STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 09-3159
NORTHPOINTE RETIREMENT COMMUNITY, INC., d/b/a NORTHPOINTE RETIREMENT COMMUNITY,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to proper notice this matter came on for formal proceeding and hearing before P. Michael Ruff, duly-designated Administrative Law Judge of the Division of Administrative Hearings. The hearing was conducted in Pensacola, Florida, on September 10, 11, 30, and October 21, 2009. The appearances were as follows:

APPEARANCES

For Petitioner: Richard Joseph Saliba, Esquire
Mark H. Hinely, Esquire
Agency for Health Care Administration
Fort Know Building 3
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

For Respondent: Kerry Anne Schultz, Esquire
Fountain, Schultz & Associates, P.L.
2045 Fountain Professional Court, Suite A
Navarre, Florida 32566

STATEMENT OF THE ISSUE

The issues to be resolved in this proceeding concern whether Northpointe Retirement, Inc., d/b/a Northpointe Retirement Community (Respondent) (Northpointe) has committed five "Class I" deficiencies, pursuant to the statutes and rules referenced herein, regarding circumstances surrounding the death of "Resident No. 1" and whether Northpointe should be required to pay an administrative fine totaling $50,000.00 and have its license revoked.

PRELIMINARY STATEMENT

This matter arose upon the filing of an Administrative Complaint on July 11, 2009, by the Petitioner Agency for Health Care Administration (Petitioner) or (Agency), whereby it seeks to impose administrative fines and to revoke the license of the Respondent's assisted living facility (ALF). The Amended Complaint herein was filed July 27, 2009. The case was set for hearing for August 17, 2009, but was continued by agreement of the parties. It was scheduled for hearing again on September 10, 2009, and the hearing commenced on that date. The hearing continued on to September 11, September 30, and concluded on October 21, 2009.

The matter came on for hearing as noticed over a period of four days. The Petitioner presented eight witnesses and the

Respondent presented eleven witnesses, as are named in the Transcript of the proceeding. Additionally, each party presented its exhibits in bound notebooks and the exhibits admitted into evidence are reflected in the court reporter's official Transcript. Additionally, the video-taped deposition of Dr. Jack Abramson was presented and admitted into evidence by the Petitioner. For the Respondent, the video-taped deposition of Carol Mulloy, the granddaughter and attorney-in-fact for Resident No. 1 was offered and admitted into evidence for consideration by the undersigned.

The parties elected to obtain a transcript of the proceeding, which was filed on November 10, 2009. They also requested an extended period of 30 days to submit proposed recommended orders. The Proposed Recommended Orders were therefore timely submitted on or before December 11, 2009. The Proposed Recommended Orders have been considered in the rendition of this Recommended Order.

FINDINGS OF FACT

1. The Respondent, Northpointe, operates an ALF consisting of two buildings in Pensacola, Florida. The care provided to the residents by the Respondent is primarily custodial in nature and includes assisting with activities of daily living such as bathing, dressing, grooming, and the feeding of residents. The Respondent is largely reliant on the health assessment and

orders provided by a resident's physician. Decisions regarding healthcare diagnosis and treatment are made by physicians and other healthcare professionals, outside of the Respondent's facility.

2. Resident No. 1 arrived at the Respondent's facility in March of 2008. She was an 88-year-old female, with some chronic medical conditions such as hypertension, hypothyroidism, and arthritis. She had a habit of staying awake at night and sleeping during the day. She was a vegetarian, with food allergies, so she would rarely take meals in the dining room and preferred to prepare her own food and eat in her room.

3. The resident's healthcare provider at the time she came to the Respondent's facility was James Chaney, an Advanced Registered Nurse Practioner (ARNP) under the supervision of Dr. Gotthellf, MD. Dr. Mikhchi, the administrator of the Respondent and Sara Hines, the assistant administrator, stated that Resident No. 1 came to the Respondent's facility because she needed additional assistance with activities of daily living.

4. James Chaney completed a "form 1823 assessment" of Resident No. 1 upon her arrival at the Respondent's facility.

5. In March of 2008, Resident No. 1 was taking two medications for blood pressure, as well as aspirin, a thyroid supplement, and Prozac for depression. James Chaney first

examined her at the Respondent's facility on March 28, 2008. Resident No. 1 regained her independence in terms of taking care of herself and her activities of daily living, within weeks of her arrival at the Respondent's facility. James Chaney next examined her at the Respondent's facility on April 23, 2008. At that time he communicated with the Respondent's staff regarding Resident No. 1. He noted that Resident No. 1 was doing well and adjusting well to her move to the Respondent's facility.

