STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 08-3719
WOODLANDS EXTENDED CARE, INC., d/b/a WOODLAND TERRACE EXTENDED CARE CENTER,	)	
Respondent.	)	

RECOMMENDED ORDER

A hearing was held pursuant to notice on January 13 and 14, 2009, by Barbara J. Staros, assigned Administrative Law Judge of the Division of Administrative Hearings, in Deland, Florida.

APPEARANCES

For Petitioner: Michael O. Mathis, Esquire
Mary Alice H. David, Esquire
Agency for Health Care Administration
2727 Mahan Drive
Mail Station 3
Tallahassee, Florida 32308

For Respondent: Theodore E. Mack, Esquire
Powell & Mack
803 North Calhoun Street
Tallahassee, Florida 32303

STATEMENT OF THE ISSUE

Whether Respondent committed the violations alleged in the

Second Amended Administrative Complaint and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (AHCA) filed an Amended Administrative Complaint on July 1, 2008, alleging two class I deficiencies and seeking the imposition of an administrative fine and survey fee for a total of $36,000, a six-month survey cycle, and imposition of a conditional license on Respondent. Respondent, Woodland Extended Care, Inc., d/b/a Woodland Terrace Extended Care Center, (Woodland Terrace) requested a formal administrative hearing, and AHCA forwarded the case to the Division of Administrative Hearings on or about July 29, 2008. A hearing was scheduled for October 14 and 15, 2008, in Deland, Florida.

On August 8, 2008, AHCA filed a Motion to Amend and Serve Second Amended Administrative Complaint and the parties filed a Joint Motion for Continuance on the same date. The motions were granted and the hearing was rescheduled for December 2 and 3, 2008. On September 25, 2008, Respondent filed an unopposed Motion to Reschedule Hearing, which was granted. The hearing was rescheduled for January 13 and 14, 2009, and proceeded as scheduled on the allegations contained in the Second Amended Administrative Complaint.

Count I of the Second Amended Administrative Complaint alleges that Woodland Terrace failed to conduct periodically an accurate assessment for one of 29 sampled residents in violation of Sections 400.23 and 400.102, Florida Statutes, and Florida Administrative Code Rule 59A-4.109. Count II alleges that Woodland Terrace failed to ensure that the environment remained as free of accident hazards as possible for one of six sampled residents identified as residents who smoked in the facility, in violation of Sections 400.23 and 400.102, Florida Statutes. Count III seeks to impose a conditional license and six-month survey fee totaling $6,000 pursuant to Section 400.19(3), Florida Statutes. Both Counts I and II categorize the violations as class I and seek to impose a $15,000 fine for each Count, for a total of $30,000, plus a $6,000 survey fee.

At hearing, Petitioner presented the testimony of Shane Reed, Linda Walker, Stephanie Fox, and Nancy Marsh. Petitioner's Exhibits numbered 1 through 6, and 11, including the deposition testimony of James Gregory, were admitted into evidence. Respondent presented the testimony of Lawanda Stevens, Nicole Leonard, Miriam Mercado, Bonnie Gray, and Margaret Van Der Malen. Respondent’s Exhibits 1 through 4 were admitted into evidence, including the deposition testimony of Robert Pippin.

A Transcript, consisting of four volumes, was filed on February 6, 2009. Petitioner filed an Unopposed Motion for Enlargement of Time in which to file proposed recommended orders. That request was granted. On March 23, 2009, Respondent filed an unopposed Request for Official Recognition, which is hereby granted. The parties timely filed Proposed Recommended Orders, which have been duly considered. All references to Florida Statutes are to the codification in effect at the time of the alleged violation, i.e., the 2007 or 2008 versions, unless otherwise indicated.

FINDINGS OF FACT

1. AHCA is the agency responsible for the licensing and regulation of skilled nursing facilities in Florida pursuant to Chapter 400, Florida Statutes.

2. At all times material hereto, Woodland Terrace was licensed by AHCA as a skilled nursing facility. Woodland Terrace is located in Deland, Florida, and operates a 120-bed facility.

