STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 10-4740
SA-PG SUN CITY CENTER, LLC, d/b/a PALM GARDEN OF SUN CITY,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice to all parties, a final hearing was conducted in this case on September 16, 2010, in Bradenton, Florida, before Administrative Law Judge R. Bruce McKibben of the Division of Administrative Hearings

APPEARANCES

For Petitioner: James H. Harris, Esquire
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For Respondent: R. Davis Thomas, Jr.,
Qualified Representative[1]
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STATEMENT OF THE ISSUES

The issues in this case are whether Respondent, SA-PG Sun City Center, LLC, d/b/a Palm Garden of Sun City (hereinafter

"Palm Garden" or the "Facility") failed to follow established and recognized practice standards regarding care to its residents; and whether Respondent failed to comply with the rules governing skilled nursing facilities adopted by Petitioner, Agency for Health Care Administration (hereinafter "AHCA" or the "Agency"). If the answer to those questions is in the affirmative, then there is an issue as to what penalty should be imposed on Respondent.

HOLDING: There is no competent and substantial evidence that Palm Garden failed to follow established practice standards that resulted in harm to its residents and failed to comply with rules governing skilled nursing facilities, or that otherwise warrants a fine or Conditional rating. Palm Garden was marginally deficient in two minor areas concerning their own policies, but neither violation is a Class II deficiency, nor warrants imposition of a sanction.

PRELIMINARY STATEMENT

On or about June 17, 2010, AHCA filed an Administrative Complaint against Palm Garden, alleging certain violations uncovered during a survey of the Facility. The complaint notified Palm Garden of the intent to impose a fine in the amount of $2,500.00 and to impose a Conditional license on the Facility. Palm Garden timely filed its Election of Rights, seeking a formal administrative hearing. The request for

hearing was forwarded to the Division of Administrative Hearings.

At the final hearing, AHCA called five witnesses: J.H., daughter of a resident; D.W., wife of a resident; Marilyn C. Jones, health facility evaluator for AHCA; Vicki Hart, registered nurse ("RN") surveyor; and Sandra Santiago, RN surveyor. J.H. was also called as a rebuttal witness. Petitioner's Exhibits 1 through 5 were admitted into evidence. Palm Garden called one witness, Andrea Cornwell, RN, director of nursing. Respondent's Composite Exhibit 1 was admitted into evidence.

A transcript of the final hearing was ordered by the parties. The Transcript was filed at the Division of Administrative Hearings on October 5, 2010. By rule, parties are allowed ten days to submit proposed recommended orders. However, the parties requested and were given leave to submit their post-hearing findings of fact and conclusions of law on November 30, 2010. Each party timely submitted a Proposed Recommended Order, and each was duly considered in the preparation of this Recommended Order. Subsequent to the Proposed Recommended Orders being filed, Palm Garden filed a motion to strike portions of Petitioner's Proposed Recommended Order. Petitioner filed a response to the motion. The motion

is adequately addressed in the Findings of Fact and Conclusions of Law set forth herein.

FINDINGS OF FACT

1. AHCA is the state agency responsible for licensing and monitoring skilled nursing facilities in Florida. Part and parcel of its duties is the inspection of all facilities on an approximately annual basis. Further, AHCA may conduct a survey of a facility upon receipt of a complaint from a third party about operations or conditions at a specific facility.

2. Palm Garden is a 120-bed skilled nursing facility located in Sun City, Florida. The Facility provides services to private pay residents and is also certified to provide services for residents under the Medicaid and Medicare reimbursement programs. At all times relevant hereto, Palm Garden was operating under a Standard nursing home license.

3. On April 26 through 30, 2010, AHCA conducted an annual survey at the Facility. During the course of the survey, AHCA surveyors made findings concerning two allegedly deficient practices by the Facility. The deficiencies are identified as follows: (1) One resident, identified herein as Resident 68, complained of burning on urination and said no treatment was offered to relieve the pain; and (2) One resident, identified herein as Resident 138, had wounds on his skin that his family believes were not properly treated.

