STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. GULF COAST MEDICAL CENTER, LEE MEMORIAL HEALTH SYSTEM, Respondent.	Case Nos. 09-5360 09-5363 09-5364 09-5365

RECOMMENDED ORDER

Pursuant to notice to all parties, a final hearing was conducted in this case on January 25 through 29, 2010, in Fort Myers, Florida, before Administrative Law Judge R. Bruce McKibben of the Division of Administrative Hearings. The parties were represented as set forth below.

APPEARANCES

For Petitioner: Andrea M. Lang, Esquire
Agency for Health Care Administration
2295 Victoria Avenue, Room 346C
Fort Myers, Florida 33901

For Respondent: W. David Watkins, Esquire
Watkins & Associates, P.A.
Post Office Box 15828
Tallahassee, Florida 32317-5828

STATEMENT OF THE ISSUES

The issues in this case are set forth in 11 separate counts within the four consolidated cases:

Case No. 09-5360

Count I--Whether Respondent failed to properly monitor and care for a patient in restraints.

Count II--Whether Respondent failed to ensure the physician's plan of care for patient was implemented.

Case No. 09-5363

Count I--Whether Respondent failed to properly implement the physician's plan of care for patient.

Case No. 09-5364

Count I--Whether Respondent failed to ensure a patients' right to privacy.

Count II--Whether Respondent failed to ensure that food was served in the prescribed safe temperature zone.

Count III--Whether Respondent failed to ensure that only authorized personnel had access to locked areas where medications were stored.

Count IV--Whether Respondent failed to perform proper nursing assessments of a patient.

Count V--Dismissed.

Count VI--Whether Respondent failed to maintain patient care equipment in a safe operating condition.

Case No. 09-5365

Count I--Whether Respondent failed to triage a patient with stroke-like symptoms in a timely fashion.

Count II--Whether Respondent's nursing staff failed to assess and intervene for patients or ensure implementation of the physician's plan of care.

PRELIMINARY STATEMENT

On September 1 and 2, 2009, Petitioner, Agency for Health Care Administration (AHCA), issued four Administrative Complaints against Respondent, Gulf Coast Medical Center, Lee Memorial Health System. Respondent filed a separate Petition for Formal Administrative Hearing in response to each of the Administrative Complaints. The Petitions were forwarded to the Division of Administrative Hearings so that a formal administrative hearing could be conducted. The parties asked that the four cases not be consolidated, but that the final hearing in each case be held at one time, that is, consecutively.

After much debate, four final hearings were set. Prior to the final hearing, however, the parties agreed that less time would be needed than previously anticipated. The hearing was then set to commence on January 25, 2010, for Case No. 09-5360, with each of the other cases following in chronological order. The hearing was commenced on January 25, 2010. During the first

day of hearing, the parties stipulated that it might be prudent to consolidate the cases after all. By agreed oral motion of the parties, an Order consolidating the cases was entered, and the consolidated matters were heard during the week of January 25 through 29, 2010.

At the final hearing, both parties appeared and were represented by counsel.

AHCA called 11 witnesses: Nancy Furdell, health facilities evaluator; Patricia Kaczmarek, registered nurse (RN) specialist; Basil Birch, RN specialist; Charlene Fisher, RN, surveyor supervisor; Mary Ruth Pinto, public health nutrition consultant; Gary Furdell, fire protection specialist; Ann Dolan, RN specialist; Linda Mozen, RN specialist; Patricia O'Connell, RN specialist; Eleanor Seville, RN specialist, and Donna Ford, RN specialist. Petitioner also offered 35 exhibits into evidence, of which the following were admitted: Exhibits Nos. 1 through 24, 26 through 30, 34, and 35.

Respondent called seven witnesses: Holly Muller, vice-president of Patient Care Services; June Schneider, nursing director of the Surgical Progressive Care Unit; Kathleen Moore, food services director; Linda Odnoha, director of the Intensive Care Unit; Peter Duggan, director of Pharmacy Services; Claude Houle, administrative director of Surgical Services; and Delecia Tidaback, nursing director of the Emergency Department.