The May 2008 Survey

3. On May 5 through 9, 2008, AHCA conducted an annual survey of Woodland Terrace. Shane Reed is a registered dietician employed by AHCA. One of her job duties is to survey nursing homes for compliance. She was part of the survey team

during the annual survey that gave rise to the Second Amended Administrative Complaint and to this proceeding.

4. Ms. Reed was assigned to review Resident #164. On May 6, 2008, Ms. Reed looked for Resident #164 in his room. He was not in his room, but, after being told that he was outside smoking, Ms. Reed found Resident #164 sitting in his wheelchair smoking outside in front of the facility. Because there is glass in the area near the door where he was located, Resident #164 could be seen through the glass. He did not have oxygen with him.

5. Ms. Reed observed what appeared to be a cigarette burn hole in Resident #164's housecoat, ashes on his lap, and noted that his cigarette was burning close to his fingers.

6. Ms. Reed asked Resident #164 15 to 20 questions as part of stage I of the survey, which is for purposes of interviewing and getting data. Ms. Reed found him to be alert and oriented. When she asked him if he knew if he had a burn hole in his housecoat, he replied affirmatively, but indicated he did not care because he had two others.

7. On May 7, 2008, Ms. Reed again reviewed Resident #164 as part of stage II of the survey, which is the investigative part. Resident #164 was one of the residents who was reviewed under stage II because he was also a hospice patient.

8. Ms. Reed went to Resident #164's room. She saw him lying in bed with his oxygen nasal cannula on while a certified nursing assistant (CNA) took his vital signs. Resident #164 was the only resident in the room.

9. When Ms. Reed observed Resident #164, he was not smoking. However, she asked the CNA where Resident #164 kept his cigarettes. The CNA opened the drawer of the nightstand next to Resident #164's bed. Ms. Reed observed a carton of cigarettes and a full, plastic cigarette lighter.

10. At that point, Ms. Reed looked at Resident #164's care plan. Because his care plan identified him as having a problem in the past with the facility's smoking rules and indicated that his smoking materials were to be kept at the nurses' station, Ms. Reed asked another surveyor, Linda Walker, RN, to come into the room.

11. Ms. Walker is employed by AHCA as a registered nurse specialist and is responsible for conducting surveys of licensed facilities. Ms. Walker entered Resident #164's room with Ms. Reed. She observed Resident #164 sitting in bed with an oxygen cannula in his nose, with the oxygen running. Ms. Walker also observed the smoking materials in Resident #164's nightstand drawer.

12. Ms. Walker than asked Resident #164 a few questions about where he went to smoke. Resident #164 informed Ms. Walker that when he smoked, he went outside. He also informed her that he was aware that he was not to smoke while on oxygen. Neither Ms. Reed nor Ms. Walker asked Resident #164 whether he was aware that the smoking materials were in his nightstand or if he knew they were supposed to be at the nurses' station or on a cart.

13. Ms. Reed then approached the team leader, Robert Pippin, RN, regarding her concerns about Resident #164 having smoking materials in his room. Ms. Walker and Mr. Pippin then went to Resident #164's room. After a brief observation, Mr. Pippin and Ms. Reed left to call the area office for guidance.

14. After discussions with the area office, Ms. Reed and Mr. Pippin contacted the Director of Nursing, Bonnie Gray, and the administrator, who did not testify, and took them to Resident #164's room. Ms. Gray and the administrator saw the nightstand drawer open with the smoking materials inside. The administrator immediately removed the cigarettes and the lighter, while the Ms. Gray adjusted the oxygen cannula on Resident #164, which was slightly askew.

15. The survey team then broadened their review to include all other smokers in the building. They found one other resident who was a smoker and on oxygen, but found no problems

regarding that resident. They also found that another smoking resident, not on oxygen, had been once found smoking in his room. However, because that incident had been handled appropriately and quickly, they did not cite the facility for any violation regarding that resident. The survey team did not interview any other CNAs who provided care to Resident #164.

16. According to Ms. Walker, the reason for the team's determination to assign class I violations was that the cigarettes and lighter were found in the nightstand drawer by the CNA who did not immediately remove the smoking materials. According to Mr. Pippin, the decision to call the situation an "immediate jeopardy" came from the central office in Tallahassee. Immediate jeopardy is a term found in federal regulations.