6. James Chaney examined Resident No. 1 at the Respondent's facility essentially once a month over the ensuing months, until November 2008. He noted generally, during those visits, that Resident No. 1 was doing well, aside from having elevated blood pressure.

7. Mr. Chaney examined the Resident at the Respondent's facility on October 14, 2008. He communicated with the Respondent's staff at the facility regarding Resident No. 1 at that time. He noted that she was well-dressed and pleasant, as usual, and noted that she had a high functional level.

8. James Chaney next examined Resident No. 1 on November 11, 2008, at the Respondent's facility. He communicated with his staff at that time regarding Resident No. 1 and noted that there were no unusual occurrences. Resident No. 1 was continuing to do well and was maintaining a good level

of independence, according to Mr. Chaney. He did not feel the need to change her medication at that time.

9. On or about November 18, 2008, Sara Hines, the Assistant Administrator, had a conversation with Resident No. 1's granddaughter. She then learned that Resident No. 1 had hallucinations. This apparently involved Resident No. 1's coming out of her room several times saying that the "little boy next door" was crying because his father was trying to kill him or else that someone next door was being killed. On November 19th she was observed to be roaming the halls and yelling that a man was beating a child. Dr. Mikhachi testified that a meeting was held between he, Sara Hines, and Dr. Christina Mikhchi as a result of his learning of Resident No. 1's hallucinations. James Chaney or his office was apparently contacted by the Respondent's staff on or about November 21, 2008, and he replied that he would be out to see Resident No. 1 on November 24, 2008. Dr. Mikhachi directed the staff at the Respondent's facility to increase supervision of Resident No. 1, should she experience another hallucination, by making attempts to calm her, take her back to her room to talk about her family photographs, which she enjoyed doing. He directed them to get her involved in tasks she enjoyed, such as folding clothes or serving ice tea in the dining room to other residents; or to take her to visit a friend at the facility and to call her granddaughter.

10. Mr. Chaney examined Resident No. 1 at the Respondent's facility on November 24, 2008. He indicated that the staff had informed him that Resident No. 1 had hallucinations. He conducted the examination because of the staff's request. Delusions are a significant change in status of the resident. Resident No. 1's mental status had changed significantly between Mr. Chaney's November 11, 2008, visit and his November 24, 2008, visit.

11. On December 3, 2008, Resident No. 1 was again having hallucinations and called the emergency 911 number. She summoned Sheriff's deputies to the Respondent's facility and her room by acting on her delusion or hallucination concerning children being beaten or killed. A CNA note for that occasion reflects the incident, but Mr. Chaney was not told, and no call was made to him or his office. This was a significant change once again, because now Resident No. 1 was acting out on her hallucinations.

12. The CNA note for December 6, 2008, indicates that Resident No. 1 was "wandering like crazy," "very hard to keep up with," "going out the door so many times." Mr. Chaney testified that he felt the behavior amounted to "exit seeking" or seeking to leave the facility. This was important for him to know and seemed to be a change in behavior, in terms of increased agitation and excitability on the part of Resident No. 1.

Mr. Chaney's notes from that December 9, 2008, visit do not indicate that he was then aware of "exit seeking" behavior. Mr. Chaney said he would have recommended more frequent monitoring if he had known. He would have told the staff that Resident No. 1 was a high risk for that type of behavior if he had known about it.

13. A significant change was noted on Mr. Chaney's December 9, 2008, visit, when he diagnosed Resident No. 1 with "agitation" for the first time. He felt she had an escalation in her symptoms and ordered a psychological evaluation. She was starting an atypical, anti-psychotic medication, Risperdal, coupled with a decrease in the amount of Prozac she was being prescribed. He therefore felt he needed an expert evaluation.