Respondent offered 50 exhibits into evidence, of which the following were admitted: Exhibits Nos. 1 through 21, 30 through 38, 40 through 45, and 47 through 49. At the conclusion of the final hearing, Respondent asked to submit another exhibit (No. 51) into evidence. Leave was given to submit the exhibit, followed by any objection Petitioner might have to its admission. The exhibit was filed; Petitioner objected on various grounds. Based upon a review of the exhibit and the objection, Exhibit No. 51 was rejected and will not form a basis for any finding in this Recommended Order.

A transcript of the final hearing was ordered by the parties. The Transcript was filed at the Division of Administrative Hearings on March 11, 2010. (A portion of the transcript was erroneously omitted from the initial filing. The missing pages were filed as Volume 5 of the transcript on April 8, 2010.) By rule, parties were allowed ten days to submit proposed recommended orders. However, the parties requested and were allowed 30 days after filing of the Transcript, or April 12, 2010, to file their proposed findings of fact and conclusions of law. Each party timely submitted a Proposed Recommended Order, and each was duly considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. Petitioner is the state agency responsible for, inter alia, monitoring health care facilities in the state to ensure compliance with all governing statutes, rules and regulations. It is the responsibility of AHCA to regularly inspect facilities upon unannounced visits. Often AHCA will inspect facilities for the purpose of licensure renewal, certification, or in conjunction with federal surveys. AHCA will also inspect facilities on the basis of complaints filed by members of the general public.

2. Respondent, Gulf Coast Medical Center ("Gulf Coast" or "GCH") is a hospital within the Lee Memorial Health System. South West Florida Regional Medical Center ("SWF") was another hospital within the Lee Memorial Health System. SWF closed in March 2009, when it was consolidated with Gulf Coast.

3. On October 15, 2008, the Agency conducted a complaint investigation at SWF; a follow-up complaint investigation was done on November 13, 2008. SWF filed and implemented a plan of correction for the issues raised in each of the investigations. The November investigation resulted in an Administrative Complaint containing two counts.

4. On December 16, 2008, AHCA performed another complaint investigation at Gulf Coast. Gulf Coast filed and implemented a plan of correction for the issues raised in the investigation.

The investigation resulted in an Administrative Complaint containing one count.

5. On January 5 through 9, 2009, AHCA conducted a routine licensure survey at Gulf Coast. The hospital filed and implemented a plan of correction for the issues raised in the survey. The survey resulted in an Administrative Complaint containing six counts (although Count V was dismissed during the course of the final hearing).

6. On February 18, 2009, AHCA did its follow-up survey to the previous licensure survey. Gulf Coast filed and implemented a plan of correction for the issues raised in the survey. The survey resulted in an Administrative Complaint containing two counts.

Case 09-5360

7. The complaint investigation at SWF on November 13, 2008, was conducted under the supervision of Charlene Fisher.

8. Count I in this case addresses findings by the Agency concerning a patient who was placed in restraints at the hospital on August 28, 2008. The patient, A.D., came into the hospital emergency department under the Baker Act seeking medical clearance to a facility. The patient presented at approximately 4:00 p.m., with back pain. He had a history of drug abuse, so there was concern by the hospital regarding the use of narcotics or certain other medications to treat the

patient. The patient engaged in some scuffling with police. A physician signed and dated a four-point restraint (one on each limb) order, resulting in the patient being physically restrained. The restraint was deemed a medical/surgical restraint, rather than a behavioral restraint. AHCA had concerns about the restraint, specifically whether there was a notation for Q 15 (or every 15 minutes) monitoring of the restrained patient. However, medical/surgical restraints only require monitoring every two hours. The restraint worksheet for the patient confirms monitoring every two hours. The patient was ultimately admitted to the hospital at 9:37 p.m., and, thereafter, began complaining of left shoulder pain. The hospital responded to the patient's complaints about back pain and began treating the pain with analgesics. However, the patient continued to complain about the pain. An X-ray of the patient's shoulder was finally done the next morning. Shoulder dislocation was confirmed by the X-ray, and the hospital (four hours later) began a more substantive regimen of treatment for pain. Surgery occurred the following morning, and the shoulder problem was resolved.