17. Ms. Nancy Marsh is the field office manager for AHCA in the Jacksonville area office, which covers Volusia County where Respondent is located. The survey team called Ms. Marsh during the survey visit. Based upon the information provided to her, and after discussions with the Tallahassee office of AHCA, a decision was made that a class I violation existed at Woodlands. According to Ms. Marsh, it was the degree of possible harm to Resident #164 that convinced her that a class I situation existed.

18. Ms. Marsh based this opinion in part on her mistaken belief that Resident #164 was continually non-compliant regarding his smoking restrictions.

Background-Resident #164

19. Resident #164 was admitted to Woodland Terrace on July 2, 2007. His diagnosis was end-stage chronic obstructive pulmonary disorder (COPD). Upon admission, he was evaluated, as are all persons admitted to the facility, by a nurse who completed a Nursing Evaluation Tool (evaluation).

20. On this initial evaluation, Resident #164's mental status was described as "alert," and demonstrated no fluctuation in safety awareness due to cognitive decline.

21. Section "G" of the evaluation is entitled "smoking screen." In answer to the question, "Does the resident smoke?", the nurse who completed the form checked "yes" and added the notation, "but not at the moment." In answer to the next question, "If yes, is he/she interested in smoking cessation program?", the notation appears "no, has nicotine patch." A nurse's note on the date of admission noted that Resident #164 was oxygen dependent and his nicotine patch was to be ordered only as long as he was not smoking.

22. Because Resident #164 was not smoking at the time of admission, he was not screened for smoking under section "G."

The evaluation form also indicates that he was given a document entitled “Woodland Terrace Smoking Rules & Regulations,” which was signed by Resident #164’s power of attorney in his presence.

23. Resident #164 was consistently described by staff who worked with him as alert and oriented. He was very likeable and known by everyone in the facility. He independently propelled himself in his wheelchair, and was one of the few residents who could carry on a conversation with staff. He was the only resident who was allowed to administer his own medication (eye drops).

24. On July 16, 2007, a Minimum Data Set (MDS) for resident assessment and screening was completed for Resident #164. As with the Nursing Evaluation Tool, this form is completed by a nurse upon admission, readmission, quarterly, or when there has been a significant change in the resident. The MDS confirmed the initial evaluation regarding Resident #164’s cognitive ability. That is, his long and short-term memory was marked “OK”, he was able to recall the current season, the location of his own room, staff names and faces, and that he was in a nursing home. Additionally, the MDS assessment indicates that he had no limitation in range of motion and no loss in voluntary movement.

25. The MDS generates a trigger sheet of specific areas of concern that are then addressed in care plans. A care plan

addresses the needs of the resident and sets out interventions to meet those needs. A typical resident has 20-to-30 care plans. Resident #164's care plans were first generated on July 16, 2007, shortly after the MDS was completed.

26. The facility had care plans for Resident #164 for, among other things, COPD and Cognitive Loss/Dementia. The primary problem the facility had with Resident #164 was his noncompliance in taking oxygen. Staff observed that he apparently believed that if he could wean himself off oxygen, he could go home. Several staff members described him, initially at least, to be in denial of his terminal condition.

27. Care plans are reviewed quarterly or earlier and are updated based upon the continuing assessment of the resident. Upon review, each care plan is not totally rewritten, but is updated. When changes are made, the changes are noted on the care plans. In the case of Resident #164, care plans were reviewed and changes made on July 16 and 17, 2007, October 18, 2007, January 17, 2008, and February 27, 2008. For example, his COPD care plan included the following as an intervention: "encourage [Resident #164] not to smoke and do teaching with him on benefits of not smoking." At a later care plan review, the notation "provide education on" was added to the previous intervention regarding his smoking.

28. From the time Resident #164 first was admitted into Woodland Terrace in July 2007, until approximately November 2007, he would attempt to go periods of time without his oxygen. This created problems because his oxygen level would drop in his blood and he would become short of breath. To address the occasional problem of his cognition being affected by either a drop in his oxygen level or other health issues, facility staff and hospice frequently worked with him to educate and encourage him to use his oxygen.

