that the allegation that Healey Center "failed to properly meet the needs of a resident who acts inappropriately" was confirmed and that Healey Center had to achieve substantial compliance by May 17, 2006.

6. A follow-up survey was conducted on June 12, 2006. By letter dated July 10, 2006, AHCA notified Healey Center, among other things, that the deficiency had been corrected.

7. Subsequently, AHCA determined that the deficiency was an isolated Class II deficiency. By letter dated August 8, 2006, AHCA notified Healey Center, among other things, that its (Healey Center's) license status was being changed to conditional, effective for the period April 17, 2006 through September 30, 2006, attaching the license thereto. Also, by separate letter of the same date, AHCA notified Healey Center, among other things, that its (Healey Center's) license status was being changed to standard, effective for the period June 8, 2006 through September 30, 2006, attaching the license thereto.

8. As a result of AHCA's determination that an isolated Class II deficiency had been committed, it filed an Administrative Complaint against Healey Center.

9. Ms. Ashton's survey focused on Resident No. 1, involving incidents documented in the Nurses Notes from March 10, 2006 through April 17, 2006. Also, she met with the Director of Nursing (DON), Ingrid Kerindongo, because the administrator of Healey Center was on vacation; with Healey Center's social worker, Jackie Loving; and with the unit manager, Edgar Francois. Further, Ms. Ashton reviewed the medication administration record (MAR).

10. On October 20, 2005, Resident No. 1 was admitted to Healey Center from St. Mary's Medical Center. He was suffering from traumatic brain injury and had a diagnosis of bipolar disorder. He was prescribed medication for his bipolar disorder. Resident No. 1 was homeless and had no family members who were willing or able to take care of him. He had resided in an assisted living facility but the facility refused to re-admit him.

11. Resident No. 1 was placed in an all male unit, Held 3 unit, in a semi-private room. Healey Center has two other units, Held 1 and 2 units, wherein both male and female residents are housed.

12. Healey Center was unable to provide Resident No. 1 with 24-hour male nursing staff but used its best efforts to assign male staff to Resident No. 1. Healey Center employs 35-40 licensed practical nurses (LPNs) of which one is male and 75-78 certified nursing assistants (CNAs) of which two are male.

13. On or about March 10, 2006, Resident No. 1's behavior began to escalate.

14. Resident No. 1 was involved in numerous incidents with staff wherein he displayed sexually aggressive behavior -- using sexually inappropriate words, making sexually inappropriate propositions, and inappropriately touching them. One particular incident occurred on March 22, 2006, involving a female on the laundry staff. While placing clothes in the closet, she turned around to find Resident No. 1 too close in proximity to her and blocking the exit door with his wheelchair.[2] Resident No. 1 indicated to the staff person that he wanted to touch her hands. The staff person managed to exit the room and reported the incident. Resident No. 1 was counseled not to be so close to the staff, not to talk to the staff, and not to make sexual offers to the staff. Further, Resident No. 1's physician and psychiatrist were notified of his behavior.

15. Approximately a week later, on March 30, 2006, Resident No. 1 was acting in an aggressive and threatening manner towards staff, resulting in law enforcement being

contacted. He approached a CNA in his wheelchair and was making biting actions at the CNA, acting as if he were going to bite her. Also, Resident No. 1 was being verbally abusive and sexually aggressive towards another staff member, who notified security, who removed Resident No. 1 from the unit and secured him. Law Enforcement was summoned, and the officers determined that the incident did not constitute a crime but was a matter for Healey Center to address. Resident No. 1's physician was notified, who, the night before, had prescribed Zyprexa to address Resident No. 1's escalated aggressive behavior.

16. Furthermore, on March 30, 2006, the physician ordered Ms. Loving, the social worker, to discharge Resident No. 1 to the 45th Mental Health Center. Ms. Loving discussed the discharge with Resident No. 1, and he refused to go to the Mental Health Center. She contacted the Mental Health Center to come to Healey Center to assess Resident No. 1, but the Mental Health Center refused to do so. Resident No. 1 remained at Healey Center.

17. As to the incidents in which Resident No. 1 was verbally abusive, aggressive, and sexually aggressive towards staff, Ms. Ashton determined that Healey Center had addressed the incidents appropriately and used appropriate interventions, where necessary.