9. It is clear the patient had a shoulder injury, but it is unclear as to when that injury became more painful than the back injury with which the patient had initially presented. The evidence is unclear whether or when the shoulder injury became

obvious to hospital staff. During its course of treating this patient, the hospital provided Motrin, Tylenol, Morphine, Percocet and other medications to treat the patient's pain.

10. Count II in this case also involved a restrained patient, M.D., who had presented to the emergency department under the Baker Act. The patient was released from handcuffs upon arrival at the hospital. After subsequently fighting with a deputy, this patient was also placed in a medical/surgical restraint pursuant to a physician's order. The doctor signed and dated, but did not put a time on, the restraint order. A time is important because there are monitoring requirements for patients in restraints. However, the time of 0050 (12:50 a.m.) appears on the patient's chart and is the approximate time the restraints were initiated. The proper procedure is to monitor a restrained patient every two hours. This patient, however, was removed from his restraints prior to the end of the first two-hour period. Thus, there are no records of monitoring for the patient (nor would any be necessary).

11. The evidence presented by AHCA was insufficient to establish definitively whether the hospital nursing staff failed to properly respond to the aforementioned patients' needs. It is clear the patients could have received more care, but there is not enough evidence to prove the care provided was inadequate.

Case No. 09-5363

12. On December 16, 2008, AHCA conducted a complaint investigation at SWF. The Agency had received a complaint that the hospital did not properly implement a physician's plan of care.

13. Count I in this complaint addresses alleged errors relating to two of four patients reviewed by the surveyors. Both of the patients came to the hospital from a nursing home. One patient, I.A., had presented to the emergency department complaining of chest pains. The medication list sent to the hospital by the nursing home for I.A. actually belonged to someone other than I.A. I.A.'s name was not on the medication list. The drugs listed on the patient chart were different than the drugs I.A. had been taking at the skilled nursing facility from which she came. The skilled nursing facility actually sent I.A.'s roommate's medication list. The erroneous medications were then ordered by the admitting physician and administered to the patient.

14. The hospital is supposed to review the medication list it receives and then enter the medications into the hospital system. The person reviewing the medication list does not necessarily have to be a nurse, and there is no evidence that the person making the error in this case was a nurse or was some other employee. It is clear, however, that the person reviewing

the medication list did not properly ascertain that the list belonged to patient I.A.

15. The other patient from the nursing home had been admitted for surgery at SWF. Again, the nursing home from whence she came sent a medication list that was incorrect. The medications on the incorrect list were entered into the system by a SWF employee. The erroneous medications were ultimately ordered by the attending physician for the patient, but there is no evidence the patient was ever administered those medications. Neither of the residents was harmed by the incorrect medications as far as could be determined.

Case 09-5364

16. From January 5 through 8, 2009, AHCA conducted a licensure survey at Gulf Coast and SWF in conjunction with a federal certification survey.

17. Count I of the complaint resulting from this survey addressed the right of privacy for two residents. In one instance, a patient was observed in her bed with her breasts exposed to plain view. In the other instance, a patient's personal records were found in a "public" place, i.e., hanging on the rail of a hallway in the hospital.

18. AHCA's surveyor, Nancy Furdell, saw a female patient who was apparently asleep lying in her bed. The patient's breasts were exposed as she slept. Furdell observed this fact

at approximately 1:15 p.m., on January 7, 2009. Furdell did not see a Posey vest on the patient. She did not know if anyone else saw the exposed breasts. Furdell continued with her survey duties, and at approximately 5:00 p.m., notified a staff member as to what she had seen. Furdell did not attempt to cover the patient or wake the patient to tell her to cover up.