29. While he was not smoking when he was admitted into the facility, Resident #164 started smoking again at some point. He would take the oxygen off and go outside to smoke. Because he had resumed smoking, his nicotine patch was discontinued by his doctor at the facility's request, and, later, his oxygen prescription was changed from "continuous" to "as needed." This was done because he had to remove the oxygen to smoke.

30. Resident #164's resident records are replete with notations that when he smoked, he went outside the facility. There was no indication that he ever took his oxygen with him when he went outside to smoke. On the contrary, most of the notes specifically state that he left his oxygen in his room when he went outside to smoke.

31. When Resident #164 went outside to smoke, he would propel himself in his wheelchair and could be seen through glass near the door by the nurses at the nursing station.

The October 31, 2007, Incident

32. At 5:30 a.m. on October 31, 2007, a CNA went into Resident #164's room and noticed the smell of cigarette smoke. She notified the unit manager, an LPN, who went into the room, smelled smoke, and saw cigarette ashes on the nightstand. The unit manager asked Resident #164 whether he had been smoking. He acknowledged to her that he had been smoking in his room and showed signs that he was confused, as he thought he was in a garage. The unit manager again explained to him the dangers of smoking in his room and he acknowledged that he understood this.

33. An Incident Report was completed. The report does not indicate whether Resident #164 was or was not on oxygen at the time he was found smoking in his room.[1/]

34. A morning meeting is conducted every day at 9:00 a.m. When an Incident Report is filed, it is discussed at the next morning meeting. The incident was discussed at the next morning meeting. The Investigation Report form that was filled out at that meeting notes, "Nursing to hold cig and lighter for resident, to prevent further incident."

35. At that time, Ms. Gray was the Assistant DON. She called Resident #164's power of attorney, his nephew, and informed him that all cigarettes and lighters that he or any visitors bring into the facility for Resident #164 were to be delivered to the nurses' station, not to the resident's room. This was important because it was well known by facility staff that Resident #164 had friends and relatives who would bring him cigarettes and lighters when they came to visit, or when they took him on outings outside of the facility.

36. Resident #164's Smoking Care Plan was reviewed to address the incident. That care plan required that a smoking assessment be done quarterly and as needed, that his smoking materials be kept at the nurses' station, not in his room or on his person, that Resident #164 be given only one cigarette at a time, and that a nurse light the cigarette for him, and that he may smoke only with supervision.

37. At hearing, Ms. Walker acknowledged that Woodland Terrace took appropriate action at that time in handling the incident.

38. As a result of the Incident Report, a 72-Hour Incident Follow-Up was conducted and the form completed. During that 72-hour period, Resident #164 was closely monitored. He was not observed smoking during that time. However, on November 1,

2007, the day following the incident, a green lighter was found in his room and was removed by a nurse.

39. On November 2, 2007, the Nursing Standards Committee discussed the smoking incident concerning Resident #164, and noted it on the summary of the committee's discussion. This was not a notation of another smoking incident, just a recapitulation of the events of the week.[2/]

40. On November 15, 2007, Resident #164 left the facility and went out of the facility with a friend. When he returned, he stayed outside to smoke. Lawanda Stevens was the LPN on duty. Ms. Stevens went outside to the smoking area to check on him. She noticed that he had two cigarette lighters in a pack of cigarettes. When she asked him for the lighters, he initially refused to hand them over to her. Ms. Stevens noted in the nurse's notes that he had possession of the lighters.

41. When Resident #164 came inside the building, Resident #164 voluntarily handed the lighters and his cigarettes to Ms. Stevens. Ms. Stevens did not make a notation in the nurse's notes that he voluntarily gave her the lighters when he re-entered the building, as she was going off shift and assumed the problem was solved. Ms. Stevens told the oncoming nurse what had happened regarding Resident #164 and the lighters.

Woodland Terrace's Smoking Policy and Smoking Safety Assessment

42. Both Counts I and II reference Woodland Terrace's "smoking policy." Count I alleges that the facility failed to complete a smoking assessment for Resident #164, "which was not in keeping with the facility's smoking policy and procedure for residents who smoke in the facility." Count II alleges that the facility's "smoking policy with Addendum A and Addendum B did not ensure precautions for individual safety in securing smoking items which created a fire hazard for all residents in the facility."