14. Mr. Chaney's next visit was on December 14, 2008. During that visit he was not told about an incident that occurred on December 12, 2008, in which Resident No. 1 was observed walking out the front door while talking about "killings" occurring, apparently a recurrence of the hallucination about persons or children being murdered. Another nurse or CNA note for that day stated that Resident No. 1 was wandering around outside of her room carrying a blanket and trying to enter another resident's room with the blanket, because she believed it was her granddaughter's room. Mr. Chaney was not told of these incidents. If he had been told

of them he would have recommended increased monitoring and supervision of Resident No. 1. On December 14, 2008, at his visit to the Respondent's facility and Resident No. 1, he noted a significant decline in her status as to dementia and delirium, agitation, and hallucinations.

15. After Mr. Chaney left the facility on December 14, 2008, Resident No. 1 suffered a fall. Mr. Chaney was not immediately informed of it by the Respondent. Resident No. 1 was transported to the emergency room at the hospital by ambulance because of confusion, irritation, hallucination, and falling. Mr. Chaney was not informed by the Respondent concerning the circumstances surrounding the fall. Resident No. 1 was diagnosed at the hospital with a urinary tract infection. She was given Bactrim, an antibiotic, and discharged back to the Respondent's facility. The fall and the urinary tract infection constituted a significant change in Resident No. 1's condition.

16. Mr. Chaney, as her medical provider was not called by the Respondent. Rather he found out about that situation a day or so after the diagnosis was made as to the urinary tract infection. He learned of the fall by reading the Adverse Incident Report prepared by the Respondent, but was not made aware of the particular circumstances surrounding Resident No. 1's fall. It was important for Mr. Chaney to have been informed of the urinary tract infection because it could have affected

the resident's treatment regimen. Urinary tract infections in elderly people can result in symptoms indicating delirium.

17. If Resident No. 1 made statements regarding suicidal ideation, such as that "voices were telling her to jump out of a window," it would be important for Mr. Chaney and his supervising physician to know because she should then have been transported for an inpatient psychiatric evaluation as soon as the statements were made. However, it has not been proven by persuasive evidence that she made such statements. The testimony in this regard was by Ms. Endress, the surveyor, who based her testimony about the statements on her interview with Brenda Wilson. Brenda Wilson, however, recanted her statements to Ms. Endress to that effect, in her testimony at hearing, saying essentially that she had felt intimidated during her interview with Ms. Endress during Ms. Endress' survey. Brenda Wilson, in her testimony, denied that Resident No. 1 had made such statements involving self-harm. Brenda Golden testified that Brenda Wilson had told her, after the interview, that she had basically told Ms. Endress what she wanted to hear. It was thus not persuasively established that the suicidal statements at issue were actually made.

18. Mr. Chaney diagnosed Resident No. 1 with agitation, depression, hallucinations, and dementia. Those diagnoses show that Resident No. 1 was in a circumstance where she could change

for the worse quickly. It was thus important for the facility to contact Mr. Chaney immediately following significant changes in condition, in order for him to provide appropriate care.

19. Brenda Wilson is an employee of the Respondent and provided direct care to Resident No. 1 in the course of her employment. She observed Resident No. 1 hallucinating, concerning hearing voices about a man beating two screaming children. She had observed Resident No. 1 walking down the hall to other resident rooms and stating that a man was beating children inside the room.

20. Ms. Wilson was on duty on the night of December 23, 2008, until the morning of December 24, 2008. She provided care for Resident No. 1 during that time. She observed that Resident No. 1 became agitated that night, walking out of her room and down the hall, putting her head up to other resident's doors trying to find the voices she was apparently "hearing." Ms. Wilson called Sara Hines, the assistant administrator, and told her that Resident No. 1 was a little agitated, but more importantly she was talking very loud.

21. Resident No. 1 was more agitated than normal on that morning which is why Ms. Wilson called Ms. Hines. Ms. Wilson indicated to Ms. Hines that she was unable to care for all the residents under her supervision on the morning of December 24th, because Resident No. 1 was following her to other resident

rooms. Ms. Hines told Ms. Wilson to stay with Resident No. 1 and watch her closely.

22. Brenda Golden is a Med Tech Manager for Northpointe. She was so employed during the entirety of 2008 and is a member of the Respondent's management. She provided care for Resident No. 1 as well. She had observed Resident No. 1 hallucinating. On the morning of December 24, 2008, she was working in the Westpointe building next door. It is part of the same facility, but a separate building. Around 6:30 a.m. the administrator informed her that something was wrong with Resident No. 1 and asked her to check on Resident No. 1 right away. The administrator did not tell her that Resident No. 1 was agitated.