19. The female patient with exposed breasts was in the intensive care unit (ICU) of the hospital. Visiting hours in ICU at that time were 10:00 to 10:30 a.m., and again from 2:00 till 2:30 p.m. Thus, at the time Furdell was present, no outside visitors would have been in the ICU. ICU patients are checked on by nursing staff every half-hour to an hour, depending on their needs. This particular patient would be visited more frequently due to her medical condition. On the day in question, the patient was supposed to be wearing a Posey vest in an effort to stop the patient from removing her tubing. The patient had been agitated and very restless earlier, necessitating the Posey vest.

20. Also on January 7, 2009, a surveyor observed some "papers" rolled up and stuffed inside a hand-rail in the hospital corridor. This occurred at 1:15 p.m., on the fourth floor of the south wing of the hospital. A review of the papers revealed them to be patient records for a patient on that floor.

21. The surveyor could not state at final hearing whether there were hospital personnel in the vicinity of the handrail where she found the patient records, nor could she say how long the patient records had been in the handrail. Rather, the evidence is simply that the records were seen in the handrail and were not in anyone's possession at that moment in time.

22. Count II of the complaint was concerned with the temperature of certain foods being prepared for distribution to patients. Foods for patients are supposed to be kept at certain required temperatures. There is a "danger zone" for foods which starts at 40 degrees Fahrenheit and ends at 141 degrees Fahrenheit. Temperature, along with time, food and environment, is an important factor in preventing contamination of food and the development of bacteria.

23. Surveyor Mary Ruth Pinto took part in the survey. As part of her duties, she asked hospital staff to measure the temperature of foods on the serving line. She found some peaches at 44 degrees, yogurt at 50 degrees, and cranberry juice at 66 degrees Fahrenheit. According to Pinto, the hospital's refrigerator temperatures were appropriate, so it was only food out on the line that was at issue. Pinto remembers talking to the hospital dietary manager and remembers the dietary manager agreeing to destroy the aforementioned food items.

24. The hospital policies and procedures in place on the date of the survey were consistent with the U.S. Food and Drug Administration Food Code concerning the storage, handling and serving of food. The policies acknowledge the danger zone for foods, but allow foods to stay within the danger zone for up to four hours. In the case of the peaches and yogurt, neither had been in the danger zone for very long (not more than two hours). The cranberry juice was "shelf stable," meaning that it could be stored at room temperature.

25. The food services director for the hospital remembers the peaches and yogurt being re-chilled in a chill blaster. She does not believe any of the food was destroyed.

26. Count III of the complaint addressed whether an unauthorized person had access to a room where medications were being stored. A state surveyor, Gary Furdell, was part of the survey team on January 5, 2009. Furdell was touring the second floor of the hospital when he noticed a locked door. Furdell asked a hospital medical technician who was standing nearby about the door. The medical technician gave Furdell the code to unlock the door. Furdell peeked inside and noticed bottles that he presumed were medications. It would be a violation for a medical technician to have access to medications, because medical technicians cannot distribute drugs.

27. The room Furdell looked into is a "mixed use" room located behind a nursing station. A mixed use room is used to store medical supplies, including medications, as long as there is a locked cabinet in the room for that purpose. This particular mixed use room had a locked cabinet. The room is used for the preparation of medications and for other purposes. No narcotics were stored in this particular mixed use room. The room contained locked cabinets used to store other medications. The evidence presented was insufficient to determine what "medications" Furdell may have seen in the room.