4. During the survey, Resident 68 purportedly complained to a surveyor that she was currently having pain when she urinated and was not being treated for the condition. The surveyor reviewed the resident's chart and determined that Resident 68 had previously complained of urination pain on April 10, 2010. In response to her complaint, a Diascreen test was performed on that same date. The test came back negative for urine infection. The test was normal in all regards, except for glucose level. The resident was at 250 mg/dL (milligrams per deciliter) of glucose when the normal range is between 50 and 150 mg/dL. The Agency expert opined that the glucose level discrepancy renders the test result less reliable. In her opinion, the report would be inconclusive as to whether a urinary tract infection ("URI") existed. There are, as the Facility's expert opined, other conditions, including diabetes, which can cause a high glucose rating. Resident 68 suffered from diabetes at the time the test was done. On balance, it appears that the test was viable.

5. On the date the Diascreen test was performed, a checklist for potential URI was placed in the resident's medication administration record. That checklist set forth a protocol to follow over the next 72 hours in order to better assess the resident's condition. There is no evidence the protocol was followed. The Facility's infection control nurse,

Sue Fuller, admitted that sometimes it is difficult to get all nurses to strictly follow established procedures. However, Resident 68 was receiving 24-hour care by the Facility and was monitored regularly as part of that care.

6. The resident's chart does not indicate any further problems concerning urination pain until April 27, 2010, i.e., day two of the annual survey. On that date, there is a doctor's note indicating dysuria, i.e., painful urination condition. The doctor prescribed Pyridium, a urinary antiseptic (not an antibiotic) for treatments. The physician did not order any additional tests or other treatment. It is apparent a physician was involved in Resident 68's care, but he did not diagnose a UTI.

7. AHCA concluded from its investigation that Resident 68 suffered actual harm between April 10 and April 27, 2010, because there is no documentation that the resident's pain was being addressed. However, Palm Garden charts by exception, meaning that they only place into the chart events which are abnormal or negative. Ignoring the issue of whether that is the best way to chart a resident's care, the absence of chart notations relating to URI or painful urination means, from the Facility's perspective, that there was no complaint of pain on the days it was not mentioned. The resident was visited by a physician on April 16 and 22, 2010, but the doctor's notes do

not indicate a complaint concerning pain when urinating. The resident's chart does indicate that Resident 68's activities of daily living, meal consumption, and therapy records reflect normal activity without any notable exceptions. It is unlikely an elderly person with an untreated UTI would be able to pursue normal activities.

8. AHCA did not independently ascertain whether Resident 68 experienced pain during the period between April 10 and April 27, 2010. The Agency's conclusion in that regard is based on pure speculation by the surveyor. There is no competent evidence that there was harm to the resident.[2] The resident purportedly told the surveyor that she (resident) had experienced pain during that time, but the clinical records do not support that claim.[3]

9. During the survey, Resident 138 was noted to have two skin wounds on his buttocks. The resident's wife had complained to surveyors about the wounds because she did not believe appropriate treatment was being provided by the Facility. A surveyor contacted the Facility's wound nurse to inquire about the wounds, which the surveyor believed to be pressure sores. No measurements had been taken of the wounds, a deficient practice from the surveyor's perspective. The surveyor stated, "And they were Stage II pressure ulcers. I mean, she was saying they were excoriations, but they were on the bony prominence.

It was a Stage II. It wasn't very deep when I saw it. The one on the left buttocks was irregular, and the one on the right buttocks was smaller. I didn't see any drainage and there was no odor and it was actually superficial. It would be a Stage II pressure ulcer." (See Transcript, page 84.)

10. In fact, the wounds were considered excoriations, rather than pressure sores by the Facility. The Facility's director of nursing, who was very familiar with Resident 138 and had examined him prior to and during the survey, described the wounds as excoriations based on the way they were healing. Excoriations are not normally measured because they change rapidly and tend to heal quickly. Conversely, pressure sores must be measured as a part of their on-going treatment because they heal slowly and must be monitored. The surveyors found the wounds to be very small and superficial. If they were pressure sores, they would have been Stage I sores. Stage I pressure sores do not blanch. To blanch means that if pressure is applied to the area, blood would rush back after the pressure is released. The wounds on Resident 138 were personally blanched by the Facility's director of nursing.[4]

11. There are other wounds that look like pressure sores, but actually come about due to other causes. For example, a sore may occur when a person lies in urine, thus, agitating the

skin. Sores may be caused by frequent contact with liquids and by residents being moved in their beds.