23. Ms. Golden went to check on Resident No. 1 in her room and saw that the screen on the window was torn. When she went over to the screen and looked out she saw Resident No. 1 lying on the ground below. Ms. Golden stated that Resident No. 1 told her, when she went down to assist her, that she had jumped out of the window because the "voices" had told her to do so. Ms. Golden also heard Resident No. 1 tell the paramedics who were summoned, that voices had told her to jump. Ms. Wilson was not in Resident No. 1's room when Resident No. 1 jumped out of the window.

24. Resident No. 1 was conscious and appeared lucid when the paramedics arrived. She did not appear to have any broken

bones. She was transported to the hospital, but later that morning or that day declined precipitously and died.

25. Sara Hines was the assistant administrator in 2008. She was aware of the hallucinations and that they had gotten more intense in December of 2008. After Ms. Hines spoke with Ms. Wilson on the morning of December 24th she waited approximately 25 minutes to speak to the administrator about Resident No. 1's condition that morning. She did not contact Resident No. 1's health care provider after speaking with Ms. Wilson and the administrator. After Resident No. 1's fall that day she completed the adverse incident report and stated that Resident No. 1 had jumped from the window because of voices.

26. Ms. Hines did not make any determinations to increase supervision of the resident after finding out about the scheduled psychiatric evaluation which Mr. Chaney and the resident's family had scheduled. The administrator did not make any changes in the resident's supervision based on that information either.

27. Rebecca Yokom is an employee with Northpointe who provided care to Resident No. 1 during 2008. She observed Resident No. 1 hallucinate approximately six times that year. None of the other residents she cared for hallucinated.

28. Mohamad Mikhici is the owner and administrator for Northpointe. He acknowledged that Resident No. 1 was re-located from the Westpointe Assisted Living Facility to the Northpointe because she had fallen several times.

29. After the hallucinatory episodes began, on November 18, 2008, the administrator told Resident No. 1's granddaughter that, if the frequency and intensity of hallucinations continued, Resident No. 1 would not be appropriately placed in the facility. He was told by Ms. Hines, his assistant, that Resident No. 1 was still hallucinating from December 16th through December 22, 2008. Obviously she also hallucinated on December 3 and 12; as well as on the nights of December 23-24, 2008, based upon the above findings.

30. The administrator, Dr. Mikhici, did not communicate with the Sheriff's Department on December 3, 2008, when deputies were mistakenly summoned to the facility because Resident No. 1 had called 911, as prompted by her hallucination at the time. The administrator acknowledged that the only intervention they initiated as a result of the that incident was to remove the phone from the resident's room.

31. The administrator acknowledged that he knew he had authority to increase monitoring and supervision of Resident No. 1. He acknowledged that he did not personally read the CNA log

nor did he regularly review Resident No. 1's records. He relied on his staff to do so.

32. Dr. I. Jack Abramson holds medical licenses in a number of states including Florida. He completed a residency in psychiatry at Beth Israel Hospital and at Harvard Medical School. He holds sub-specialty certifications in geriatric psychiatry, as well as forensic and addiction psychiatry. The parties stipulated to his expertise and the introduction of his video-taped deposition into evidence. Dr. Abramson reviewed the documents, including survey documents, statements of deficiencies, hospital records, staff sheets and the facility records for Resident No. l, all of which were stipulated into evidence by the parties and attached and incorporated into his deposition.

33. Dr. Abramson opined that Resident No. 1 was impaired by delusional thinking, paranoid ideations and hallucinations. This produced a great deal of psychic turmoil inside her, ultimately resulting in her jumping from the window on December 24, 2008. She was significantly impaired in the last month of her residence and not functioning independently while residing at an ALF which was unable to adequately provide care needed for her safety and security. She was actively psychotic and delusional thinking influenced her behavior. She was unable

to control her behaviors at various points in time after the middle of November 2008.

34. Based upon the facts found above concerning her delusions and hallucinations, there was a period of a month to five weeks where the hallucinations manifested themselves in a sufficiently pronounced way to provide adequate warning to the facility that her mental status was deteriorating. There were many opportunities to observe decline in her functioning and then the fall occurred on December 14, 2008, which is a proto-typical decline in function in terms of the evaluation and treatment of geriatric patients. With the hallucinations and confusion around the beginning of December, with Resident No. 1 yelling about a little boy being murdered, or someone being murdered in the room next to hers; with the evidence concerning her going into other rooms to look for her granddaughter, who she believed was in some sort of distress, and the other aspects of the hallucinatory episodes, Resident No. 1 was inappropriate for placement in a ALF environment, at least after late November or early December 2008.