28. Count IV of the complaint concerned the nursing assessment of a patient, and whether the assessment was properly and timely performed. A patient, M.S., had been admitted to the hospital on June 18, 2008, for lung surgery. Following the surgery, Amiodarone (a very toxic drug which can cause clots and other complications) was administered to treat M.S. for heart arrhythmia. The Amiodarone was administered intravenously and M.S. developed blisters and irritation at the intravenous site. That is not an uncommon complication with Amiodarone. M.S.'s attending physician was notified about the irritation and prescribed a treatment. He also ordered a consult with an infectious disease specialist who ultimately changed M.S.'s antibiotics. Although M.S. was seen daily by her physicians, the nursing notes do not reflect the assessment and treatment of

her blisters. It appears that proper care was rendered, but the care was not documented properly.

29. Another patient was admitted to the hospital on December 15, 2008, with End Stage Renal Disease and diabetes mellitus for which she began dialysis treatment. The patient was not weighed before and after a particular dialysis treatment on January 5, 2009. However, the patient had been moved to an air mattress bed on that date for comfort. The air mattress bed did not allow for a weight to be taken as it could be on a regular bed.

30. There is an allegation in the Administrative Complaint concerning the discontinuation of the calorie count for a patient. This issue was not discussed in AHCA's Proposed Recommended Order, nor was sufficient evidence of any wrong-doing concerning this matter presented at final hearing.

31. During the survey, the hospital was found to be storing the medication Mannitol in blanket warmers, rather than in warmers specifically designed for the drug. The blanket warmers maintained the Mannitol at 100-to-110 degrees Fahrenheit. The manufacturer's label on the drug calls for it to be dispensed (injected) at between 86 and 98.5 degrees Fahrenheit. In order to meet this requirement, the hospital takes the drug out of the blanket warmer in time for it to cool

sufficiently before it is injected. There is nothing inherently wrong with using a blanket warmer to store Mannitol.

32. On January 5, 2009, a surveyor found two vials of Thrombin, one vial of half-percent Lidocaine and Epi, and one vial of Bacitracin in operating room No. 4. The operating room is within the secured and locked suite of surgical rooms on the second floor. Two of the vials had syringes stuck in them and one of them was spiked. Whoever had mixed the medications was not attending to them at the time the surveyor made her observation. There were two unlicensed technicians in the room preparing for the next surgery. A registered nurse anesthetist was present as well. There was no identifying patient information on the medications. The hospital's policies and procedures do not require the patient's name to be on the label of medications prepared for impending surgery. That is because the procedures for the operating room include a process for ensuring that only the correct patient can be in the designated operating room. There is a fail-safe process for ensuring that only the proper patient can receive the medications that are set out.

33. At around 2:45 p.m. on January 5, 2009, there were patient records in the emergency department showing that several drugs had been administered to a patient. The surveyor did not see a written order signed by a physician authorizing the drugs.

When the surveyor returned the next morning, the order had been signed by the physician. The hospital policy is that such orders may be carried out in the emergency department without a doctor's signature, but that a physician must sign the order before the end of their shift. AHCA cannot say whether the physician signed the order at the end of his shift or early the next day.

34. Count V of the complaint was voluntarily dismissed by the Agency.

35. Count VI of the complaint concerned the status of certain patient care equipment, and whether such equipment was being maintained in a safe operating condition. A patient was weighed at the hospital upon admission on December 27, 2008, and found to weigh 130 pounds using a bed scale. Six days later, on January 2, 2009, the patient's weight was recorded as 134 pounds. Two days later, in the same unit, the patient weighed 147 pounds and the next day was recorded as weighing 166 pounds. During the survey process, the patient was weighed and recorded at 123 pounds on a chair scale.

36. The hospital does not dispute the weights which were recorded, but suggests there are many factors other than calibration of the equipment that could explain the discrepant weights. For example, the AHCA surveyor could not say whether the patient sometimes had necessary medical equipment on his bed

while being weighed, whether different beds were involved, or whether any other factors existed. AHCA relies solely on the weight records of this single patient to conclude that the hospital scales were inaccurate.

Case No. 09-5365

37. On February 18, 2009, AHCA conducted a licensure survey at Gulf Coast.

38. Count I of the complaint from this survey concerned the timeliness of triage for a patient who presented at the hospital emergency department with stroke-like symptoms.

