STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 11-4457
FAITH HOME HEALTH, INC.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, on February 10, 2012, a formal hearing in this cause was held in Tampa, Florida, before the Division of Administrative Hearings (Division) by its designated Administrative Law Judge Lynne A. Quimby-Pennock.

APPEARANCES

For Petitioner: James H. Harris, Esquire
Agency for Health Care Administration
The Sebring Building, Suite 330D
525 Mirror Lake Drive, North
St. Petersburg, Florida 33701

For Respondent: Thomas W. Caufman, Esquire
Tammy Stanton, Esquire
Quintairos, Prieto, Wood and Boyer, P.A.
4905 West Laurel Street
Tampa, Florida 33607

STATEMENT OF THE ISSUES

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

PRELIMINARY STATEMENT

Respondent, Faith Home Health, Inc. (Faith Home), operates a home health agency located at 3202 North Howard Avenue, Tampa, Florida. On February 3, 2011, Petitioner, Agency for Health Care Administration (AHCA), conducted a recertification survey of Faith Home. On August 1, 2011, AHCA filed a two-count Administrative Complaint against Faith Home based on its survey. AHCA is seeking $46,000.00 in fines and the investigative cost associated with the survey.

On August 23, 2011, Faith Home filed a Petition for Formal Administrative Hearing (Petition). On September 1, 2011, AHCA referred the Petition to the Division for a disputed-fact hearing and the issuance of a recommended order.

A Notice of Hearing by Video Teleconference was issued setting the case for formal hearing on November 8 and 9, 2011. On October 20, 2011, Faith Home filed an uncontested Motion for Continuance. On October 21, 2011, an Order granting the continuance was issued, and the parties were directed to provide three mutually–agreeable dates for a hearing in January 2012. The parties complied with the Order.

On October 31, 2011, an Order was entered setting the case for hearing on January 30 and 31, 2012. On January 13, 2012, AHCA filed an unopposed Motion to Amend Administrative Complaint, which was granted, and all future references will be to the Amended Administrative Complaint (AAC), filed with the Division on January 23, 2012.

On January 30, 2012, Faith Home made an ore tenus motion for continuance based on the unavailability of its chief witness due to an unexpected illness. The ore tenus motion was granted. Although this case was originally scheduled for two hearing days, prior to the last Notice of Hearing being issued, the parties notified the Division that only one hearing day was required. The hearing was re-scheduled to February 10, 2012, and heard as scheduled.

AHCA presented the deposition testimony of Jeanette Peabody and the testimony of Joni Miller and Bronson Sievers. AHCA's Exhibits 1 through 4 and 6 through 18 were admitted into evidence. Faith Home presented the testimony of Beverly Eubanks and Celina Okpaleke. Faith Home's Exhibits 1 through 3, 5 through 9, 11, and 13 through 15 were admitted into evidence.[1/]

A two-volume Transcript of the proceeding was filed with the Division on February 21, 2012. The parties timely filed proposed recommended orders, and each has been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. At all times material hereto, Faith Home operated as a home health agency with its principal place of business located at 3202 North Howard Avenue, Tampa, Florida. Faith Home's license number is 299991078.

2. Joni Miller is a registered nurse (RN) surveyor for AHCA. Ms. Miller holds an associate of arts degree in nursing and practiced as an RN for almost 30 years. She practiced as an RN in the areas of coronary care, research, home health, cardiology, and sports medicine. Ms. Miller has completed the requisite classes in surveyor training and is a certified home health surveyor. Ms. Miller was received without objection as an expert in nursing.

3. Jeanette Peabody is an RN who worked for AHCA as an RN specialist. Ms. Peabody obtained an associate of arts degree in applied science with a major in nursing. In 1995, Ms. Peabody was licensed as an RN in Pennsylvania. Thereafter, she worked for various health-related entities, including (but not limited to) two home health agencies and the Pennsylvania Department of Health. She became licensed as an RN in Florida in 2004. Ms. Peabody became a certified surveyor after receiving the appropriate training. While working for AHCA, Ms. Peabody conducted surveys of health care facilities and agencies for

compliance with the applicable rules and regulations.

Ms. Peabody was received as an expert in nursing.

4. Beverly Eubanks is the chief operating officer for Faith Home, a position she has held for 15 years. Ms. Eubanks is an RN, who received her associate's degree in nursing from Manatee Community College in 1990. Faith Home primarily serves the underprivileged, low-income families, and public housing residents.

5. Celina Okpaleke is the sole owner of Faith Home and has been its owner since 1997. Ms. Okpaleke is a licensed physician assistant, having been licensed in 1996. Her duties at Faith Home are to oversee its day-to-day management. Prior to the February 2011 survey, Ms. Okpaleke had not been going to the Faith Home office every day.[2/]

6. The methodology for any survey includes the following: the team arrives at the location; the team is introduced to the survey entity's staff members; the team explains to the entity's staff members the nature of the survey, including a list of items required for the team to conduct the survey; and there is a request for work space. Upon receipt of the required items, the team reviews the material, conducts interviews, conducts visits with patients at their various locations, interviews staff, and reviews the accumulated information. In the event the surveyors have any questions, the surveyors will make requests to the

appropriate entity staff, and additional materials may be provided to the surveyors. The survey findings are reviewed with the staff, and, at the end of the survey, the team conducts an exit conference with the appropriate staff. Any entity staff is welcomed to be present. In the event any documentation is missing, the entity is allowed to provide that material after the surveyors have left the facility. In those instances when an agency is out of compliance, AHCA will make a return visit to ensure the agency has corrected the deficiencies. There was credible testimony that this survey procedure was the same procedure used during the Faith Home survey and follow-up survey.

