STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

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2009 JAN -8 A 10:54
DIVISION OF
ADMINISTRATIVE
HEARINGS

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

DOS OF CRYSTAL RIVER ALF, LLC, d/b/a CRYSTAL GEM ALF,

Respondent.
_____/

DOAH CASE NO. 08-0822
AHCA NO. 2007013718

RENDITION NO.: AHCA-09-0017-FOF-OLC

FINAL ORDER

This cause was referred to the Division of Administrative Hearings where the assigned Administrative Law Judge (ALJ), Ella Jane P. Davis, conducted a formal administrative hearing. At issue in this case is whether Petitioner Agency for Health Care Administration (Petitioner) should impose an administrative fine in the amount of $2,000 based upon two cited State Class II deficiencies pursuant to Section 429.19(2)(b), Florida Statutes (2007) on Respondent DOS of Crystal River, ALF, LLC d/b/a Crystal Gem ALF (Respondent). The Recommended Order entered on October 31, 2008, is attached to this Final Order and incorporated herein by reference, except where noted infra.

RULING ON EXCEPTIONS

The Petitioner filed exceptions to the Recommended Order to which the Respondent filed a response.

In its first exception, Petitioner took exception to the conclusions of law in Paragraph 70 of the Recommended Order, arguing that the ALJ used the wrong burden of proof in deciding the

matter. However, contrary to Petitioner's argument, the ALJ articulated the correct burden of proof in Paragraph 60 of the Recommended Order. The ALJ's use of the words "necessarily establish" in Paragraph 70 of the Recommended Order are not an incorrect burden of proof as alleged by the Petitioner, but rather just dicta contained with the conclusions of law in Paragraph 70 of the Recommended Order. Therefore, Petitioner's first exception is denied.

In its second exception, Petitioner took exception to the conclusions of law in Paragraphs 73 and 74 of the Recommended Order, arguing that the ALJ incorrectly interpreted the Respondent's duty to contact a resident's health care provider when a resident exhibits a significant change and read the definition of "significant change" too narrowly. The conclusions of law in Paragraphs 73 and 74 of the Recommended Order revolve around the ALJ's weighing of the evidence presented in the case in reaching her conclusion that the Petitioner failed to prove that the Respondent committed a violation. "The agency is not authorized to weigh the evidence presented, judge credibility of witnesses, or otherwise interpret the evidence to fit its desired ultimate conclusion." Heifetz v. Dep't of Bus & Prof'l Regulation, 475 So.2d 1277, 1281 (Fla. 1st D.C.A. 1985). Therefore, Petitioner's second exception is denied. However, the conclusions of law in this case regarding whether the Respondent committed a violation of Rule 58A-5.0182(1), Florida Administrative Code, should be solely limited to the particular facts of this case and should not be given general applicability.

In its third exception, Petitioner took exception to the conclusions of law in Paragraphs 70 and 71 of the Recommended Order, arguing that the ALJ incorrectly interpreted the Respondent's duty to maintain an accurate Medication Observation Record ("MOR"). Petitioner is correct in its assertion that the ALJ's own findings of fact demonstrate that the Respondent did not maintain an up-to-date MOR as required by Rule 58A-5.0185(5)(b), Florida Administrative

Code. However, in Paragraph 71 of the Recommended Order, the ALJ concluded that the Petitioner failed to prove that the Respondent's failure to maintain an up-to-date MOR as required by Rule 58A-5.0185(5)(b), Florida Administrative Code, was a Class II violation. Case law has held that "an agency may not rely on its own expertise to reverse the administrative law judge's finding that a particular statute was not violated." Gross v. Dep't of Health, 819 So.2d 997, 1001 (Fla. 5th DCA 2002). However, in the case at bar, the ALJ did not say that the Respondent did not violate Rule 58A-5.0185(5)(b), Florida Administrative Code, but rather stated that the Petitioner failed to prove that the factual findings constituted a Class II violation. An agency may enter a final order that reduces or increases a recommended penalty if it reviews the complete record and states in the final order its reasons therefore by citing to the record in justifying the action. See Pillsbury v. Dept. of Health & Rehab. Srvs., 705 So.2d 32, 33 (Fla. 2d DCA 1997). A complete review of the record of this case demonstrates that the Respondent did violate Rule 58A-5.0185(5)(b), Florida Administrative Code, and that the violation constituted a Class III violation under Section 429.19(2)(c), Florida Statutes (2007), because it indirectly or potentially threatened the physical or emotional health, safety or security of Resident No. 1. The ALJ's findings of fact in Paragraphs 23, 24, 25, 27 and 44 demonstrate that the MOR was not "immediately updated each time the medication [was] offered or administered" as required by Rule 58A-5.0185(5)(b), Florida Administrative Code. These findings of fact were, in turn, supported by competent, substantial evidence and stipulated to by both parties. See Transcript, Volume I, Pages 73-77; AHCA Exhibit 5; and the Pre-hearing Stipulation filed on June 27, 2008. Because the MOR was not correctly updated, it could have potentially threatened the resident's physical health by resulting in Resident No.1 being overmedicated. However, there is nothing in the record to indicate that the Respondent did not correct this deficiency, or that this was a repeat