39. AHCA surveyors witnessed two patients on stretchers in the ambulance entrance hallway leading to the emergency department. Each of the two patients had been brought in by a separate emergency medical service (EMS) team and was awaiting triage. One patient was taken to an emergency department room (ER room) 50 minutes after his/her arrival at the hospital. The other patient waited 45 minutes after arrival before being admitted to an ER room. Meanwhile, a third patient arrived at 2:20 p.m., and was awaiting triage 25 minutes later. During their observation, the surveyors saw several nursing staff in the desk area of the emergency department, i.e., they did not appear to be performing triage duties.

40. The emergency department on that date was quite busy. That is not unusual during February, as census tends to rise

during the winter months due to the influx of seasonal residents. A summary of the action within the emergency department from 1:00 p.m. to 3:00 p.m., on the day of the survey shows the following:

- Patient L.G., 74 years old with stable vital signs, was radioed in by her EMS team at 1:08; L.G. was processed into the ER at 1:21 (which is not an unreasonable time; EMS teams call in when they arrive at or near the hospital. By the time they gain access, wait their turn if multiple ambulances are present, and get the patient inside, several minutes may lapse). L.G. was stabilized and quickly reviewed by ER staff, then officially triaged at 2:04.
- Patient H.M., an 89-year-old male residing in a nursing home, arrived at 1:20 and was processed in at 1:59. He was triaged at 2:01, but ultimately signed out of the hospital against medical advice.
- Patient E.M. arrived at 2:18 and was processed at 2:25. Triage occurred one minute later. This patient presented as a stroke alert, and hospital protocol for that type patient was followed.

- Patient C.J. arrived at 1:08 and was processed at 2:38. Triage occurred immediately after C.J. was processed. This patient was not stroke alert, but had some stroke-like symptoms.[1] C.J. had not been transported to the hospital as emergent, because the symptoms had been going on for 24 hours.
- Patient W.M., an auto accident victim, arrived at 1:40 and was processed at 1:49. Triage occurred within six minutes.
- Patient M.M., W.M.'s wife (who had been with M.M. in the automobile accident, but was placed in a separate ambulance), arrived at 2:06 and was triaged at 2:34. There is no record of when M.M. was processed.
- Patient L.M. came to the hospital from a nursing home. She arrived at 1:43 and was processed at 2:35. L.M. was triaged at 2:37.
- Patient K.M. arrived at 2:45 and was processed within three minutes. Triage occurred at 2:52. Her triage was done very quickly due to the condition in which she arrived, i.e., shortness of breath and low oxygen saturation.

- Patient R.S. arrived at 1:00 and was triaged at 1:15.

41. The aforementioned patients represent the patients presenting to the emergency department by ambulance during a two-hour period on a very busy day. It is the customary procedure for ER staff to make a quick visual review (rapid triage) of patients as they come into the hospital. Those with obvious distress or life-threatening conditions are officially triaged first. Others, as long as they are stable, are allowed to wait until staff is available for them. As part of their duties, nurses necessarily have to be in the desk area (nursing station) in order to field phone calls from physicians concerning treatment of the patients who present. It is not unusual or improper for nurses to be in the nursing station while residents are waiting in the processing area.

42. It is clear that some patients waited a much longer time for triage than others. However, without a complete record of all patients who presented that day and a complete review of each of their conditions, it is impossible to say whether the hospital was dilatory in triaging any of them.

43. Count II of the complaint addressed the nursing staff and whether it failed to assess and intervene in the care of a patient or failed to implement a physician's plan of care for the patient.