18. Additionally, Resident No. 1 became verbally abusive towards other residents. One particular incident occurred on March 15, 2006 and involved his roommate in which Resident No. 1 was upset because his roommate would not turn-off the television. The supervisor was notified and the staff counseled both, Resident No. 1 and his roommate. Afterwards, Resident No. 1 went to sleep in his room.

19. In another incident occurring on March 22, 2006, Resident No. 1 was arguing with another resident in a loud voice and in a threatening manner, using threatening words. The staff talked with Resident No. 1 to determine why he was upset. After determining the reason for Resident No. 1 being upset and calming both residents, the staff counseled Resident No. 1 and the other resident and re-directed them.

20. As to the incidents in which Resident No. 1 was verbally abusive to other residents, and in particular the two incidents previously mentioned, Ms. Ashton determined that Healey Center appropriately addressed the incidents and was effective in resolving them, and that the interventions were effective.

21. Further, Resident No. 1 engaged in inappropriate sexual behavior towards and inappropriate touching of staff. In particular, on April 15, 2006, while answering Resident No. 1's call bell, a CNA found him naked, waiting for her. Also, on

April 16, 2006, Resident No. 1 attempted to grab a nurse's buttocks.

22. Furthermore, Resident No. 1 engaged in several incidents involving inappropriate touching of other residents. Two incidents occurred on April 16, 2006, the day before AHCA's survey. One incident involved Resident No. 1 being in another unit, during lunch time, and the staff observing him touching the breast of a female resident, who was ambulating to the dining room, under the pretense of assisting the female resident to the dining room. The supervisor was immediately notified and, upon hearing the notification to the supervisor, Resident No. 1 left the unit. The other incident on April 16, 2006, involved the staff observing Resident No. 1 kissing another resident on the forehead. This incident was also reported.

23. Another incident, involving inappropriate touching of another resident, occurred on April 17, 2007, the day of the survey. Resident No. 1 was observed rubbing the shoulders of another resident, as if massaging the shoulders. The staff advised him not to touch the other residents, and he left. However, he soon returned, rubbing his own shoulders. The staff again advised Resident No. 1 not to touch the other residents at which time he laughed and walked away. This incident was also reported.

24. Resident No. 1 had been refusing to take his medication which was prescribed to control his behavior and included Zyprexa, Seroquel, and Effexor. Numerous entries were made on the MAR indicating his refusal, including March 15, 16, 18, 19, 21, 23, 24 and April 11, 12, 13, and 14, 2006.

25. The evidence did not demonstrate that Resident No. 1's Care Plan was not appropriate, was not appropriately revised and did not contain appropriate interventions or that the interventions were not appropriately implemented by Healey Center. Furthermore, the evidence did not demonstrate that the behavior of Resident No. 1 was not addressed in accordance with his Care Plan.

26. Resident No. 1's physician and psychiatrist were kept informed of all the incidents involving staff and other residents and of Resident No. 1's refusal to take his medication. Resident No. 1's psychiatrist discussed with him his refusal to take medication and, at times, obtained compliance and partial compliance. Resident No. 1's Care Plan contained interventions to obtain his compliance to take medication, and Ms. Ashton found the interventions to be appropriate.

27. The evidence demonstrates that a resident has a right to refuse medication and cannot be compelled to take medication.

28. From April 1 through 6, 2006, Resident No. 1 refused to take his medication. On April 6, 2006, the necessary documentation to Baker Act Resident No. 1 was completed by the doctor, and Resident No. 1 was Baker Acted. On April 11, 2006, Resident No. 1 was returned to Healey Center, and he began to take his medication again.

29. On April 17, 2006, the day of the survey, Resident No. 1 had agreed, after having a discussion with the psychologist, to submit himself for assessment at a psychiatric facility for voluntary admission.

30. On the day of the survey, Ms. Ashton informed Healey Center that it should not accept Resident No. 1 back. She was very concerned that his aggressive and sexually inappropriate behavior had escalated and had moved from being directed at the staff to the residents.

31. Ms. Ashton determined and testified at hearing that Healey Center should have discharged Resident No. 1. Her testimony is found to be credible. She also determined and testified that, when Resident No. 1 was Baker Acted on April 6, 2006, Healey Center should not have re-accepted Resident No. 1 but should have discharged him. Her testimony is again found credible.