7. It is recognized as a good nursing practice to document in a patient's record or chart the care, treatment or other services being provided to a patient. This includes all medical and medically-related support services.

8. Faith Home has numerous policies that govern how it is to be run. A few of the pertinent policies are set forth below. "Patient Visits," last revised on December 1, 2010, provides:

> All patients will be seen according to physician's orders and in compliance with the plan of treatment. At each visit, a progress or visit note will be completed. On the visit note (progress not [sic]/visit note) the patient's progress toward meeting established goals shall be documented.
>
> In addition, the patient's response to treatment will be documented as well as any other pertinent assessment information.

> All patient visits will be performed according to a pre-established schedule. If there is [sic] any changes in visit schedule, time or staff, the patient will be consulted prior to the change.

"Initial Assessment Process for Medicare [P]atients," last revised on December 1, 2010, reflects in pertinent part:

> Upon admission, each patient will receive initial assessment in order to determine patient's needs. To achieve this goal, the following important processes must be performed:
>
> * * *
>
> More in depth functional assessments performed by a qualified PT [physical therapist] or OT [occupational therapist] are available to those patients who need one. These assessments are documented on the appropriate PT/OT Evaluation form.
>
> * * *
>
> Initial assessments will be performed within 48 hours of referral or within 48 hours of a patient's return home from an impatient [sic] stay, or on the physician-ordered start of care [SOC] date.
>
> MSW will make assessments within one (1) week of referral based on the patient's priority level as determined by RN and/or MD, PT, ST, and OT will make evaluations within one (1) week of referral based on the patient's priority level as determined by the RN and/or MD.
>
> - Administration/start of care assessment data must be completed within five (5) calendar days of the SOC date. The agency then has seven (7) calendar days from the SOC date to encode the data, check for errors and lock the data for

> transmission. The data will than [sic] be transmitted on a monthly basis; data minimum no later than the month[.]

"Oasis Data Set," last revised on December 1, 2010, reflects in pertinent part:

> The agency has implemented the OASIS data set and is actively collecting data as of March 15, 1999. Current assessment data and notes utilized by the agency have been incorporated into the OASIS core data.
>
> OASIS requirements apply to all patients . . The only exclusions are as follows:
>
> 1. Patients under the age of 18
> 2. Patients receiving maternity services
> 3. Patients receiving ONLY no skilled services such as personal care, homemaker, chore, or companion services.
>
> OASIS data are collected at the following points:
>
> 1. Start of Care
>
> * * *
>
> 2. Resumption of Care following impatient [sic] stay
>
> * * *
>
> 3. Follow-up/Recertification
>
> * * *
>
> 4. Follow-up/SCIC
>
> * * *
>
> 5. Discharges and Death
>
> * * *

> Do not administer OASIS data set as an interview. Questions are meant to be part of the professional opinion of the staff member performing the assessment, based upon the evaluation of the patient.
>
> Be sure to incorporate agency assessment material (Discharge Summary, etc.) with the OASIS data set. The OASIS data set does not constitute a complete assessment.

"Policies & Procedures for Accectance [sic] of Patients/Cases"

last revised on December 1, 2010, reflects in pertinent part:

> B) Qualifying Criteria for Accepting a Patient
>
> * * *
>
> 7) Client must have a telephone or use of phone in close distance for emergency situation. Running water and electricity are also important factors for providing adequate care in the home.
>
> * * *
>
> D) Criteria for Acceptance of Skilled Nursing Clients
>
> * * *
>
> 5) A copy of MD orders may accompany Skilled Nursing Admission. If nurse [is] able to receive a faxed copy of orders, Faith Home Health will fax them. If not, a copy of the order will be sent to patient's residence with supplies.

"Policies & Procedures for Admissions," last revised on

December 1, 2010, reflects in pertinent part:

> A) Admission & Assessment Policies & Procedures

* * *

7) All documentation will be kept in the patient's Faith Home Health folder.

"Caregiver Job Descriptions," last revised on December 1, 2010, reflects in pertinent part:

A) Registered Nurses

* * *

Activities may include:

* * *

11. Recording pertinent information.

* * *

B) LICENSED PRACTICAL NURSE

* * *

Activities may include:

* * *

7. Recording all pertinent observations and treatments[.]

* * *

C) Certified Nurse Aide

* * *

Activities may include:

* * *

22. Keeping a record of observations and care given[.]

D) Home Health Aide

* * *

Activities may include:

* * *

10. Maintaining a proper record of activities.

The February 2011 Survey

9. In early February 2011, Ms. Peabody was the lead surveyor in the annual Florida licensure recertification survey conducted at Faith Home (FH survey). Ms. Miller was also a member of the FH survey team. This FH survey team conducted reviews, interviews, home visits, and conferences over the course of three days.

10. During the February 2011 FH survey, Ms. Peabody requested and was provided Faith Home's records for patient 5. The home health certification and plan of care (HHC/POC) for patient 5 provided the SOC date as December 14, 2010. The HHC/POC ordered skilled nursing visits to occur one to two times a week for nine weeks. According to the HHC/POC, at each visit, the skilled nurse was to perform various treatments with respect to patient 5's multiple medical issues, including assessing vital signs, cleaning a toe wound and applying a dressing, instructing the patient on diet and nutrition, and reporting any changes to

the "MD [medical doctor] & supervisor ASAP [as soon as possible]."