35. That portion of Dr. Abramson's opinion concerning suicidal threats, leading to his opinion that arranging for involuntary examination might have been appropriate, is not accepted. This is because the evidence does not persuasively show that she actually made suicidal threats.

36. Dr. Abramson also believed that there was no evidence of any record of communication between the facility and the physician (or Mr. Chaney the ARNP). This is only partly true. There was insufficient communication, as shown by the above findings of fact, but there was not an absolute dearth of such communication.

37. Dr. Abramson found and opined that Resident No. 1 was not functioning independently, was unable to care for her own needs of daily living, based upon cognitive difficulties, her delusional state and delirium. These factors, taken together, would have required her to be transferred to a more appropriate facility, according to Dr. Abramson. Thus he believes discharge of Resident No. 1 to another more appropriate skilled nursing facility was appropriate because of her delusional and hallucinatory state. He believes that she was a candidate for 24-hour supervision by mid-December 2008.

38. Dr. Abramson opined that within a reasonable degree of psychiatric probability, injury or death was preventable. Had Resident No. 1 been sent to a more secure skilled facility, she would have been under closer supervision and would not have been able to act in the way she did. An earlier intervention with her delusions and hallucinations might have calmed them adequately or put them into remission, so that she wouldn't have felt the need to escape from those delusions.

39. She thus became a danger to herself by mid-December, based upon her inability to adequately care for her needs and her cognitive and perceptional impairments by the time she had the urinary tract infection on December 14, 2008. She was also clearly a danger to herself on December 23 and 24, 2008, based upon the above facts even without making suicidal threats. Her injury or death would have been preventable if her care in a more structured, supervised setting had been arranged, and possibly had psychiatric consultation been arranged at an earlier date. It is true that Mr. Chaney and the family, on December 9, 2008, scheduled a psychiatric evaluation and the Respondent was informed of that. The evaluation, however, was not scheduled until early in January 2009.

40. The Respondent could have arranged for Resident No. 1 to be placed in a more skilled facility, such as a nursing home facility while psychiatric treatment was implemented or alternatively by at least providing a higher level of supervision, such as constant supervision, until a placement decision and psychiatric evaluation could be completed. The failure to accomplish a higher level, protected supervision regime, or to transfer Resident No. 1 to a higher skilled facility, as well as the inadequate communication with the treating physician and his staff, contributed to the injury and death to Resident No. 1.

41. Thus, while the specifics of Resident No. 1's death by jumping out of a window, or suicide, might not have been foreseeable, it was foreseeable, based upon the opinion of Dr. Abramson, that she was placed in a situation where serious injury could occur. Dr. Abramson's opinion that the death of Resident No. 1 was preventable and that to a great extent Resident No. 1's actions and behaviors were foreseeable and could have been avoided, with the added interventions referenced above, is deemed credible, persuasive, and is accepted.

CONCLUSIONS OF LAW

42. The Division of Administrative Hearings has jurisdiction of the subject matter of and the parties to this proceeding. §§ 120.569 and 120.57(1), Fla. Stat. (2009).

43. The Petitioner alleges, as to Count I of the Administrative Complaint, that the administrator failed to properly monitor Resident No. 1 to determine if continued appropropriate placement should be in the Respondent's facility, rather than a higher level of care facility, such as a skilled nursing home, citing Section 429.26(1), Florida Statutes (2008), and Florida Administrative Code Rule 58A-5.0181(1) and (4). The Petitioner maintains that this failure to monitor, and determine the appropriateness of continued placement. resulted in Resident No. 1's jumping out of the second story window, which

the Petitioner maintains constituted a Class I deficiency, pursuant to Section 429.19(2)(a), Florida Statutes (2008).

44. Resident No. 1 had multiple instances of hallucinations and confused unstable behavior based on those hallucinations, beginning November 18, 2008. That situation became more severe in early December, such that on December 9, 2008, Mr. Chaney the ARNT recommended, and he and the family obtained an appointment for a psychiatric evaluation, to be accomplished in early January 2009.