12. There is no mention in Resident 138's medical chart of pressure sores. Rather, the doctor's notes refer to the resident's wounds as open sores or excoriation. At one point the Wound Treatment Evaluation Record for the resident listed a Type I and a Type II for wound type and pressure ulcer stage. However, that notation was later indicated as an error by the wound nurse. There is no competent medical evidence that Resident 138's wounds on his buttocks were pressure sores.

13. Nonetheless, the surveyors observed nursing staff treating Resident 138's wounds and found some deficient practices. A treating nurse put on gloves after setting up her treatment table. The nurse then reached back and closed the curtain around the resident's bed (a proper practice), but did so with her gloved hand. That action would desterilize the glove. She then began treating the resident without re-washing her hands or re-gloving. The nurse then discarded the wound dressing and changed gloves. However, she did not wash her hands before changing gloves. She then poured saline on the wounds as required. The surveyor at this point noted what she believed were two wounds, neither of which was draining or had an odor. The wounds were superficial, not deep, according to the surveyor. At that point, the nurse cleaned both wounds

using the same piece of gauze. She then applied dressing to the wounds, completing her treatment.

14. The surveyor found that touching the curtain with a gloved hand was an infection control violation. So too was the cleaning of two wounds using the same piece of gauze. The Facility opines that the treatment process was not a sterile situation, until such time as the wound had been cleaned and dressed. Touching the curtain before that process and changing gloves without washing would not necessarily be deemed infection control issues, although transferring germs from the curtain to the wound area was a possibility. The wound area was not a pressure sore, thus did not contain infection. It was, therefore, proper to wash the wound area with the same gauze without violating infection control procedures.

15. It is the opinion of the AHCA surveyor that Resident 138 had two wounds. She believed one wound was smaller than the other and that neither of them were open or had odor, but that each of them was a Stage II decubitus ulcer. It is the opinion of the Facility that there were no decubitus ulcers on the resident. Rather, the resident had an area of excoriation that was treated pursuant to the doctor's orders. Based on the greater degree of personal involvement with the resident and the confirmation of their opinion by the treating physician, the Facility's perception is given greater weight.

16. A number of treatments were used to address Resident 138's wounds. An order for hydrocolloid was entered, followed by elimination of the hydrocolloid in favor of optase jell, then discontinuance of the optase jell in favor of methylex. The Facility properly followed the physician's prescribed treatment for this resident. No persuasive, non-hearsay evidence was presented as to the status of Resident 138's wounds as of the date of the final hearing, so there can be no finding as to whether the wounds healed (an indication of excoriation, rather than decubitus) or not (a contrary indication).

CONCLUSIONS OF LAW

17. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding pursuant to Section 120.569 and Subsection 120.57(1), Florida Statutes (2010).[5]

18. 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.[6] 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).

19. 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).

20. AHCA has not proven by clear and convincing evidence that the Facility failed to address Resident 68's dysuria or that it failed to properly identify and treat Resident 138's skin wounds. The evidence presented by AHCA does not have sufficient weight to produce a firm belief or conviction in the mind of the Administrative Law Judge. Further, the testimony of the Agency's expert was less credible than that of the Facility's professional staff.

21. AHCA has proven by clear and convincing evidence that the Facility did not properly follow all the steps outlined on its checklist for potential UTI concerns. However, there was no persuasive evidence that the failure resulted in any harm to Resident 68. Further, it is clear that Resident 68 continued to

receive daily care, even though the prescribed steps were not followed.

22. AHCA has also proven by clear and convincing evidence that a Facility nurse did not adequately follow all of the proper infection control procedures. The process employed by the wound care nurse could have been better. Again, however, there is no evidence that the errors resulted in any harm to Resident 138.