11. Patient 5 did not receive skilled nursing visits during the weeks of December 19 or 26, 2010. During the following skilled nursing visits, patient 5 did not receive wound care treatment: December 13, 2010, and January 6, 13, 18, and 21, 2011.

12. Additionally the HHC/POC called for a PT to evaluate and treat patient 5. There were orders that the PT was to administer therapeutic home care exercises in order to increase patient 5's functional abilities. Patient 5 did not have the physical therapy evaluation or treatment as directed. There was no PT evaluation or treatment documentation for patient 5, and there was no documentation that the MD or supervisor was notified that the treatments did not take place.

13. Following the review of the documentation provided, Ms. Peabody afforded Faith Home the opportunity to provide any additional documentation they had with respect to the care and treatment provided to patient 5. No additional documentation was forthcoming to the surveyors.

14. Ms. Eubanks contended that patient 5 was seen by a nurse during the week of December 18, 2010. She testified that there was no wound care treatment necessary for patient 5 because the wound had healed. Ms. Eubanks "believe[d]" the wound had

resolved by December 9, 2010, and that no PT was ordered because patient 5 was still "refusing it." Ms. Eubanks also testified that no wound care treatment was required because it was not on the OASIS data collection sheet. Ms. Eubanks's testimony is not credible as the HHC/POC is clear as to the physician's order regarding patient 5's toe wound care and the PT evaluation and treatment. The OASIS data form may be the methodology "to track your [Faith Home] benchmarks and your progression to see how you rank" among other home health agencies, but it does not take the place of a HHC/POC executed by a physician. Further, although a patient always has the right to decline a health care service, that response does not preclude the physician from ordering the particular care to be provided.

15. Based on the violations observed and documented during the February 2011 survey, Ms. Miller went back to Faith Home in June 2011 to follow up on the areas of concern. Ms. Miller reviewed five patients at the June 2011 revisit, one of whom was part of the February 2011 survey, patient 5.[3/]

16. Patient 5J's HHC/POC, signed on April 16, 2011, ordered skilled nursing visits to occur one to two times a week for nine weeks. According to the HHC/POC, at each visit, the skilled nurse was to perform various treatments with respect to patient 5J's multiple medical issues. The HHC/POC included an assessment of patient 5J's vital signs including the endocrine,

cardiac, and neuro, with instructions regarding the disease process and management; fall prevention; diet and nutrition; and skin, nail, and foot care. It also included an order to report "any changes or concerns to [the] MD & supervisor ASAP."

17. This April 16, 2011, HHC/POC also ordered a home health aide (HHA) to provide services two to three times a week for nine weeks for patient 5J. The HHA was to assist patient 5J with the activities of daily living (ADL).

18. During the follow-up survey, Ms. Miller was unable to find documentation of any nurse's treatment for patient 5J during three of the nine-week certification period. The skilled nursing visit notes on April 21 and May 5, 2011, failed to reflect any assessment of patient 5J's vital signs, including the cardiovascular system. The lines drawn through certain boxes do not indicate review or assessment of patient 5J.

19. Further, there was no evidence of any HHA visits during the seventh week through the ninth week of the certification period for patient 5J. This totaled six missed HHA visits for patient 5J.

20. With respect to patient 7, the HHC/POC, with a SOC date of December 18, 2010, ordered a PT to evaluate and treat patient 7. The PT was to administer a therapeutic home care exercise program to patient 7 to increase strengthening.[4/] The

HHC/POC also ordered the skilled nurse to "report any changes and or concerns to the MD & RN ASAP."

21. Patient 7 did not receive the physical therapy evaluation until December 29, 2010, 11 days after it was ordered. The PT's care plan for patient 7 involved physical therapy two times a week for three weeks. At the time of the FH survey, there was no documentation that the physician was notified of the delay or the reason for the delay in performing the PT evaluation on patient 7.

22. Ms. Eubanks provided a "Communication/Status Report" (C/SR) pertaining to patient 7, dated January 3, 2011. Although this C/SR purports to put Faith Home services (including the PT) on hold until the patient returns from being with the "daughter and family for a couple of weeks," it is at odds with the credible evidence presented by AHCA. The physical therapy documentation reflects that patient 7 was provided PT services twice during the week of January 9, 2011, just one week after Faith Home was "notified" the patient would be gone "for a couple of weeks." Additional physical therapy documentation reflects that service was also provided twice during the week of January 17, 2011.[5/]

23. Ms. Eubanks's contention that this C/SR was faxed to patient 7's physician to notify him/her of the change in plans is not credible. There was no testimony or documentation of the

physician's actual fax number or the actual number to which this C/SR was purportedly faxed, nor did the person who actually faxed the C/SR testify.

24. Patient 11's HHC/POC, signed December 15, 2010, ordered skilled nursing care two to three times a week for nine weeks. At the end of the HHC/POC orders, there is an order to "Report any changes and or concerns to MD & supervisor ASAP." Although it is noted on the HHC/POC that the "Certification period [was] extended due to [a] procedure on [the] left second toe," there was no actual doctor's order to provide wound care to patient 11's left second toe. There is, however, a "60 Day Summary" notation which states:

> Wound to [the] right great toe healed without complication. Skilled nurse currently caring for left second toe. No S&S of infection noted. Blood pressure and blood sugar has remained stable through out [sic].

This summary statement is not an order for care to patient 11's left second toe.

25. When a nurse observes a new wound in need of care, the nurse should immediately document the toe wound and contact the physician. The burden then falls to the physician to decide what, if any, order is appropriate for the wound care. This recording/reporting process was not followed, and there was no documentation of patient 11's wound to the left second toe.