45. The administrator cautioned Resident No. 1's granddaughter in late November 2008, that if the resident's behavior did not correct itself or improve, concerning the hallucinations and related behavior, the resident might no longer be appropriately placed in the Respondent's facility. Documentation of the Respondent, specifically the CNA notes for the months of November and December, 2008 show that, starting in late November, Resident No. 1 had multiple instances of hallucinations and mentally unstable behavior based on the hallucinations.

46. The Petitioner maintains that the testimony of Marlene Hunter, the administrator, Mohammad Mikhici; Dr. Jack Abramson and Barbara Alford; and the purported lack of documentation in the record regarding monitoring Resident No. 1, shows that the monitoring was deficient as to the question of appropriateness

of continued residency of Resident No. 1 at the Respondent's facility. See § 429.26(1), Fla. Stat. (2008), and Fla. Admin. Code R. 58A-5.0181(1) and (4). The monitoring requirement in Section 429.26(1), Florida Statutes (2008), is based on the resident's specific needs. Resident No. 1 had significant monitoring needs because of the fact that she was hallucinating and in early December started acting on those hallucinations. She was on anti-psychotic medication and, as of December 9, 2008, was scheduled for a psychiatric consultation.

47. The administrator demonstrated that he was aware of monitoring requirements for purposes of determining continued appropriateness of placement, as shown by his admonition to Resident No. 1's granddaughter, in late November, that if the hallucinatory behavior continued then the resident may have to be placed in a more skilled care facility. The Petitioner demonstrated, however, that the administrator failed to monitor the resident closely enough by observing the resident and adequately consulting with the resident's health care provider concerning this question. The resident's particular needs demanded that he do so, as shown by the above-found facts concerning the progression of the resident's aberrant behavior. As shown by Dr. Abramson's testimony the failure to monitor the resident for continued appropriate placement resulted in

Resident No. 1 remaining placed at the facility through December 24, the day she died.

48. The direct cause of the death of Resident No. 1 was her hallucinations, prompting her to jump out of the window when no staff member was present in the room to stop her. However, the failure of the administrator to monitor her continued placement at the facility had an indirect effect simply because it likely caused her to remain at the facility long enough for this to occur. This constituted a Class I deficiency, pursuant to Section 429.19(2)(a), Florida Statutes (2008).

Count II

49. The Petitioner maintains that the Respondent failed to ensure that Resident No. 1 received adequate care, in violation of Florida Administrative Code Rule 58A-5.019(1), by failing to initiate proceedings pursuant to the Baker Act, Section 394.463(1), Florida Statutes (2008). The Petitioner contends that this resulted in the resident's jumping out of the second story window and dying shortly thereafter. It is alleged that this failure constituted a Class I deficiency, pursuant to Section 429.19(2)(a), Florida Statutes (2008).

50. It is true that Resident No. 1 hallucinated, and acted on the hallucination, in terms of wandering to other residents' rooms, verbalizing her delusional ideas, and ultimately jumping from the window because of hallucinations. She was diagnosed by

the health care provider with delirium, agitation, and dementia and had been prescribed Prozac and, more recently, Risperdal, an anti-psychotic. As of December 9, 2008, Mr. Chaney had scheduled her for a psychological evaluation. Mr. Chaney's testimony, which is accepted, indicates that he did not believe that an involuntary mental illness examination, pursuant to the Baker Act, was necessary. This was because of his diagnosis, the scheduling of the psychological evaluation, and the lack of indication of threats of self-harm by the resident.

51. In light of the above findings of fact concerning Brenda Wilson and Norma Endress, and their interview during the investigation, it has not been established by preponderant, persuasive evidence that Resident No. 1 actually made threats of self-harm in the nature of wanting to kill herself. The testimony of Barbara Alford, Marlene Hunter, and Dr. Abramson, as well as Norma Endress concerning the resident's purported threats of self-harm, were all based upon the version of events described by Brenda Wilson in the interview with Norma Endress. That was later recanted, and in the above Findings of Fact show that there is no persuasive, substantial evidence that the self-harm threats were actually made.

52. In any event, the question only arose on the last night or morning of the resident's life, shortly before she jumped from the window. It is noteworthy that under the

pressure of events at that time, it is understandable that a report to the health care provider, concerning the threats, would not have been made early on the morning of December 24, 2008, because of the immediate emergency concerning the resident.