32. Ms. Ashton testified that she determined that Healey Center had committed an isolated Class III deficiency. Her

supervisor, Maryanne Salerni, has final approval for the classifications of deficiencies. Ms. Salerni agreed and testified at hearing that the violation was an isolated Class III deficiency.

33. As to Healey Center committing an isolated Class III deficiency, the testimony of Ms. Ashton and Ms. Salerni is found to be credible.

34. On May 15, 2006, Resident No. 1 was Baker Acted. On May 16, 2006, Resident No. 1 was discharged to a mental health facility. At hearing, Ms. Ashton testified that the deficiency had been corrected by May 17, 2006, because Resident No. 1 had been discharged from Healey Center on May 16, 2007.

CONCLUSIONS OF LAW

35. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and the parties thereto pursuant to Sections 120.569 and 120.57(1), Florida Statutes (2006).

36. To impose a fine, AHCA has the burden of proof to show by clear and convincing evidence that Healey Center committed the offense in the Administrative Complaint. Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Company, 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

37. To impose a conditional license, AHCA has the burden to show by a preponderance of the evidence that a basis exists for reducing the licensure status of Healey Center from standard to conditional. See Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981); §120.57(1), Fla. Stat.(2005).

38. Section 400.022, Florida Statutes (2005), provides in pertinent part:

> (1) All licensees of nursing home facilities shall adopt and make public a statement of 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:
>
> * * *
>
> (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

39. Section 400.23, Florida Statutes (2005), provides in pertinent part:

> (7) The agency shall . . . assign a licensure status of standard or conditional to each nursing home.
> (a) A standard licensure status means that a facility has no class I or class II deficiencies and has corrected all class III

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

* * *

(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 scope shall be cited as isolated, patterned, or widespread. An isolated deficiency is a deficiency affecting one or a very limited number of residents, or involving one or a very limited number of staff, or a situation that occurred only occasionally or in a very limited number of locations. . . The agency shall indicate the classification on the face of the notice of deficiencies as follows:

* * *

(b) A class II deficiency is a deficiency that the agency determines has compromised the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. A class II deficiency is subject to a civil penalty of $2,500 for an isolated deficiency . . . A

> fine shall be levied notwithstanding the correction of the deficiency.
>
> (c) A class III deficiency is a deficiency that the agency determines will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or reach his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. A class III deficiency is subject to a civil penalty of $1,000 for an isolated deficiency . . . 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.

40. The Administrative Complaint charged Healey Center with committing an isolated Class II deficiency. AHCA failed to demonstrate that an isolated Class II deficiency existed as to Resident No. 1 at Healey Center. The evidence demonstrates that an isolated Class III, not Class II, deficiency existed. Consequently, AHCA failed to demonstrate the existence of an isolated Class II deficiency at Healey Center.

41. Furthermore, the evidence demonstrates that the isolated Class III deficiency was corrected within the required time period.

42. Hence, Healey Center's licensure status should have remained standard.

43. Further, because the evidence failed to demonstrate an isolated Class II deficiency as charged in the Administrative Complaint, a fine of $2,500 should not be imposed.

RECOMMENDATION

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

RECOMMENDED that the Agency for Health Care Administration enter a final order finding that Health Care District of Palm Beach County, d/b/a Edward J. Healey Rehabilitation and Nursing Center did not commit an isolated Class II deficiency and dismissing the Administrative Complaint.

DONE AND ENTERED this 1st day of May 2007, in Tallahassee, Leon County, Florida.

ERROL H. POWELL
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 1st day of May, 2007.

ENDNOTES

[1/] Page 22 of Petitioner's Exhibit 1 was excluded.

[2/] Resident No. 1 was not ambulatory at that time.

COPIES FURNISHED:

Tria Lawton-Russell, Esquire
Agency for Health Care Administration
Spokane Building, Suite 103
8350 Northwest 52nd Terrace
Miami, Florida 33166

Lori C. Desnick, Esquire
Zumpano Patricios & Winker, P.A.
999 Ponce de Leon Boulevard
Penthouse 1110
Coral Gables, Florida 33134

Andrew C. Agwunobi, Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308

Craig H. Smith, General Counsel
Agency for Health Care Administration
Fort Knox Building, Suite 3116
2727 Mahan Drive
Tallahassee, Florida 32308

Richard Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
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.