However, the skilled nursing visits record that wound care was provided to patient 11's left second toe.

26. Ms. Eubanks testified that patient 11's podiatrist, Dr. Rappaport, wrote an order to discontinue wound care to the right great toe because it had healed. Other than the 60-day summary note found in the HHC/POC signed December 15, 2010, there was no order signed by Dr. Rappaport that discontinued care to the right great toe, and no order for care to patient 11's left second toe was introduced at hearing. Although Ms. Eubanks testified that patient 11 had the left second toe nail bed removed, she never testified that she was present when that nail bed was removed or that she was the attending skilled nurse who provided the post nail bed removal care. Her testimony is at odds with the credible evidence presented by AHCA.

27. Patient 13's HHC/POC, with a SOC date of December 21, 2010, ordered skilled nursing care one to two times a week for six weeks with specific skilled nursing tasks to be performed. There was no documentation that a skilled nurse provided care during the weeks of December 26, 2010, or January 9, 2011.

28. Patient 13's HHC/POC also ordered a physical therapy evaluation. As part of the HHC/POC, the PT was to administer therapeutic home care exercises to increase functional strength, range of motion (ROM), balance and endurance, and transfers and

to report "any changes and or concerns to [the] MD & RN CM [case manager] ASAP."

29. Patient 13's physical therapy evaluation was not conducted until January 5, 2011, roughly two weeks after it was ordered. The physical therapy care plan directed that patient 13 was to be seen two times a week for the first week and three times a week for the next four weeks. Although there are "missed visit reports" that document a PT's attempt to see the patient on six different January 2011 dates, there is no credible evidence that patient 13's physician was notified of those six missed visits as soon as possible.

30. Ms. Eubanks points to a January 24, 2011, C/S Report (January note) for the reason the PT missed the visits with patient 13. This January note reflects that patient 13 had gone to Georgia to be with her daughter and would return the end of January 2011 or the first Tuesday in February. This January note prompts more questions than answers because it does not reflect exactly when patient 13 went to Georgia and only asks that the "nursing services" not the physical therapy services be held until patient 13's return.

31. The missed visit reports indicate that a PT went to the residence and knocked on patient 13's door, but no one came to the door. Although the missed visit reports provide space for the patient's name (appropriately redacted), the date (of

service), the discipline (in this case "PT" was checked), the reason (for the missed service; in this case phrases to the effect: drove by, no one answered door, etc.), and who completed the missed visit report (the PT's signature is illegible), none of these missed visit reports have a checkmark (or any indication) next to the "Y," which signifies that the physician was notified. Ms. Eubanks's posturing that these missed visit reports were left in an inbox at a public housing building facility so that the physician was notified is not credible.

32. Ms. Eubanks also testified that patient 13 did not have a telephone, and "so there was no other way to contact [her] but actual face to face." This statement is in direct contradiction to Faith Home's policy that a client must have a telephone or that a phone be close by for communication purposes.

33. Further, there was evidence that two skilled nursing visits took place: one on January 26, 2011, and the other on January 29, 2011, just two and five days, respectively, after the January note stating patient 13 would be gone until the end of January or the first of February.

34. Patient 2's HHC/POC, signed September 13, 2010, ordered skilled nursing visits to occur up to seven days a week, and the nurse was to provide a complete assessment with each shift. According to the HHC/POC, the skilled nurse was to, among other things, monitor patient 2's GI status and provide G-tube care

every shift, weigh the child weekly on Mondays when scales became available, and document it in the mom's notebook. Based on patient 2's condition, care had to be taken that the patient did not become dehydrated or lose a lot of weight. There was no documentation of patient 2's weight being recorded by the Faith Home skilled nurses during the scheduled Monday visits. Patient 2's records provided to the surveyors during the February 2011 FH survey failed to reflect documentation as to any G-tube care being provided on every shift.

35. Ms. Eubanks testified that patient 2 was weighed weekly at his school. Based on the phrase in the HHC/POC "when a scale becomes available," Faith Home took the position it was not obligated to secure a scale to ensure it weighed the patient per the HHC/POC. Rather, Faith Home unilaterally decided that, because the Department of Children and Families (DCF) was having patient 2 weighed weekly at school, Faith Home was meeting its obligation. However, this position flies in the face of the physician's order for patient 2. Patient 2's record does not reflect where patient 2's weight was being recorded, either at home or school, nor does it reflect that the physician was being made aware of patient 2's weight on a regular basis. Faith Home did not document the lack of a scale, did not inform the physician that the weight was being monitored by DCF at

patient 2's school and did not ensure that the physician was aware of patient 2's weekly weight status.

36. Patient 3's HHC/POC, signed November 30, 2011, ordered an RN to be present 20 hours a day up to seven days per week. Additionally, the skilled nurse was to assess the patient and perform other specific care. One specific task was for patient 3's tracheotomy care to be performed twice a day and as needed.[7/] Documentation for patient 3 failed to reflect the tracheotomy care twice a day or as needed between December 20, 2010, and January 22, 2011.

37. Ms. Eubanks testified to patient 3's medical circumstances. Although Ms. Eubanks understood that AHCA's surveyors had patient 3's pediatric notes, she only pulled "random notes" for the "period because they had already copied everything that they wanted to take." Of Faith Home's documents that she discussed, Ms. Eubanks only presented two dates (out of the 34 days alleged in the AAC) that recorded some type of tracheotomy care for patient 3. Hence, her testimony lacks credibility in light of the overwhelming evidence AHCA provided.

