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2009 OCT 30 P 1:20

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

DOAH CASE NO. 09-1235
FRAES NOS. 2008014009
2008014010
RENDITION NO.: AHCA-09- 1163 -FOF-OLC

NF SUWANNEE, LLC, d/b/a
SUWANNEE HEALTH CARE CENTER,

Respondent.
_______________________________/

FINAL ORDER

This cause was referred to the Division of Administrative Hearings where the assigned Administrative Law Judge (ALJ), Barbara J. Staros, conducted a formal administrative hearing. At issue in this case is whether Respondent committed the violations alleged in the Administrative Complaint and, if so, what penalty should be imposed. The Recommended Order dated September 22, 2009, is attached to this Final Order and incorporated herein by reference.

RULING ON EXCEPTIONS

The parties did not file any exceptions to the Recommended Order.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW

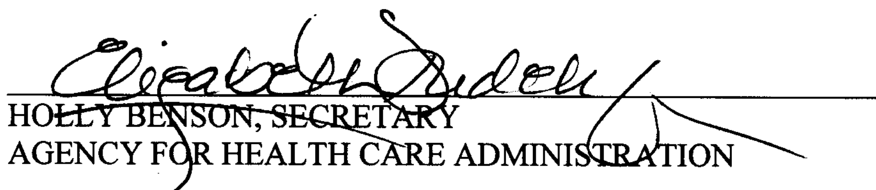
The Agency adopts the conclusions of law set forth in the Recommended Order. However, the conclusions of law in the Recommended Order regarding whether the Respondent committed the violations alleged in the Administrative Complaint should be solely limited to the particular facts of this case and should not be given general applicability.

Filed November 3, 2009 2:48 PM Division of Administrative Hearings.

ORDER

Based upon the foregoing, the Administrative Complaint issued by the Agency in this matter is hereby dismissed.

DONE and ORDERED this 29 day of October 2009, in Tallahassee, Florida.



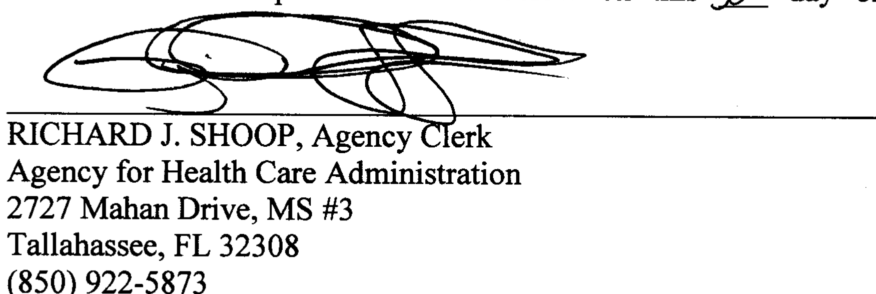
HOLLY BENSON, SECRETARY
AGENCY FOR HEALTH CARE ADMINISTRATION

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 30th day of October, 2009.



RICHARD J. SHOOP, Agency Clerk
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COPIES FURNISHED TO:

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STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. NF SUWANNEE, LLC, d/b/a SUWANNEE HEALTH CARE CENTER, Respondent.	)	Case No. 09-1235

RECOMMENDED ORDER

A hearing was held pursuant to notice on July 8, 2009, by Barbara J. Staros, assigned Administrative Law Judge of the Division of Administrative Hearings, in Live Oak, Florida.

APPEARANCES

For Petitioner: Shaddrick Haston, Esquire
Agency for Health Care Administration
2727 Mahan Drive
Fort Knox Building, Mail Stop 3
Tallahassee, Florida 32308

For Respondent: R. Davis Thomas, Jr.
Qualified Representative
Delta Health Group, Inc.
2 North Palafox Street
Pensacola, Florida 32502

STATEMENT OF THE ISSUE

Whether Respondent committed the violations alleged in the Administrative Complaint and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (AHCA) filed an Administrative Complaint on February 19, 2009, seeking to impose an administrative fine and to impose a conditional licensure rating from December 12, 2008 through January 20, 2009, on Respondent alleging a Class II deficiency. Specifically, the Administrative Complaint alleged that Respondent, NF Suwannee, LLC, d/b/a Suwannee Health Care Center (Suwannee or the facility) failed to ensure that one of 23 residents in a sample received supervision, care, and services to prevent falls, failed to assess and care plan the resident for falls, which resulted in the resident receiving an injury. Suwannee requested a formal administrative hearing, and AHCA forwarded the case to the Division of Administrative Hearings on or about March 10, 2009.

A hearing was scheduled for May 6, 2009, in Live Oak, Florida. Two motions for continuance were granted and the hearing was ultimately rescheduled to be heard on July 8, 2009. The parties filed a Joint Prehearing Stipulation on July 1, 2009. The hearing took place as scheduled.

At hearing, Petitioner presented the testimony of three witnesses. Petitioner's Exhibits 3 through 10 were admitted into evidence and Petitioner's Exhibits 1 and 11 were admitted in part.