44. Patient D.W. was a 67-year-old female who was morbidly obese, diabetic, debilitated, had end stage renal disease, and was receiving dialysis. Upon admission, D.W. had a Stage 3 pressure ulcer to her sacrum and a Stage 4 ulcer on her left calf. A wound care protocol was initiated immediately, and a Clinitron bed was obtained for her on the day of admission. Due to the seriousness of her condition, the wound care physician declined to accept her case at first. He later ordered Panafil, and it became part of the protocol for treating the patient. The nursing documentation for D.W. was only minimally sufficient, but it does indicate that care was provided.

45. Patient R.H. was an 83-year-old male who presented on February 10, 2009, in critical condition. R.H. was suffering from congestive heart failure, pneumonia, and respiratory failure. Due to the critical nature of his respiratory problems, R.H. was placed on a ventilator. As a ventilator patient, he did not fit the profile for obtaining wound care. Nonetheless, the hospital implemented various other measures to deal with R.H.'s pressure wounds.

CONCLUSIONS OF LAW

46. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding pursuant to Section 120.569, Subsection 120.57(1), and Chapter 395, Florida Statutes (2009). Unless otherwise

stated specifically herein, all references to Florida Statutes will be to the 2009 codification.

47. AHCA is asserting the affirmative of the issue in this case and, therefore, has the burden of proof. Inasmuch as the fines proposed by AHCA are penal in nature, the standard of proof is clear and convincing evidence. Department of Banking and Finance, Division of Securities and Investor Protection v. Osbourne Stern & Co., 670 So. 2d 932, 934 (Fla. 1996); see also Young v. Department of Community Affairs, 625 So. 2d 831 (Fla. 1993).

48. Clear and convincing evidence has been described as follows:

> [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

49. Except for Count I in Case No. 09-5363 and Count VI in Case No. 09-5364, AHCA failed to prove the allegations set forth in the Administrative Complaint by clear and convincing evidence. Therefore, no fines should be imposed in the other counts in Case Nos. 09-5360, 09-5364 and 09-5365.

50. As to Case No. 09-5363, AHCA did show by clear and convincing evidence that the hospital erroneously listed the wrong medications for two patients who presented from a nursing home. However, it is a mitigating factor that the patients presented to the hospital with nursing home records already containing the wrong medications. There is no evidence, however, that the nursing staff committed the error of failing to correct the erroneous records sent by the nursing home. However, someone on the hospital staff should have discovered the error. Due to the mitigating factor and the lack of actual harm to either resident, a fine of $500.00 would be appropriate for that violation.

51. As to Count VI in Case No. 09-5364, the discrepancies in the patient's weight is a strong suggestion that either the hospital's equipment was malfunctioning or necessary care was not being taken when weighing the patient. Due to the lack of actual evidence as to any particular scale's being defective, an administrative fine of $500.00 would be appropriate for that violation.

52. AHCA relies upon Subsection 395.1065(2)(a),(b), Florida Statutes, as its authority to impose fines in this case. That statutory subsection states:

> (2)(a) The agency may impose an administrative fine, not to exceed $1,000 per violation, per day, for the violation of any provision of this part, part II of

> chapter 408, or applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine.
>
> (b) In determining the amount of fine to be levied for a violation, as provided in paragraph (a), the following factors shall be considered:
>
> 1. The severity of the violation, including the probability that death or serious harm to the health or safety of any person will result or has resulted, the severity of the actual or potential harm, and the extent to which the provisions of this part were violated.
>
> 2. Actions taken by the licensee to correct the violations or to remedy complaints.
>
> 3. Any previous violations of the licensee.

53. Subsection 395.1055(1), Florida Statutes, sets forth the Agency's authority to adopt and enforce rules regarding the provisions of Chapter 395, Part I, Florida Statutes, which governs the operation of hospitals. Under that authority, AHCA adopted Florida Administrative Code Rule 59A-3.2085, which states in pertinent part:

> (5)(e) The nursing process of assessment, planning, intervention and evaluation shall be documented for each hospitalized patient from admission through discharge.
>
> 1. Each patient's nursing needs shall be assessed by a registered nurse at the time of admission or within the period established by each facility's policy.