38. Patient 6's HHC/POC for the certification period of October 14, 2010, to December 12, 2010, ordered skilled nursing care three to four times a week for nine weeks and also provided for specific disciplines and treatments to be performed. There was evidence that a skilled nurse provided one visit to patient 6

on October 15, 2010; yet, there was no evidence that a skilled nurse provided the minimum number of visits to patient 6 during the remainder of the nine-week certification period. It was noted that two skilled nursing visits were made during the week of November 14, 2010. However, the HHC/POC ordered a minimum of three, up to four skilled nursing visits to be made.

39. Patient 6's HHC/POC also ordered HHA services to be provided two to three times a week for nine weeks. The HHA was to assist patient 6 with ADLs. The HHA failed to provide patient 6 the minimum number of visits during weeks one, two, or three of the certification period.

40. Ms. Eubanks testified that Faith Home could not provide services to patient 6 after October 14, 2010, as patient 6 was admitted to a local hospital. Further, Ms. Eubanks testified that the HHA documentation "has to be incorrect," although she also testified that the Faith Home documents were "true. There has been an error."[8/] Ms. Eubanks's testimony is at odds with the credible evidence presented by AHCA.

41. Patient 14's HHC/POC dated January 20, 2011, ordered skilled nursing services to be provided one to two times a week for four weeks then every other week (EOW) for nine weeks. The HHC/POC also ordered that a HHA was to assist patient 14 with ADLs, a PT was to evaluate and treat patient 14, a speech therapist was to evaluate and treat patient 14, and an

occupational therapist was to evaluate and treat patient 14. On January 25, 2011, patient 14's medical doctor again ordered the physical therapy and directed the HHA to provide services three times a week for nine weeks.

42. The evidence regarding patient 14 documented two skilled nursing visits missed during the first two weeks of the certification period (January 16, 2011, to March 16, 2011), and there was no evidence of any HHA service visits for the first two weeks of patient 14's certification period. Additionally, patient 14 did not receive three physical therapy visits.

43. Ms. Eubanks testified that patient 14 was in an adult day care setting and that Faith Home missed no less than four skilled nursing visits. The "Missed Visit" reports (MVR) provided by Faith Home purport that patient 14 was in an adult day care setting; yet, that same MVR documentation fails to record that patient 14's physician was notified of the lack of services being provided. Further, the MVR dated (Wednesday) January 26, 2011, reflects that patient 14's daughter "made arrangements to have [patient 14] home next on Thursday by 3 p.m. Understands nurse do [sic] not go to day care." This MVP reflects that the date of the next Faith Home service visit will be February 4, 2011, a Friday, not a Thursday.

44. Also, within the material provided by Faith Home, there is a C/SR dated January 20, 2011. That C/SR records that

patient 14 is "requesting a hold on home health aide visit. Daughter will be able to provide service for the next few weeks." Yet, there is also a HHA note dated January 22 or 23, 2011,[9/] detailing HHA services provided to patient 14 on that date. The inconsistencies in Faith Home's documentation presented during the hearing are damaging to its credibility as a whole.

45. Patient 15's HHC/POC, dated December 15, 2010, ordered skilled nursing services to be provided two to three times a week for nine weeks. As part of the skilled nursing services, patient 15 was to have her vital signs assessed along with other specific assessments. The HHC/POC also contained an order to "Report any changes or concerns to [the] MD & supervisor ASAP."

46. The evidence presented regarding the skilled nursing visits for November 3 and 5, 2010, failed to reflect patient 15's neurological assessments or any observations by the nurse and also failed to provide the "nursing diagnosis/problem." Other portions to these specific records contain words or phrases to provide information, a number with a percentage sign, a zero (Ø), or simple checkmarks indicating a system was observed or treated. These written words or markings provide clarity to patient 15's completed assessments or status. Patient 15's skilled nursing records for December 29 and 31, 2010, and January 2, 12, and 14, 2011, failed to document one or more of the patient's systems: cardiovascular, genitourinary, neurological, or musculoskeletal.

47. Ms. Eubanks testified that certain portions of patient 15's skilled nursing notes were completed using a method called "charting by exception." According to this method, when the professional leaves an area of the chart blank, it indicates that nothing is wrong with the patient. A review of patient 15's skilled nursing notes simply does not support the use of this methodology. Specifically as an example, on the November 5, 2010, skilled nursing visit note, nothing is checked or notated in the neuro-sensory section; yet, at the "PAIN" section, there is a "Ø" marked through all five lines. If the "charting by exception" method was being used, this area should have been left blank as there was no pain. It is impossible to determine when charting by exception is in place when one area of a record has check marks or specific notations regarding an assessment or status and another section (or sections) is left blank even though the HHC/POC specifically ordered that assessment. There is no base line by which the next skilled nurse would know if there had been a change in patient 15's assessment or status such that her attending physician or the supervisor should be appropriately notified. Ms. Eubanks's testimony is not credible in light of the evidence presented by AHCA.

The June 2011 Follow up Survey

48. Both parties presented medical records for Patient 2J. Patient 2J's two HHC/POCs appear to be identical in scope; yet,

one was signed on April 25, 2011, while the other was signed on April 27, 2011. Within the HHC/POCs, the doctor ordered skilled nursing services to be provided once in the first week, then one to two times a week for eight weeks. As part of the skilled nursing services, patient 2J was to have her vital signs assessed and other specific assessments completed.

