STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. SENIOR LIFESTYLES, L.L.C., d/b/a KIPLING MANOR RETIREMENT CENTER, Respondent.	)	Case No. 11-4643

RECOMMENDED ORDER

A hearing was held pursuant to notice on January 24 and 25, 2012, by Barbara J. Staros, assigned Administrative Law Judge of the Division of Administrative Hearings, in Pensacola, Florida.

APPEARANCES

For Petitioner: D. Carlton Enfinger, II, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

For Respondent: John E. Terrel, Esquire
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STATEMENT OF THE ISSUE

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

PRELIMINARY STATEMENT

In an Amended Administrative Complaint dated September 15, 2011, the Agency for Health Care Administration (AHCA) alleged five class II deficiencies, seeking the imposition of an administrative fine and survey fee for a total of $13,000, and the revocation of Respondent's license to operate an assisted living facility. Respondent, Senior Lifestyles, L.L.C., d/b/a Kipling Manor Retirement Center, (Kipling Manor) requested a formal administrative hearing to contest these allegations. AHCA forwarded the case to the Division of Administrative Hearings on or about September 15, 2011. A hearing was scheduled for November 15 through 17, 2011, in Pensacola, Florida.

On November 4, 2011, the parties filed a Joint Motion to Continue. The motion was granted. The hearing was rescheduled for January 24 and 25, 2012, and proceeded as scheduled.

Count I of the Amended Administrative Complaint alleges that Kipling Manor failed to provide incontinent care for 1 out of 9 sampled residents and failed to provide nail and facial care for 1 out of 9 sampled residents in violation of Florida Administrative Code Rule 59A-5.0182(1). Count II alleges that Kipling Manor failed to honor the rights of residents by not providing a safe and decent living environment to prevent the spread of disease for all residents, in violation of section

429.28, Florida Statutes. Counts III and IV allege that Kipling Manor failed to administer medications according to the medication observation record for 1 out of 9 sampled residents and failed to ensure that prescribed medications were available in violation of Florida Administrative Code Rule 58A-5.0185. Count V alleges that Kipling Manor failed to complete a criminal background check as required by law; Count VI seeks to impose a survey fee totaling of $500 pursuant to section 429.19(7); Count VI seeks revocation of the facility's license to operate. Counts I through IV categorize the violations as class II and seek to impose fines totaling $12,500, in addition to the revocation.

At hearing, Petitioner presented the testimony of Norma Endress and Patricia McIntire. Petitioner's Exhibits numbered 1 and 2 were admitted into evidence. Respondent presented the testimony of five witnesses. Respondent’s Exhibits 1 through 11, 15 and 23 were admitted into evidence.

A Transcript, consisting of three volumes, was filed on February 21, 2012. Petitioner filed a Motion for Extension of Time in which to file its proposed recommended order. The motion was granted. The parties timely filed Proposed Recommended Orders, which have been duly considered. All references to Florida Statutes are to the 2011 version, unless otherwise indicated.

FINDINGS OF FACT

1. AHCA is the agency responsible for the licensing and regulation of assisted living facilities in Florida pursuant to chapters 429 and 408, Part II, Florida Statutes.

2. At all times material hereto, Kipling Manor was licensed by AHCA as an assisted living facility. Kipling Manor is located in Pensacola, Florida, and operates a 65-bed facility, license number 7285, and holds a specialty limited health license.

3. Norma Endress is a registered nurse employed by AHCA. She conducts surveys of nursing homes and assisted living facilities for compliance.

4. Ms. Endress is supervised by Patricia McIntire, a nurse consultant supervisor for AHCA. Ms. McIntyre has been with AHCA for 13 years.

5. Belie Williams is the administrator of Kipling Manor. He has been involved with health care services for approximately 35 years, and has been an administrator of ALFs for approximately 15 years. He has been involved with the Florida Assisted Living Association (FALA) and served on its board. Mr. Williams helped implement training sessions for ALFs in conjunction with FALA for the past eight years.

6. Kipling Manor has two nurses who visit the facility to provide care to the residents. Elizabeth McCormick is an advanced nurse practitioner (ARNP) in family, psychiatric and mental health. She has been a nurse since 1983 and has extensive experience dealing with inpatient and outpatient psychiatric residents in long-term facilities. Nurse McCormick works with a VA facility providing inpatient and outpatient care on a high intensity psychiatric unit. She was also an assistant professor at the University of West Florida in the Mental Health Nursing Program.

7. Nurse McCormick provides medical and mental healthcare for residents at several ALFs in Pensacola, including Kipling Manor. She sees patients at Kipling Manor several times a month. She manages the healthcare of residents, diagnoses illnesses, and writes prescriptions as needed. She describes Kipling Manor as not being a typical setting because her patients there are seriously mentally ill, which presents huge challenges.

8. Angela Lavigne is a registered nurse certified by Medicare to provide psychiatric care to patients. She is employed by a company called Senior Care. Among other things, she works with assisted living facilities providing therapeutic counseling, assisting doctors with adjusting medication, and

providing in-service training to staff of these facilities in regard to psychiatric care.