43. The Woodland Terrace Smoking Policy was given to Resident #164 upon admission, along with the Smoking Rules and Regulations referenced in paragraph 22 above. The Smoking Policy states in pertinent part:

> 1. Smoking is prohibited in any room, ward or compartment where flammable liquids, combustible gases or oxygen is used or stored and in any hazardous location.
>
> 2. Smokers who are residents must have the smoking safety assessment completed and in the medical record.
>
> * * *
>
> 4. It shall be the responsibility of the nursing staff to develop and implement a smoking care plan for any resident that is determined to be incapable of abiding by the safe smoking policy. See Addendum A for Smoking Safety Assessment.

> 5. All residents who smoke will sign the smoking rules and regulations upon admission into the facility. See Addendum B for Smoking Rules and Regulations.

44. The Woodland Terrace Smoking Rules and Regulations clearly state that residents who smoke may only do so in designated areas if they are able to keep their cigarettes safely in their possession, and may not smoke in their rooms or in the bathrooms. The smoking rules also state that anyone who does not abide by the rules will lose the privilege of smoking and will be able to do so only with supervision.

45. In addition to these policies, there is a form entitled “Smoking Safety Assessment.” According to the DON, Ms. Gray, Woodland Terrace interprets the facility’s policy to require a Smoking Safety Assessment to be completed when a resident exhibits an inability to follow the smoking policy and rules and regulations. Using the facility’s interpretation of the policy, it was not necessary for the Smoking Safety Assessment to be completed for Resident #164 until he began exhibiting an inability to follow the smoking rules.

46. As discussed earlier, Resident #164 was not screened for smoking safety upon admission to the facility under section G of the Nursing Assessment Tool because he was not smoking at the time of admission.

47. Following the October 31, 2007, incident, Woodland Terrace developed a Smoking Care Plan discussed in detail above. However, the Smoking Safety Assessment form was not completed for Resident #164 until January 12, 2008.

48. The Smoking Safety Assessment form consists of a scoring system, wherein a resident can score between zero and 18 points. A score of six or higher required that a resident may only smoke with certain restrictions. Resident #164 scored 10 on the Smoking Safety Assessment.

49. As a result of this score, the Smoking Safety Assessment noted that Resident #164 must request smoking materials from nursing staff and must be supervised by staff, a volunteer, or a family member at all times while smoking.

50. The restrictions noted on the Smoking Safety Assessment Form are consistent with the more detailed smoking care plan, as updated immediately following the October 31, 2007, incident, which required that Resident #164's smoking materials were to be kept at the nursing station, that he would be supervised when smoking, and that he was to receive one cigarette at a time with a nurse lighting the cigarette.

51. There was considerable testimony from nurses on all three shifts that Resident #164’s smoking supplies were kept on the nurse’s medicine cart, and that he would let a nurse know that he wanted to go outside and smoke. Once he was outside, a

nurse would light his cigarette. Often, someone would stay with him, but, in any event, the nurses at the nursing station were able to observe Resident #164 through the glass near the door to the front of the building, which they could observe from the nursing station.

52. Between October 31, 2007, and the May 2008 survey, Resident #164 was assessed for smoking in his smoking care plan on October 31, 2007, January 17, 2008, and again on February 27, 2008, when he was readmitted after going into the hospital. The next quarterly smoking assessment was not due until May 27, 2008, after the survey took place.

53. Between October 31, 2007, and the survey in May 2008, Resident #164 did not smoke in his room, consistently went outside to smoke after a nurse got his cigarettes out of the medicine cart and assisted him.

54. The facility staff is educated to follow a resident's care plan which addresses the needs of the residents and interventions to meet those needs. Basic information and specific care issues from the care plan are noted on Care Cards to assist staff in remembering the needs of the residents. Resident #164's care card had a notation reminding staff that he was on oxygen, that he smoked, and that the nurses kept his smoking materials. The staff, including the CNA who failed to remove the smoking materials from Resident #164's drawer,

received in-service training on care cards on March 11, 2008. The CNA who failed to remove the smoking materials also attended another in-service training on March 20, 2008, that included reminders to check rooms for inappropriate items.