49. The HHC/POCs also ordered a PT to evaluate and treat patient 2J.

50. Ms. Eubanks testified that the PT evaluation was ordered on April 8, 2011, when it "came upon [sic] assessment." However, the HHC/POCs ordering the PT evaluation were not signed until April 25 or April 27, 2011. Patient 2J's actual physical therapy evaluation occurred on April 21, 2011, either four or six days before it was ordered. Faith Home either delayed 13 days in having the physical therapy evaluation completed, or Faith Home obtained a physical therapy evaluation prior to having a physician's order to provide the service. In either instance, Faith Home did not follow its own policies for providing services.

51. Although the PT created a care plan for patient 2J, there is no physician's order directing the physical therapy care plan be used. Further, the physical therapy services were actually performed by a physical therapist assistant (PTA) and provided to patient 2J during weeks four, five, six, and seven of

the certification period. An extra PTA visit was noted in week seven. Again, Faith Home provided services that were not in compliance with their own policies.

52. Patient 3J had an April 5, 2011, order for physical therapy to be provided three times a week for six weeks based on her gait instability, her osteoarthritis in her knees, and her degenerative spinal joint disease. There was no evidence of any physical therapy being provided to patient 3J during the applicable certification period.

53. Ms. Eubanks testified that patient 3J's actual care started in February 2011, despite the HHC/POC documentation that it started on March 24, 2011. Ms. Eubanks blamed a nursing supervisor for the wrong start date (March 24, 2011) and confirmed that the difference in start dates would make a difference in the dates of Faith Home services. Even if one were to accept the February 2011, order for physical therapy services, that order is incomplete because it fails to enumerate how many times a week and how many weeks the physical therapy services were needed. It is an incomplete order. Ms. Eubanks's testimony is not credible in light of the evidence presented by AHCA.

54. Patient 4J's HHC/POC contained a SOC date of April 8, 2011. Therein it ordered skilled nursing services to be provided two to three times a week for nine weeks. As part of the skilled nursing services, patient 4J was to have her vital signs assessed

along with other specific assessments. Additionally, the HHC/POC contained an order for a PT to evaluate and treat.

55. Ms. Miller was unable to locate any documentation of home health services provided to patient 4J after May 5, 2011 (four missed visits), and there was no evidence that any physical therapy services were provided to patient 4J.

56. Ms. Eubanks testified that patient 4J was in the hospital when Faith Home services were not provided to patient 4J. Although Ms. Eubanks relied on a discharge instruction sheet to make the claim, there is no date on the discharge instruction sheet, and no one testified as to the exact date that patient 4J was admitted to or discharged from the hospital. Ms. Eubanks's testimony is not credible as it relied on an undated discharge instruction sheet.

57. Further, although the physical therapy referral for patient 4J was faxed to the physical therapy agency, that agency never received the referral and never provided the service. Faith Home failed to have a system in place to ensure services ordered by the physician were obtained.

58. Ms. Okpaleke, as the owner of Faith Home, engaged an expert to help Faith Home "correct all the cites . . . and implement a plan of correction . . . to make sure that we were in compliance." Ms. Okpaleke terminated the expert's employment after the summer. Ms. Okpaleke then started monitoring Faith

Home's practices and ensured that Faith Home returned to compliance with AHCA's regulations.

59. Ms. Miller's salary at the time of the FH survey was $20.15. Ms. Miller expended approximately 30 hours in conducting the recertification survey of Faith Home. Based on her rate of pay, AHCA expended $1,370.20 for Ms. Miller's services.

60. Ms. Peabody's salary while employed by AHCA during the FH survey was $21.07 an hour. Ms. Peabody expended approximately 42 hours preparing for, conducting, and completing the FH survey. Based on her rate of pay, AHCA expended $1,048.23 for Ms. Peabody's services.

61. Mr. Bronson Sievers is the health facility evaluator supervisor for AHCA. His salary is $19.87 an hour. Mr. Sievers expended approximately ten hours reviewing the statement of deficiencies to determine if the appropriate citations had been used and the appropriate penalty assessed. Based on his rate of pay, AHCA expended $198.70 for Mr. Sieivers services.

62. Mr. Sievers responsibility included the supervision of several AHCA programs and included the home health agencies. Mr. Sievers determined that the repeated violation warranted a Class III violation, which resulted in a $1,000.00 fine because it may affect the clients' well-being and health.

63. Mr. Sievers provided AHCA's interpretation of the fine imposed when a home health agency demonstrates a pattern of

failing to provide the specified services to its clients or patients.

CONCLUSIONS OF LAW

64. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this proceeding. §§ 120.569 and 120.57(1), Fla. Stat. (2011).[10/]

65. In the instant case, AHCA has the burden of proving by clear and convincing evidence that Faith Home committed the violations as alleged, and, if there are violations, the appropriateness of any fine resulting from the alleged violations. Dep't of Banking & Fin., Div. of Securities & Investor Prot. v. Osborne, Stern & Co., 670 So. 2d 932 (Fla. 1996).

66. In Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983), the court held that:

> Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify 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.

67. Section 400.462, Florida Statutes, provides in pertinent part certain definitions as follows:

(12) "Home health agency" means an organization that provides home health services and staffing services.

* * *

(14) "Home health services" means health and medical services and medical supplies furnished by an organization to an individual in the individual's home or place of residence. The term includes organizations that provide one or more of the following:

(a) Nursing care.
(b) Physical, occupational, respiratory, or speech therapy.
(c) Home health aide services.
(d) Dietetics and nutrition practice and nutrition counseling.
(e) Medical supplies, restricted to drugs and biologicals prescribed by a physician.

(15) "Home health aide" means a person who is trained or qualified, as provided by rule, and who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation or exercises, or assists in administering medications as permitted in rule and for which the person has received training established by the agency under s. 400.497(1).