deficiency. Thus, by law the Agency cannot impose a fine on the Respondent. See Section 429.19(2)(c), Florida Statutes (2007). The Agency finds that it has substantive jurisdiction over the conclusion of law in Paragraph 71, and that it could substitute a conclusion of law that is as or more reasonable than that of the ALJ. Therefore, Petitioner's third exception is partially granted to the extent that Paragraph 71 of the Recommended Order is modified to state:

> 71. As to Count I of the Administrative Complaint, while the Petitioner did not prove that Respondent was guilty of a Class II deficiency, the evidence demonstrates that the Respondent is guilty of a Class III deficiency because not correctly updating the MOR could have potentially threatened Resident No. 1's physical health. However, because there is nothing in the record to indicate that the Respondent did not correct this deficiency or that it was a repeat deficiency, the Agency is prohibited by law from imposing a fine on the Respondent.

FINDINGS OF FACT

The Agency adopts the findings of fact set forth in the Recommended Order.

CONCLUSIONS OF LAW

The Agency adopts the conclusions of law set forth in the Recommended Order, except where noted supra.

ORDER

Based upon the foregoing, Respondent committed a Class III deficiency by violating Rule 58A-5.0185(5)(b), Florida Administrative Code, based on the allegations in Count I of the Administrative Complaint. However, because there is no record evidence to indicate that the Respondent failed to correct the deficiency or that this was a repeat deficiency, the Agency is prohibited by law from imposing a fine on the Respondent for this violation. Count II of the Administrative Complaint is hereby dismissed. The parties shall govern themselves accordingly.

DONE and ORDERED this 31st day of December, 2008, in Tallahassee, Florida.

HOLLY BENSON, SECRETARY
AGENCY FOR HEALTH CARE ADMINISTRATION

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been furnished by U.S. or interoffice mail to the persons named below on this 6th day of January, 2009.

RICHARD J. SHOOP, Agency Clerk
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stated that because the two types of records did not match, no one can be sure what happened. With regard to the Lorazepam, he testified that there were no more missing doses than the doses which were indicated to have been given, and that the doses which were indicated to have been given to the resident to self-administer were in accordance with her prescription.

34. According to Mr. Brooker, all that can be said, based on Respondent facility's records for Hydrocodone is that something was not given but not that too much was given. The facility's written record in no way indicated an overdose of Hydrocodone.

35. It is Respondent facility's protocol that if a resident falls, the incident must be documented and the facility administrator, the resident's doctor (health care provider), and the resident's family must be notified. A "follow-up" document is also required to be made out 24 hours later. Respondent's protocol concerning any injury to a patient is similar, and if the fall/other injury is severe enough, the facility personnel must call 911 for medical aid and transport of the resident to a hospital. There is no reason for facility employees to fail to report a resident's fall. This facility had all it needed to contact this resident's doctor.

36. It was not established that the resident ever fell in Respondent's facility.

37. However, on the morning of Sunday, April 8, 2007, the resident was having difficulty walking. She was unsteady on her feet and complained of pain consistent with what the facility knew about her fractured ribs, that from her admission she had occasionally complained of discomfort or pain on her right side. (See Finding of Fact 13). She had decreased gait and balance and was brought to the facility's dining room for breakfast in a wheelchair. These observations were recorded in the Observation Log by "C.E," Ms. Erick.

38. On April 8, 2007, the resident ate only twenty-five per cent of her breakfast, but that was not unusual. There is no discernable pattern for her consumption of food while in the facility.[3/] There is no evidence that the resident lost weight in Respondent's facility.

39. On April 8, 2007, Ms. Erick telephoned the resident's daughter in Key West and notified her that her mother had suffered a change of ambulation and was having difficulty walking, with decreased gait and balance. Further content, duration, and sequence of the exchange during this telephone call are in dispute, particularly as to whether Ms. Erik told the daughter that the resident had right hip pain or informed her about the use of a wheelchair, and whether the daughter instructed the facility to take the resident to a hospital if necessary, but it is undisputed that ultimately, Ms. Erick

suggested to the daughter, and the daughter agreed, that they give the pain medication, which the Observation Log states had been self-administered at breakfast-time, a chance to work and talk later in the day.