55. Despite this training, the CNA who was in the room on May 6, 2008, failed to remove the smoking materials. While she did not normally work with Resident #164, she had a duty to be familiar with the issues regarding his oxygen use, smoking and smoking materials that were on his care plan and on his care card. Because she failed to adequately familiarize herself with his care plan and care card, evidenced by her failure to remove the smoking materials, she was terminated from employment with Woodland Terrace.

Other Fire Safety Requirements

56. As noted in paragraph 43 above, AHCA alleges that the smoking policy did not ensure precautions for individual safety in securing smoking items, which created a fire hazard for all residents of the facility. Considerable evidence was presented as to whether or not Woodland Terrace's smoking policy met or violated various federal regulations, as AHCA does not have rules or its own fire safety codes regarding smoking or smoking policies in nursing homes.[3/]

57. James Gregory works for AHCA in the Office of Plans and Construction. Mr. Gregory is an architect who manages the activities of 46 architects, engineers, and fire protection specialists who review and approve all of the new health care construction in Florida having to do with hospitals, nursing homes, and surgical centers. He also coordinates five fire protection specialists and training for ten fire safety inspectors who do all of the inspections of nursing homes for certification. Mr. Gregory was tendered at his deposition, without objection, as an expert in fire and life safety codes concerning long-term care facilities, and is accepted as such.

58. Mr. Gregory had not visited Woodland Terrace, but answered questions regarding the facts and circumstances surrounding this case. In particular, Mr. Gregory focused on the dangers of smoking in the presence of oxygen use.

59. Smoking in the presence of concentrated oxygen creates a high probability of fire. In order for such a fire to occur, there must be combustible materials and the ignition of those smoking materials. Although oxygen is not combustible, it supports combustion.

60. Mr. Gregory and Ms. Marsh were particularly sensitive to the dangers of smoking in the presence of oxygen use because another nursing home had experienced a fire due to a resident smoking while using oxygen. The resident in that facility was

getting smoking materials from other residents and smoking in his room while on oxygen, with his door closed. That facility was not fully sprinklered and did not have smoke detectors in residents' rooms.

61. Woodland Terrace is a fully sprinklered building, and its residents' doors are not closed unless they are receiving care in their rooms. According to Mr. Gregory, the danger of fatality in a sprinklered facility is to the person in the room where the fire occurs. Also according to Mr. Gregory, there has never been a multiple death fire in a fully sprinklered health care facility.

62. In its Life Safety Code inspection done in conjunction with the May 2008 survey, AHCA determined that the facility was in compliance with relevant portions of the National Fire Protection Association's Life Safety Code.

CONCLUSIONS OF LAW

63. The Division of Administrative Hearings has jurisdiction over the parties and subject matter in this case. §§ 120.569 and 120.57, Fla. Stat. (2008).

64. The burden of proof in this proceeding is on the agency. Because of the proposed penalties in the Second Amended Administrative Complaint, the agency is required to prove the allegations against Respondent by clear and

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

65. Count I of the Second Amended Administrative Complaint alleges as follows:

> On or about May 9, 2008, Woodland Terrace Extended Care Center failed to conduct periodically an accurate assessment for one of 29 sampled residents, Resident #164.
>
> The facility failed to comprehensively assess Resident #164's smoking needs and behaviors which had the potential to result in a fire hazard, putting the safety and well-being of all facility residents in harms way. The facility failed to complete a smoking assessment for this resident which was not in keeping with the facility's smoking policy and procedure for residents who smoke in the facility.
>
> Resident #164 was found smoking in their room hooked up to the oxygen canister next to the bed on more than one occasion per the nurses notes and the direct care staff interviewed. The lack of an updated accurate comprehensive assessment that would give the staff the interventions to prevent a fire created Immediate Jeopardy, endangering the health and safety of not only Resident #164 but all residents residing in the facility.