53. In summary, it has not been proven that the resident had become the apparent danger to herself that the Respondent should have seen or foreseen, in terms of threatened self-harm. Therefore, the Respondent should not be held to the standard of having to seek an involuntary examination. Therefore, Count II of the Administrative Complaint has not been established as a violation of Florida Administrative Code Rule 58A-5.019(1). Therefore, as to this count, there was not a Class I deficiency, as envisioned in Section 429.19(2)(a), Florida Statutes (2008).

Count III

54. Concerning Count III, the persuasive evidence establishes that the Respondent failed to notify the resident's healthcare provider of certain changes and conditions (although it did so as to some). It failed to adequately document contact with the healthcare provider. It is determined that significant changes were documented in the CNA notes. Nonetheless, the failure to consistently and timely notify the healthcare provider of significant changes and conditions is a violation of Florida Administrative Code Rule 58A-5.0185(4)(b).

55. Witness Alford for the Petitioner noticed some pattern of failing to contact the healthcare provider of the resident concerning some significant changes, although some, as delineated in the above Findings of Fact, were notified to the healthcare provider. The first hallucinatory incident of November 18 and 19, 2008, were timely reported to Mr. Chaney. According to witness Alford, the primary healthcare provider should be notified of such changes within a 24-hour period or a resident can be placed at a continued risk.

56. Mr. Chaney established that he was not made aware of some significant changes in Resident No. 1's behavior and condition and the failure had an effect on his assessments of the resident. The administrator Dr. Mikhici admitted that he had not personally contacted the healthcare provider regarding significant changes, although it was his position that his staff had done so, or that he relied on them to do so.

57. The above Findings of Fact, based upon the persuasive evidence, show that the Respondent was repeatedly deficient in adequately reporting to the healthcare provider regarding significant changes in Resident No. 1's condition and behavior. That failure to adequately report affected the type and quality of care the resident received because it likely delayed or prevented the ordering by the physician of enhanced supervision of the resident. This would tend to place the resident at a

heightened risk for injury or death. The failure to adequately report significant changes in the resident's condition and behavior was a violation of Florida Administrative Code Rules 58A-5.0185(4)(b) and 58A-5.0182(1)(d) and (e). The testimony of Mr. Chaney and Dr. Abramson shows that a failure to adequately communicate significant changes in condition, and to adequately document such changes and contacts, would limit the ability of the healthcare provider to provide adequate care, at least in terms of recommending enhanced supervision of the resident. It would place the resident in imminent danger, which constitutes a Class I deficiency, pursuant to Section 429.19(2)(a), Florida Statutes (2008).

Count IV

58. The evidence, culminating in the above Findings of Fact, establishes that the Respondent violated Florida Administrative Code Rule 58A-5.0182(1)(b) by failing to provide adequate supervision for Resident No. 1. This constituted a Class I deficiency.

59. Mr. Chaney would have ordered more monitoring and supervision of Resident No. 1 if he had known about some of the behaviors which were not reported to him. The resident had greater supervision needs than the typical ALF resident. Despite the Resident's condition, the hallucinatory behavior and the attendant appointment for a psychological consult after

December 9, 2008, the assistant administrator, Ms. Hines, did not make any determination about increasing supervision of the resident. The administrator did not make any such changes to the supervision regime, based upon the condition of Resident No. 1 and the scheduling of a psychological evaluation for her.

60. Resident No. 1's condition, on December 24, 2008, was reported by Brenda Wilson to management. Her past behavior was known to the staff and management. However, neither Brenda Wilson, whose shift was just ending at 7:00 a.m. nor Rebecca Yokom who was coming on duty at that time, and responsible for caring for Resident No. 1 that morning, was in the resident's room when the resident jumped out of the window. Someone should have been present to supervise her.

61. The Respondent failed to ensure the resident's safety and health when it failed to provide a higher level of supervision for the resident. The Respondent was thus negligent and the negligence resulted in imminent danger of injury or death to the resident.

62. Florida Administrative Code Rule 58A-5.0182(1)(b) requires ALF's to provide supervision appropriate for each resident. The Respondent failed to provide supervision that was necessary for Resident No. 1's heightened needs, and the failure to do so resulted in an immediate risk and potential for injury

or death. It constituted a Class I deficiency, pursuant to Section 429.19(2)(a), Florida Statutes (2008).