Respondent did not present the testimony of any witness. Respondent's Exhibit numbered 1 was admitted into evidence and Exhibit 2 was rejected.

A Transcript, consisting of two volumes, was filed on August 7, 2009. The parties timely filed Proposed Recommended Orders, which have been considered in the preparation of this Recommended Order. Unless otherwise indicated, all references to Florida Statutes are to the 2008 codification.

FINDINGS OF FACT

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

2. At all times material hereto, Suwannee was licensed by Petitioner to operate a skilled nursing facility located in Live Oak, Florida.

3. From December 8 through 12, 2008, Selena Beckett, who is employed by AHCA as a Health Facility Evaluator II, conducted an unannounced licensure survey at Suwannee. Ms. Beckett has been in this position for 15 years and is Surveyor Minimum Qualification Test (SMQT) qualified.

4. One of the residents assigned to Ms. Beckett was Resident #162. Resident #162 was a 57-year-old female who was admitted to Suwannee in April or May 2008. Prior to her admission to Suwannee, Resident #162 had been diagnosed with

ovarian cancer that had metastasized to her brain. As a result of this, Resident #162's cognitive status fluctuated. She was high-functioning and was lucid the majority of the time, but would have times when she was confused, agitated, and would attempt to do things she could not do. While a resident of Suwannee, Resident #162 was also receiving Hospice services by Hospice staff.

5. During the December 2008 survey visit, Ms. Beckett determined through interviews and record review that the facility failed to ensure that Resident #162 received supervision, care, and services to prevent falls and failed to assess and care plan this resident for falls, which resulted in Resident #162 receiving injury.

6. In determining her findings, Ms. Beckett took into consideration that Resident #162 had fallen four times between July 31, 2008, and September 18, 2008, and cited Respondent for failing to ensure that steps were put in place to prevent falls once it became apparent that the resident needed assistance to prevent falls. Based on Ms. Beckett's findings during this survey, Respondent was cited for violation of Section 400.102(1)(a), Florida Statutes.[1/]

7. A Minimum Data Set (MDS) must be conducted on nursing home residents upon admission and quarterly thereafter, and after each significant change experienced by the resident. The

MDS identifies areas of concern. The MDS nurse assesses the resident and determines whether the facility should prepare a care plan for the identified problem.

8. An MDS was conducted on Resident #162 on June 20, 2008, which identified Resident #162 as being at risk for falls due to her declining medical and physical condition. A care plan addressing falls was prepared on June 20, 2008, for this resident. The care plan included the following strategies and interventions: encouraging Resident #162 to ask staff for assistance with all transfers; placing her call bell within reach; wearing non-skid shoes; placing a lap tray and alarm on her wheelchair; using side rails when she was in bed; using a scoop mattress; and making visual checks every two hours for comfort and safety when she was in her room.

9. On July 31, 2008, at 6:50 a.m. a certified nursing assistant (CNA) entered Resident #162's room, saw urine on the floor and found the resident sitting on her toilet. The Exception Report of the incident reflects that Resident informed the CNA that she got up from bed, was going to the bathroom, did not call for assistance, slipped in urine, then got herself up to go to the bathroom. Resident #162 received a small abrasion on her back.

10. On August 30, 2008, at 9:00 p.m., Resident #162 fell while trying to walk from the bathroom located in the facility's family room to her wheelchair. The Exception Report of the incident indicates that she removed the lap tray from her wheelchair, and did not use the call light in the bathroom when she wanted to return to her wheelchair.

11. On September 3, 2008, Resident #162 fell in her room. The Exception Report of the incident reflects that a CNA heard a loud bang coming from Resident #162's room, entered the room and found Resident #162 lying on her back. The CNA noted bleeding from the back of Resident #162's head. The resident was sent to the hospital and received sutures for the wound on the back of her head.

12. On September 18, 2008, at 12:10 p.m., Resident #162 was found on the floor of her bathroom after attempting to toilet herself. The Exception Report of the incident reflects that Resident #162 told the CNA that she did not fall, but that she sat down on the floor. Despite this assertion, the facility treated this incident as a fall.

13. Each of these four falls was documented in an Exception Report, prepared by the nurse on duty, which included what measures were put in place to prevent recurrence. Each Exception Report was then reviewed by the Director of Nursing

(DON) or Assistant Director of Nursing (ADON) as part of Respondent's assessment of the resident for risk for falls.

14. Following the July 31, 2008 fall, a bed alarm was applied to the resident's bed. Following the August 30, 2008 fall, the resident's wheelchair alarm was replaced and relocated on her wheelchair so she could not remove it again. Following the September 3, 2008 fall, a physical therapy screening was ordered for the resident. Following the September 18, 2008 fall, the resident was placed on a low bed to reduce her risk of injury if she attempted to get up by herself and an anti roll-back device was applied to her wheelchair.

15. Following each fall, staff observed Resident #162 for 72 hours. A 72-hour report was completed during this observation period following each fall.