66. Count II of the Second Amended Administrative Complaint alleges as follows:

> On or about May 9, 2008, Woodland Terrace Extended Care Center failed to ensure the environment remained as free of accident hazards as possible for 1 of 6 residents identified as residents who smoked in the facility. The facility failed to ensure that Residents [sic] #164 was safe and that

> the individualized plan of care, which reflected behavior problems in relationship to poor safety awareness and smoking in their room, was followed. The facility failed to include the oxygen use of this residents [sic] while smoking as a part of their plan of care. This use of oxygen was observed during the survey and the staff indicated that the resident had smoked in their room.
>
> The facility's Smoking Policy with Addendum A and Addendum B did not ensure precautions for individual safety in securing smoking items which created a fire hazard for all residents in the facility.
>
> The lack of supervision of this resident, who was known by staff as a smoker, had been known to have smoked in their room, and was observed using oxygen during the survey, places this resident and all other residents residing in the facility in danger of serious injury or possible death.

67. Counts I and II classified the violations as class I, scope-widespread, and noted a correction date of June 9, 2008.

68. AHCA cites as authority for Counts I and II Section 400.23(8)(a), Florida Statutes, which defines class I deficiencies and licensure status as a result of those deficiencies, and cites Section 400.23(7)(b), Florida Statutes, in Count III regarding the imposition of a conditional license. Section 400.23, Florida Statutes, reads in pertinent part as follows:

> 400.23 Rules; evaluation and deficiencies; licensure status--

(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.
. . .
(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.
. . .

* * *

(8) The agency shall adopt rules pursuant to this part and part II of chapter 408 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. 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. 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. 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.

69. AHCA further cites Section 400.102(1), Florida Statutes, as authority for Counts I and II. Section 400.102(1) reads as follows:

> Section 400.102--Action by agency against licensee: grounds.--

> In addition to the grounds listed in part II of chapter 408, any of the following conditions shall be grounds for action by the agency against a licensee:
>
> (1) An intentional or negligent act materially affecting the health or safety of residents of the facility.

70. AHCA also cites as authority for Count I Florida Administrative Code Rule 59A-4.109(1), which reads as follows:

> Resident Assessment and Care Plan
>
> (1) Each resident admitted to the nursing home facility shall have a plan of care. The plan of care shall consist of:
>
> (a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential.
>
> (b) A preliminary nursing evaluation with physician's orders for immediate care, completed on admission.
>
> (c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment shall be:
>
> 1. Reviewed no less than once every 3 months.
>
> 2. Reviewed promptly after a significant change in the resident's physical or mental condition.
>
> 3. Reviewed as appropriate to assure the conditioned accuracy of the assessment.

71. The Second Amended Administrative Complaint seeks to impose a $15,000.00 administrative fine for each class I

deficiency with the scope characterized as “widespread” in both Counts I and II.

72. Count III seeks to impose a conditional license, and a six month survey fine of $6,000. AHCA cites as authority Sections 400.19(3) and 400.23(7)(b), Florida Statutes,

73. Section 400.19(3), Florida Statutes, requires that a survey be conducted every six months for the next two-year period if the facility has been cited for a class I deficiency, and authorizes the imposition of a fine of $6,000 for each facility that is subject to the six-month cycle.

74. AHCA failed to prove the allegations in Count I. The evidence established that, upon admission to the facility, Woodland Terrace identified Resident #164 as a smoker who was not currently smoking because he was on a nicotine patch, appropriately assessed Resident #164 when he began smoking again, assessed him again in a care plan after the October 31, 2007, incident, and updated that care plan quarterly as required.

75. Woodland Terrace should have completed their Smoking Safety Assessment Form following the October 31, 2007, incident. However, while it did not fill out that particular form at that time, the evidence is clear that they continually assessed Resident #164 regarding his smoking and, therefore, the failure of completing the form was in the nature of a

documentation error. Woodland Terrace did what it was required to do to assess Resident #164 for his safety and the safety of the other residents.

76. Moreover, the evidence is clear that the allegation in Count I that Resident #164 was found smoking in his room while hooked up to the oxygen canister next to his bed on more than one occasion, is simply not correct and not supported by the evidence. First, the evidence showed that he smoked in his room once. There was no evidence to establish that he was on oxygen the one time he smoked in his room. To the contrary, AHCA conceded that he must not have been on oxygen at the time of the incident because he was still alive during the survey.