* * *

(22) "Organization" means a corporation, government or governmental subdivision or agency, partnership or association, or any other legal or commercial entity, any of which involve more than one health care professional discipline; a health care professional and a home health aide or certified nursing assistant; more than one home health aide; more than one certified nursing assistant; or a home health aide and a certified nursing assistant. The term does not include an entity that provides services

using only volunteers or only individuals related by blood or marriage to the patient or client.

(23) "Patient" means any person who receives home health services in his or her home or place of residence.

* * *

(25) "Physician" means a person licensed under chapter 458, chapter 459, chapter 460, or chapter 461.

* * *

(28) "Skilled care" means nursing services or therapeutic services required by law to be delivered by a health care professional who is licensed under part I of chapter 464; part I, part III, or part V of chapter 468; or chapter 486 and who is employed by or under contract with a licensed home health agency or is referred by a licensed nurse registry.

(29) "Staffing services" means services provided to a health care facility, school, or other business entity on a temporary or school-year basis pursuant to a written contract by licensed health care personnel and by certified nursing assistants and home health aides who are employed by, or work under the auspices of, a licensed home health agency or who are registered with a licensed nurse registry.

68. Section 400.464 provides in pertinent part:

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and entities licensed or registered by or applying for such licensure or registration from the Agency for Health Care Administration pursuant to this part. A license issued by the agency is required in

order to operate a home health agency in this state

69. Section 400.474 provides in pertinent part:

(1) The agency may deny, revoke, and suspend a license and impose an administrative fine in the manner provided in chapter 120.

(2) Any of the following actions by a home health agency or its employee is grounds for disciplinary action by the agency:

(a) Violation of this part, part II of chapter 408, or of applicable rules.

(b) An intentional, reckless, or negligent act that materially affects the health or safety of a patient.

* * *

(d) Preparing or maintaining fraudulent patient records, such as, but not limited to, charting ahead, recording vital signs or symptoms that were not personally obtained or observed by the home health agency's staff at the time indicated, borrowing patients or patient records from other home health agencies to pass a survey or inspection, or falsifying signatures.

* * *

(5) The agency shall impose a fine of $5,000 against a home health agency that demonstrates a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the patient's legal representative, or the plan of care for that patient, unless a reduction in service is mandated by Medicare, Medicaid, or a state program or as provided in s. 400.492(3). A pattern may be demonstrated by a showing of at least three incidences, regardless of the patient or service, where the home health agency did not

provide a service specified in a written agreement or plan of care during a 3-month period. The agency shall impose the fine for each occurrence. The agency may also impose additional administrative fines under s. 400.484 for the direct or indirect harm to a patient, or deny, revoke, or suspend the license of the home health agency for a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the plan of care for that patient. (emphasis added).

70. Section 400.484 provides:

(1) In addition to the requirements of s. 408.811, the agency may make such inspections and investigations as are necessary in order to determine the state of compliance with this part, part II of chapter 408, and applicable rules.

(2) The agency shall impose fines for various classes of deficiencies in accordance with the following schedule:

(a) A class I deficiency is any act, omission, or practice that results in a patient's death, disablement, or permanent injury, or places a patient at imminent risk of death, disablement, or permanent injury. Upon finding a class I deficiency, the agency shall impose an administrative fine in the amount of $15,000 for each occurrence and each day that the deficiency exists.

(b) A class II deficiency is any act, omission, or practice that has a direct adverse effect on the health, safety, or security of a patient. Upon finding a class II deficiency, the agency shall impose an administrative fine in the amount of $5,000 for each occurrence and each day that the deficiency exists.

(c) A class III deficiency is any act, omission, or practice that has an indirect,

adverse effect on the health, safety, or security of a patient. Upon finding an uncorrected or repeated class III deficiency, the agency shall impose an administrative fine not to exceed $1,000 for each occurrence and each day that the uncorrected or repeated deficiency exists.

(d) A class IV deficiency is any act, omission, or practice related to required reports, forms, or documents which does not have the potential of negatively affecting patients. These violations are of a type that the agency determines do not threaten the health, safety, or security of patients. Upon finding an uncorrected or repeated class IV deficiency, the agency shall impose an administrative fine not to exceed $500 for each occurrence and each day that the uncorrected or repeated deficiency exists.

(3) In addition to any other penalties imposed pursuant to this section or part, the agency may assess costs related to an investigation that results in a successful prosecution, excluding costs associated with an attorney's time.

71. Section 400.487 provides in pertinent part:

(2) When required by the provisions of chapter 464; part I, part III, or part V of chapter 468; or chapter 486, the attending physician, physician assistant, or advanced registered nurse practitioner, acting within his or her respective scope of practice, shall establish treatment orders for a patient who is to receive skilled care. The treatment orders must be signed by the physician, physician assistant, or advanced registered nurse practitioner before a claim for payment for the skilled services is submitted by the home health agency. If the claim is submitted to a managed care organization, the treatment orders must be signed within the time allowed under the provider agreement. The treatment orders

shall be reviewed, as frequently as the patient's illness requires, by the physician, physician assistant, or advanced registered nurse practitioner in consultation with the home health agency.

* * *

(4) Each patient has the right to be informed of and to participate in the planning of his or her care. Each patient must be provided, upon request, a copy of the plan of care established and maintained for that patient by the home health agency.

(5) When nursing services are ordered, the home health agency to which a patient has been admitted for care must provide the initial admission visit, all service evaluation visits, and the discharge visit by a direct employee. Services provided by others under contractual arrangements to a home health agency must be monitored and managed by the admitting home health agency. The admitting home health agency is fully responsible for ensuring that all care provided through its employees or contract staff is delivered in accordance with this part and applicable rules.