23. Section 400.022, Florida Statutes, says in pertinent part:

> (1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:
>
> * * *
>
> (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

24. The Agency may suspend or revoke a license or impose an administrative fine for failure to comply with the above

cited provision. Further, the Agency may impose sanctions in accordance with Section 400.121, Florida Statutes, which states:

> (1) The agency may deny an application, revoke or suspend a license, and impose an administrative fine, not to exceed $500 per violation per day for the violation of any provision of this part, part II of chapter 408, or applicable rules, against any applicant or licensee for the following violations by the applicant, licensee, or other controlling interest:
>
> (a) A violation of any provision of this part, part II of chapter 408, or applicable rules; or
>
> * * *
>
> (2) Except as provided in s. 400.23(8), a $500 fine shall be imposed for each violation. Each day a violation of this part or part II of chapter 408 occurs constitutes a separate violation and is subject to a separate fine, but in no event may any fine aggregate more than $5,000. A fine may be levied pursuant to this section in lieu of and notwithstanding the provisions of s. 400.23. Fines paid shall be deposited in the Health Care Trust Fund and expended as provided in s. 400.063.

25. Under Section 400.23, Florida Statutes, there is a definition of a Class II deficiency. Subsection (8) of that statute says:

> (8) The agency shall adopt rules pursuant to this part and part II of chapter 408 to provide that, when the criteria established under subsection (2) are not met, such deficiencies shall be classified according to the nature and the scope of the deficiency. . . .

* * *

> (b) A class II deficiency is a deficiency that the agency determines has compromised the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. A class II deficiency is subject to a civil penalty of $2,500 for an isolated deficiency, $5,000 for a patterned deficiency, and $7,500 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection. A fine shall be levied notwithstanding the correction of the deficiency.

26. There is no competent and substantial evidence that the actions of the Facility compromised either resident's ability to maintain their highest practicable physical, mental or psychological well-being. AHCA's expert stated that the distinction between a Class II and Class III deficiency is that with a Class II, there is actual harm to the resident. In the case of the two residents at issue in this proceeding, there was no showing of actual harm.[7]

27. There is no persuasive, non-hearsay evidence to support the existence of actual harm to either resident as a result of the Facility's actions.

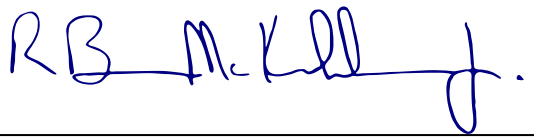
28. There is no basis in law or fact warranting a fine or imposition of a Conditional licensure rating for the Facility.

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, denying the imposition of a fine or a Conditional license against Respondent, SA-PG Sun City Center, LLC, d/b/a Palm Garden of Sun City, and dismissing the Administrative Complaint.

DONE AND ENTERED this 21st day of December, 2010, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 21st day of December, 2010.

ENDNOTES

[1/] Mr. Thomas is an attorney, but is not licensed to practice in the state of Florida. He was accepted as a qualified representative in this matter pursuant to Florida Administrative Code Rule 28-106.106.

[2/] It should be noted that much of the surveyor's determinations were allegedly based on the statements of residents, but there was no persuasive non-hearsay evidence to support the surveyor's findings.

[3/] There would be no reason not to believe the testimony of the resident had she testified, but reliance on hearsay representations allegedly made by the resident are not sufficient for making a finding of fact in this matter.

[4/] Any decubitus ulcer beyond a Stage I would not be blanched. Once a wound reached that level, there would be no need or reason to blanch it.

[5/] Unless specifically stated otherwise herein, all references to Florida Statutes shall be to the 2010 version.

[6/] While it may be argued that the imposition of a Conditional licensure rating may require a preponderance of the evidence standard, inasmuch as the elements to prove each allegation in the Administrative Complaint are the same, the higher standard of proof will apply.

[7/] Actual harm is not technically an element of the Class II (State) deficiency, but inasmuch as the senior nurse on the survey team used the term in describing the alleged deficiencies, it is addressed herein.

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.