40. The daughter did not request, and Ms. Erick did not offer, to put the resident on the phone at the time of this initial phone call so that the daughter could get the resident's assessment of the situation. However, Ms. Erick and the daughter concur that the daughter called back that evening to inquire about her mother, and that during the daughter's return phone call, Ms. Erick told the daughter that the resident had no current complaints of pain and the daughter said she would pick her mother up on Tuesday.

41. On April 8, 2007, Ms. Erick initialed a single long comment in the Observation Log covering Findings of Fact 39 and 40.

42. Following Ms. Erick's April 8, 2007, Observation Log entry, there is a later, April 8, 2007, entry in a different handwriting, signed by someone else. The entry includes that the resident complained of slight pain in the rib area and stated that she was a little stiff. It further states that the resident ate 75 per cent of her meal and received nourishment via a snack; that the daughter was told of pain; that the daughter stated she would be in "tomorrow" to pick up her

mother, and that pain meds were again provided to the resident. Whether the person who signed this second notation for April 8, 2007, actually spoke with the daughter is unclear, because that writer did not testify, and both Ms. Erick and the daughter are clear that only two telephone conversations took place between them, but this later April 8, 2007, notation in the Observation Log does confirm that April 8, 2007, is the only day that the resident ingested two "pain" tablets of Hydrocodone.

43. Based upon the evidence as a whole, including the candor, demeanor, and reasonableness of the respective testimony of Ms. Erick and the daughter, and particularly the contemporaneous Observation Log in its entirety, it is not credible that pain specifically in the right hip was complained-of by the resident on April 8. Also, the next day, April 9, 2007, the Observation Log shows a notation of no complaints of pain from the resident, only stiffness, and this notation is also signed by a staff member other than Ms. Erick.

44. In summary, the Observation Log shows that "Hydrocodone prn for pain" is the pain medication, and that on April 5, one pain pill was given; on April 7, one pain pill was given; and on April 8, two pain pills were given. The CSCR shows two, and the MOR shows only one, Hydrocodone pill was given on April 8, 2007.

45. Respondent did not contact the resident's health care provider during the period beginning when she entered the facility on April 5, 2007, and ending when she was discharged from the Crystal Gem facility on April 10, 2007. (Stipulated)

46. Breakfast at the facility is served in the dining room at approximately 7:00 a.m. Residents are dressed before they go to the dining room, but the Observation Log for April 10, 2007, contains no entry concerning the resident's breakfast. On April 10, 2007, when the daughter arrived between 8:30 and 9:00 a.m., the resident was lying on her bed, fully clothed. Ms. Erick assisted the resident into a wheelchair, and the daughter took the resident to her car, later returning the wheelchair to the facility. The daughter was not assisted in this endeavor by any facility employee. The daughter testified that someone in the parking lot assisted her with getting the resident into her car. She described the resident as pale, weak, unresponsive, and confused during this period.

47. Facility protocol calls for Ms. Erick to count out each of a resident's medications with the family member who signs out the resident and to have the family member sign for the pills being returned. Although neither Ms. Erick nor the daughter has any memory of counting out the pills, there is a notation in the Observation Log by another staff person for that day, stating that medications were given to the daughter.

Because of this contemporaneous notation, and because the daughter signed for the pills returned to her at the bottom of the CSCR, it is more likely than not that the pills were counted out by another staff member and the daughter, than that they were not counted out at all and were already bagged in the resident's luggage, as testified-to by the daughter. This CSCR sign-out sheet shows that from April 5-10, 2007, five Hydrocodone tablets were used and nine Lorazepam tablets were used. (See Findings of Fact 25-26.)

48. On April 10, 2007, during the 25-minute drive home from Respondent's facility, the daughter was unable to converse with the resident, who was moaning and unresponsive.

49. Upon arriving at the home, the daughter realized that she could not lift or carry the resident to the house.

50. At approximately 11:00 a.m. April 10, 2007, the daughter appeared at the door of her next door neighbor's home, asking for assistance. The neighbor is a registered nurse. The neighbor went with the daughter and found the resident sitting on the walkway between the car and the family home, several feet from the car. The resident was sleepy, difficult to move, and was unable to stand. The women moved the resident into her bedroom inside the house, using a rolling computer chair.