> 2. Nursing goals shall be consistent with the therapy prescribed by the responsible medical practitioner.
>
> 3. Nursing intervention and patient response, and patient status on discharge from the hospital, must be noted on the medical record.

54. AHCA would be within its rights under Florida Administrative Code Rule 59A-3.2085(5)(e) to impose a fine against the hospital for failure to properly assess the two patients' medication needs at the time of admission in Case No. 09-5363.

55. Florida Administrative Code Rule 59A-3.276 states:

> (1) Each hospital shall develop, implement, and maintain a written preventive maintenance plan, in conjunction with the policies and procedures developed by the infection control committee, to ensure that the facility is maintained in accordance with the following:
>
> (a) The interior and exterior of buildings shall be in good repair, free of hazards, and painted as needed;
>
> (b) All patient care equipment shall be maintained in a clean, properly calibrated, and safe operating condition;
>
> (c) All plumbing fixtures shall be maintained in good repair to assure proper functioning, and provided with back flow prevention devices, when required, to prevent contamination from entering the water supply;
>
> (d) All mechanical and electrical equipment shall be maintained in working order, and shall be accessible for cleaning and inspection;

(e) Loose, cracked, or peeling wallpaper or paint shall be promptly replaced or repaired to provide a satisfactory finish;

(f) All furniture and furnishings, including mattresses, pillows, and other bedding; window coverings; including curtains, blinds, shades, and screens; and cubicle curtains or privacy screens, shall be maintained in good repair; and

(g) The grounds and buildings shall be maintained in a safe and sanitary condition and kept free from refuse, litter, and vermin breeding or harborage areas.

(2) Each hospital shall employ or otherwise arrange for sufficient personnel to implement and maintain its preventive maintenance program.

56. AHCA would be within its rights under Florida Administrative Code Rule 59A-3.276(b) and (d) to impose a fine against the hospital for failure to properly maintain its equipment as alleged in Count VI in Case No. 09-5364.

57. AHCA also adopted Florida Administrative Code Rule 59A-3.253 pursuant to its authority granted in Subsection 395.1055(1), Florida Statutes. That rule includes the following provision:

(11) SANCTIONS.--The agency shall impose sanctions, in accordance with Section 395.1065, F.S., on those hospitals which fail to submit an acceptable plan of correction or implement actions to correct

deficiencies identified by the agency or an appropriate accrediting organization which are specified in an approved plan of correction or as identified as a result of a complaint investigation.

58. Respondent argues that inasmuch as it submitted plans of correction which were accepted by AHCA, there is no basis for imposing a fine against Respondent. Respondent's interpretation of Florida Administrative Code Rule 59A-3.253 is rejected. AHCA is not prohibited from imposing a fine in this case pursuant to its authority in Section 395.1065, Florida Statutes.

RECOMMENDATION

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

RECOMMENDED that a final order be entered by Petitioner, Agency for Health Care Administration, imposing a fine in the amount of $500.00 in DOAH Case No. 09-5363 and a fine in the amount of $500.00 in DOAH Case No. 09-5364, Count VI.

DONE AND ENTERED this 30th day of April, 2010, in Tallahassee, Leon County, Florida.

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

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Division of Administrative Hearings
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ENDNOTE

[1/] A stroke alert is a patient with the onset of stroke-like symptoms within the previous three hours. Such patients can receive treatment that can vastly improve their chances of avoiding long-term effects of the stroke. Stroke patients, on the other hand, have had the symptoms for longer than three hours and are not candidates for the preventative treatment.

COPIES FURNISHED:

Thomas W. Arnold, Secretary
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308-5403

Justin Senior, General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

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

Andrea M. Lang, Esquire
Agency for Health Care Administration
2295 Victoria Avenue, Room 346C
Fort Myers, Florida 33901

W. David Watkins, Esquire
Watkins & Associates, P.A.
Post Office Box 15828
Tallahassee, Florida 32317-5828

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.