Count V

63. Florida Administrative Code Rule 58A-5.0181(5) provides that a resident should be discharged if the resident's needs can no longer be met under the criteria for assisted living facility residence. The persuasive, substantial evidence and the above Findings of Fact show that, at least as of December 3, 2008, when Resident No. 1 acted on her hallucinations and made the call to the 911 number which ultimately summoned Sheriff's deputies; that the Respondent knew or should have known that her placement in the ALF facility of the Respondent was no longer appropriate. While it is true that it may take some extended period of time to secure a placement in a skilled nursing facility or other appropriate facility, the Respondent, under the above-found facts, should have initiated steps to secure a change of her placement. The resident was not independently functioning, required skilled observation and likely required skilled nursing observation because of her delusional and hallucinatory state. These required more intensive services than could have been provided at Northpointe.

64. The administrator himself had warned the resident's granddaughter, after the November 18 and 19 hallucinatory incidents, that there was a possibility that she would have to

be discharged to another facility, if the behavior did not alleviate. Therefore, he was aware of the need to consider transferring the resident to another facility such as a skilled nursing facility. The Respondent simply failed to act quickly enough on this issue. The Respondent, in light of the above Findings of Fact, violated Rule 58A-5.0181(5), by failing to discharge Resident No. 1 when her needs exceeded the capabilities of the Respondent's facility and when she no longer met the criteria for assisted living facility residence. She was thus placed in imminent danger due to a lack of adequate supervision, which constituted a Class I deficiency, for purposes of Section 429.19(2)(a), Florida Statutes (2008).

Count VI

65. Given the above Findings of Fact, based upon persuasive evidence, the Respondent has committed a negligent act which affected the health and safety of Resident No. 1. See § 429.141(a), Fla. Stat. (2008). The Respondent has also committed one or more Class I deficiencies for purposes of Section 429.14(1)(e)1., Florida Statutes (2008). The Respondent facility is subject to revocation by committing the Class I violations, pursuant to Section 408.815(1)(c), Florida Statutes (2008).

66. In light of the gravity of the violations proven, substantial or maximum penalties are recommended to be imposed.

Although revocation is legally available, the interest of the many other residents of the facility in continued placement there should be strongly considered. It is also true that, as serious as this situation was, it was an isolated occurrence and not reflective of a pattern of care as to other residents. Accordingly, it is recommended that revocation be withheld, subject to the Respondent submitting quarterly corrective action plans, to be accompanied with quarterly inspections or surveys by the Petitioner, to ensure compliance and correction, for a period at the discretion of the Agency, not to exceed two years, and contingent upon timely payment of the monetary penalties imposed, based upon a schedule determined at the discretion of the Petitioner Agency.

RECOMMENDATION

Having considered the foregoing Findings of Fact, Conclusions of Law, the evidence of record, the candor and demeanor of the witnesses and pleadings and arguments of the parties, it is, therefore,

RECOMMENDED that a final order be entered by the Agency for Health Care Administration, as to Count VI, imposing the referenced alternative to revocation, under the conditions and in the manner referenced in the last paragraph of the Conclusions of Law above; that as to Count I, a fine of $5,000.00 be imposed; that Count II found to be dismissed; that,

as to Count III, that a $10,000.00 fine be imposed; as to Count IV, that a $10,000.00 fine be imposed; and as to Count V that a $10,000.00 fine be imposed.

DONE AND ENTERED this 29th day of January, 2010, in Tallahassee, Leon County, Florida.

P. MICHAEL RUFF
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 29th day of January, 2010.

COPIES FURNISHED:

Richard Joseph Saliba, Esquire
Mark H. Hinely, Esquire
Agency for Health Care Administration
Fort Know Building 3
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Kerry Anne Schultz, Esquire
Fountain, Schultz & Associates, P.L.
2045 Fountain Professional Court, Suite A
Navarre, Florida 32566

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Justin Senior, General Counsel
Agency for Health Care Administration
Fort Knox Building, Suite 3431
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Thomas W. Arnold, Secretary
Agency for Health Care Administration
Fort Knox Building, Suite 3116
2727 Mahan Drive
Tallahassee, Florida 32308-5403

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.