77. An analysis of Count II requires examining each paragraph of the allegations contained therein, as the allegations are not numbered.

78. Regarding the first sentence of the first paragraph, despite all of Respondent's efforts, the CNA's failure to remove the smoking materials in May 2008 did not ensure that the environment remained free of accident hazards for Resident #164. Thus, AHCA proved the allegation in the first sentence of the first paragraph of Count II.

79. As to the second sentence, AHCA failed to prove that the facility failed to include oxygen use of Resident #164 in his plan of care.

80. As to the second paragraph, AHCA failed to prove that the facility's smoking policy did not ensure precautions for individual safety in securing smoking items thereby creating a fire hazard for all residents of the facility.

81. In its Proposed Recommended Order, AHCA cited as authority Florida Administrative Code Rule 59A-4.130, which deals with fire prevention, fire protection, and life safety in the construction of nursing homes. This rule was also referenced by Mr. Gregory in his deposition. However, the Second Amended Administrative Complaint does not cite this rule and, therefore, does not put Respondent on notice of any alleged violation of same. See Travisani v. Department of Health, 908 So. 2d, 1108 (Fla. 1st DCA 2005), and Ghani v. Department of Health, 714 So. 2d 1113 (Fla. 1st DCA 1998).

82. While AHCA proved a deficiency as alleged in the first sentence of the first paragraph, it did not prove that "the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in the facility." More than six months had elapsed between the one smoking incident and the survey, at which time smoking materials were found in Resident #164's nightstand. All indications were that Resident #164 understood that he had to go outside the facility to smoke and, indeed, he did so consistently since the October 31, 2007 incident.

Accordingly, applying the statutory definition, the deficiency does not rise to a class I deficiency as defined in Section 400.23(8)(a), Florida Statutes. No other deficiency class was alleged in the Second Amended Administrative Complaint.

83. The third paragraph of Count II goes primarily to the scope of the deficiency. AHCA characterized the scope of the deficiency as widespread. The evidence does not support this conclusion. The smoking materials located in Resident #164's nightstand had the potential to cause serious injury to Resident #164. However, because the facility is fully sprinklered, the potential danger was to him, not to the other residents.

84. Applying the definitions found in Section 400.23(8), Florida Statutes, AHCA proved that the deficiency, which is of a level below class I, was within the scope of "isolated," as defined in Section 400.23(8), Florida Statutes.

85. In light of the disposition of Count II of the Second Amended Administrative Complaint, the $6,000 survey fee sought by AHCA to be imposed pursuant to Section 400.19(3), Florida Statutes, is not appropriate, as a class I deficiency was not established by the evidence.

86. Finally, AHCA seeks to impose a conditional status to the facility's license. Section 400.23(7)(b), Florida Statutes, states that a conditional license is appropriate "due to the

presence of one or more class I or class II deficiencies. . . . is not in substantial compliance at the time of the survey."

87. A class I deficiency was alleged and not established. No other deficiency class was alleged, and the undersigned is not inclined to assign one not alleged by the agency which has the burden of proof in this proceeding.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law set forth herein, it is

RECOMMENDED:

That the Agency for Health Care Administration enter a final order dismissing the Second Amended Administrative Complaint against Respondent, Woodland Terrace.

DONE AND ENTERED this 28th day of April, 2009, in Tallahassee, Leon County, Florida.

BARBARA J. STAROS
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 28th day of April, 2009.

ENDNOTES

1/ AHCA's Field Office Manager, Ms. Marsh, assumed that Resident #164 was not on oxygen at the time of the October 31, 2007, incident, “because he was still with us at the survey.”

2/ However, AHCA, in reaching its conclusions which resulted in the Administrative Complaint in this matter, considered this to be a separate incident of Resident #164 smoking in his room.

3/ This evidence will be discussed only in the context of the statutory and rule authority cited in the Second Amended Administrative Complaint, which did not allege any violation of federal regulations or state rules specifically regarding fire or smoking safety.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this recommended order. Any exceptions to this recommended order should be filed with the agency that will issue the final order in this case.