16. In addition to the Exception Report, a "post fall investigative tool" was completed after each fall which addressed several factors which included: the resident's condition at the time of the fall, environmental factors, and the care provided to the resident prior to the fall. Whether the resident had been toileted within the hour prior to the fall was noted on this form. This form was provided to the facility's risk manager who then completed another form or report regarding the resident's falls.

17. With the exception of the July 31, 2008 fall, the post-fall investigative tools all indicate that Resident #162 had been toileted within the hour prior to the fall. The July 31, 2008 fall occurred at 6:50 a.m. According to the DON, Resident #162 had been sleeping and there would have been no reason to wake her to toilet her on that date.

18. An interdisciplinary team met each morning which included the DON, the ADONs, the rehabilitation coordinator, a physical therapist, and the risk manager. In those meetings following Resident #162's falls, the interdisciplinary team considered the exception reports, the resident's chart, the care plans, the post-fall investigative tool, and the risk manager's report in their evaluation of the resident.

19. There are two programs or interventions which are the primary ways in which nursing homes deal with their residents who need assistance in toileting. One method entails staff checking on the resident every two hours to determine if she needs to use the bathroom. The other primary method attempts to determine a resident's toileting pattern and schedule trips to the bathroom based upon that pattern. The record does not support a finding that one method is superior to the other.

20. On August 8, 2008, a bowel and bladder retraining screen was completed on Resident #162. Based upon her medical

condition and her score on the screening tool, Resident #162 was placed on a two-hour toileting schedule.

21. One reason that resident #162 was placed on the two-hour toileting schedule is that Resident #162 was continent. According to Ms. McCall, the DON, it is difficult to determine a toileting pattern for a resident who is continent.

22. AHCA suggests that Respondent should have at least tried the patterning method and/or other interventions, e.g., a bedside commode or Hospice personnel monitoring the resident 24 hours a day.

23. However, the Administrative Complaint charged Respondent with failure to assess and care plan Resident #162. The evidence established that Respondent did assess and care plan this resident. A care plan was created on June 20, 2008, prior to the four falls in question. Following the falls, an Exception Report was completed, a risk assessment was completed, a 72-hour observation period was conducted, and interventions were put in place following each fall.

24. The evidence does not establish that providing a bedside commode would have prevented a fall for this resident. According to Ms. McCall, 24-hour supervision by Hospice staff was not available because the resident's condition did not warrant such a service at that point. That is, Hospice would not provide that service if death was not imminent.

25. The evidence presented does not establish that Suwannee failed to provide supervision, care and services to Resident #162. The evidence does not establish that Suwannee failed to assess and care plan the resident which resulted in the resident receiving an injury.

CONCLUSIONS OF LAW

26. The Division of Administrative Hearings has jurisdiction over the parties and subject matter in this case. §§ 120.569 and 120.57, Fla. Stat. (2009).

27. Count I of the Administrative Complaint seeks to impose a $2,500.00 administrative fine for failure to ensure that Resident #162 received supervision, care, and services to prevent falls which materially and adversely affected the resident's health. Count I further alleges that Respondent failed to assess and care plan the resident for falls which resulted in the resident receiving an injury. Count I describes the deficiency as an isolated Class II deficiency. AHCA cites as authority Sections 400.23(8)(b), 400.102, and 408.813, Florida Statutes (2008).

28. Count II of the Administrative Complaint seeks to assign a conditional licensure status to Respondent for the cited deficiency for the period of December 12, 2008, until January 21, 2009, due to the cited Class II deficiency, citing as authority Section 400.23(7)(b), Florida Statutes.

29. A Class II deficiency is defined as a deficiency that the agency determines has compromised a resident's ability to maintain or reach his or her highest practicable physical, mental, and psychological well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. § 400.23(8)(b), Fla. Stat. A Class II deficiency is subject to a civil penalty of $2,500 for an isolated deficiency.

30. Section 400.23(7)(b), Florida Statutes, provides that a conditional licensure status means that the facility, due to the presence of one or more Class I or Class II deficiencies, or a Class III deficiency not corrected within the time established by the agency, is not in substantial compliance at the time of the survey with established criteria.

31. The burden of proof in this proceeding is on AHCA. Regarding the proposed penalty of an administrative fine, 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). Regarding the proposed imposition of a conditional license, the agency is required to prove the allegations against Respondent by a preponderance of the evidence. Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981).

32. Section 408.813, Florida Statutes, authorizes the imposition of an administrative fine as a penalty.

33. Section 400.102, Florida Statutes, provides in pertinent part,

> 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.

34. AHCA has not met its burden of proof in regard to the imposition of a fine in that it failed to prove that a Class II deficiency existed at Suwannee.

35. AHCA has not met its burden of proof as to the imposition of a conditional license in that it did not prove that a Class II deficiency existed at Suwannee.

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 Administrative Complaint issued against Respondent.

DONE AND ENTERED this 22nd day of September, 2009, in Tallahassee, Leon County, Florida.

Barbara J. Staros

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 22nd day of September, 2009.

ENDNOTE

1/ A violation of federal Tag N216 was also referenced in Ms. Beckett's report, but the Administrative Complaint was based on state law.

COPIES FURNISHED:

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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.