(6) The skilled care services provided by a home health agency, directly or under contract, must be supervised and coordinated in accordance with the plan of care.

72. Florida Administrative Code Rule 59A-8.0215 provides:

(1) A plan of care shall be established in consultation with the physician, physician assistant, or advanced registered nurse practitioner, pursuant to Section 400.487, F.S., and the home health agency staff who are involved in providing the care and services required to carry out the physician, physician assistant, or advanced registered nurse practitioner's treatment orders. The plan must be included in the clinical record

and available for review by all staff involved in providing care to the patient. The plan of care shall contain a list of individualized specific goals for each skilled discipline that provides patient care, with implementation plans addressing the level of staff who will provide care, the frequency of home visits to provide direct care and case management.

(2) Home health agency staff must follow the physician, physician assistant, or advanced registered nurse practitioner's treatment orders that are contained in the plan of care. If the orders cannot be followed and must be altered in some way, the patient's physician, physician assistant, or advanced registered nurse practitioner must be notified and must approve of the change. Any verbal changes are put in writing and signed and dated with the date of receipt by the nurse or therapist who talked with the physician, physician assistant, or advanced registered nurse practitioner's office.

(3) The patient, caregiver or guardian must be informed by the home health agency personnel that:

(a) He has the right to be informed of the plan of care;
(b) He has the right to participate in the development of the plan of care; and
(c) He may have a copy of the plan if requested.

73. Rule 59A-8.003 provides in pertinent part:

(5) In addition to any other penalties imposed pursuant to this rule, the agency may assess costs related to an investigation that results in a successful prosecution, pursuant to Section 400.484(3), F.S. The prosecution can be resolved by stipulation settlement or final hearing. The following costs may apply: travel costs related to the

> investigation; investigative time by AHCA's surveyor or surveyors including travel time; processing time by AHCA's professional staff and administrative support staff of Field Operations, and processing time for administrative support staff and professional staff of the AHCA Licensed Home Health Programs Unit in Tallahassee. The costs related to AHCA's professional staff and support staff will be determined according to the hourly rate of pay for those positions.

74. AHCA has established by clear and convincing evidence that Faith Home has failed to assure that the plan of care was followed for various patients in its care and/or that Faith Home has failed to implement the plan of care for various patients in its care.

75. The evidence was overwhelming that Faith Home failed to provide services to patients as enumerated above by: failing to provide skilled nursing visits as ordered; failing to provide home health aide services as ordered; failing to provide timely physical therapy evaluations and/or treatments as ordered; failing to notify physicians when treatment plans were altered or changed unilaterally; and/or failing to record specific assessments or observations as ordered for various patients.

76. AHCA has established, by clear and convincing evidence, that Faith Home has demonstrated patterns of failures to provide a service specified in the home health agency's written agreement with a patient or the patient's legal representative, or the plan of care for that patient, in that Faith Home failed to provide

home health services visits as ordered in various patient's plan of care. This pattern was first demonstrated during the February 2011 AHCA survey and was also found during the June 2011 AHCA survey re-visit. The fine specified in section 400.474(5) is appropriate.

77. Faith Home has committed a Class III violation.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner, Agency for Health Care Administration, enter a final order finding that Faith Home:

1. Violated section 400.484 by committing a Class III violation as identified during the February 2011 survey and found again during the June 2011 survey and imposing an $1,000.00 administrative fine;

2. Violated section 400.474(5) as found in no less than 107 instances when Faith Home failed to provide services ordered by an appropriate authority and imposing a $45,000.00 administrative fine; and

3. Pursuant to section 400.484(3), AHCA shall assess and receive $2,617.13 for the investigation costs associated with this case as evidenced by the time expended by the three agency witnesses.

DONE AND ENTERED this 19th day of April, 2012, in Tallahassee, Leon County, Florida.

LYNNE A. QUIMBY-PENNOCK
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 19th day of April, 2012.

ENDNOTES

[1/] AHCA objected to the last page of Faith Home's Exhibit 6, an undated, unsigned "Discharge Instructions" sheet for patient 14. Although admitted into evidence, this document is not probative.

[2/] Towards the end of 2010, Ms. Okpaleke had a family member who was hospitalized, and Ms. Okpaleke was not in the office on a daily basis, as she was attending to that circumstance.

[3/] In order to keep the June 2011 survey patients distinct from the February 2011 survey patients, there will be the letter "J" attached to each patient involved in the June 2011 survey.

[4/] Although a skilled nursing visit was ordered, that was not within the AAC and will not be discussed.

[5/] It is noted that patient 7 signed the December 29, 2010, PT evaluation and the four PT revisit notes. Documents completed by Faith Home employees reflect that the patient was "unable to see," "unable to sign" or "the patient is blind" in the signature lines relating to services.

[6/] Faith Home's own policy requires that a "Client must have a telephone or use of [a] phone in close distance for emergency situation."

[7/] A tracheotomy is a surgical incision into a patient's trachea (throat) to keep the airway open (sometimes a tube is inserted therein); it helps facilitate breathing.

[8/] Although not part of this AAC, a review of billing issues based on records in error may be appropriate.

[9/] The actual date is illegible; it is either January 22 or 23, 2011. Either January day would evidence services provided by a HHA. Such services were rendered during the period Faith Home claimed that the daughter would provide the services.

[10/] All future references to Florida Statutes will be to the 2011 version, unless otherwise indicated.

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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.