9. Nurse Lavigne has been seeing patients at Kipling Manor for almost three years. She visits Kipling Manor approximately four times a week. At the time of the survey, she visited the facility once or twice a week. She provides patient care as well as in-service training to the staff regarding psychiatric issues. She also runs group sessions with the residents to make them feel more independent and feel more like they are in their homes.

10. On July 12 through 14, 2011, Nurse Endress conducted an unannounced complaint survey of Kipling Manor that gave rise to the Amended Administrative Complaint and to this proceeding.

Count I--Resident 8

11. Count I alleges that Kipling Manor failed to provide incontinent care for Resident 8 and failed to provide nail and facial care for Resident 6. Ms. Endress observed Resident 8 walking with a "med tech" to the "med room" to receive her medications. Ms. Endress observed wetness on Resident 8's clothes, and noticed the smell of urine. The med tech gave Resident 8 her medications, then assisted her to an open area where Resident 8 sat down. Ms. Endress observed Resident 8 for about two hours. Ms. Endress approached a personal care assistant (PCA), who was a new employee, and inquired of the PCA

as to whether the resident was incontinent. As a result of this inquiry, Ms. Endress believed that this resident was incontinent. After approximately two hours had passed, Ms. Endress called this to the attention of the PCA, who then changed Resident 8 immediately.

12. Ms. Endress determined that Respondent was "not providing care for this lady, incontinent care. They were not monitoring her." This determination was based in large part on her belief that Resident 8 was incontinent. However, Resident 8's health assessment indicates that Resident 8 needed supervision while toileting, but did not carry a diagnosis of incontinence. Ms. Endress acknowledged at hearing that supervision with toileting is not the same thing as being diagnosed with incontinence. Resident 8's health assessment also reflects diagnoses of personality disorder, dementia, and Alzheimer's among other conditions.

13. Ms. McCormick provided health care services to Resident 8. She quite frequently is involved with residents who have toileting issues. Had Resident 8 developed skin problems because of toileting issues, she would have been aware of it. Ms. McCormick noted that the records indicated that Resident 8 received a skin cream three times a day to prevent such skin problems.

14. Both Ms. Endress and Ms. McCormick are of the opinion that, while it is better to change a resident as soon as possible, a two-hour check is appropriate for someone with toileting issues.

15. According to Ms. McCormick, if she were looking to determine whether there existed a direct physical threat to Resident 8, there would be monitoring for skin breakdown, redness or irritation, or a possible urinary tract infection (UTI). Neither Ms. McCormick nor Ms. Lavigne were notified or saw any signs of a skin infection, other skin problems, or a UTI regarding Resident 8. There was no evidence presented that Resident had any skin problems or UTI as a result of this incident or her toileting issues.

16. Erica Crenshaw is a "med tech" and a supervisor employed by Kipling Manor. She provided care for Resident 8 and was on duty the days of the survey in question. Ms. Crenshaw verified that Resident 8 was on a two-hour check at the time of the survey. This involved checking to see if Resident 8 was wet or dry. If she were found to be wet, staff would take off the resident's brief, change and wipe the resident, put on a new brief noting the date and time, as well as recording the staff person's initials. When changing Resident 8, staff would apply a barrier cream, and check to see if any bed sores developed.

17. Ms. Endress determined that this was a Class II violation because of the potential for skin breakdown and infection as well as potential for emotional harm, in that she perceived this as a dignity issue for Resident 8. Ms. Endress based this opinion in large part on her mistaken belief that Resident 8 was incontinent.

18. Her supervisor, Ms. McIntyre, reviewed the classification recommended by Ms. Endress and concurred that Class II was appropriate because "[r]esidents, in particular elderly residents, left sitting in urine, there is a great potential for them to experience skin breakdowns, which would certainly have a severe negative impact on their physical health."

19. Mr. Williams saw Resident 8 while Ms. Endress was conducting her inspection. He saw that she was wet from urine on the back of her clothes. He did not detect any strong odor of urine although he was close to her.

Count I--Resident 6

20. Count I also includes allegations regarding Resident 6. Ms. Endress observed Resident 6 with long facial hair (Resident 6 is female) and long, dirty fingernails. Ms. Endress interviewed Resident 6 regarding these observations. Based upon this interview, Ms. Endress believed that staff did not cut her facial hair or trim her nails, despite Resident 6 wanting them

to do so. Ms. Endress estimated Resident 6's nails to be approximately one-quarter inch long but could not recall the length of her facial hair. Resident 6's health assessment reflects a diagnosis of dementia with poor short term memory, and that she needs assistance bathing, dressing, and grooming.

21. Erica Crenshaw described Resident 6 as "a little difficult to work with." Staff works on nails, hands and feet, two days a week. If at first Resident 6 was resistant to having her nails trimmed, they would "give her space" then approach her again later. She described Resident 6's nails as "pretty decent."

22. Resident 6 received health care from both Ms. Lavigne and Ms. McCormick. Both nurses are of the opinion that staff worked with Resident 6 to keep her nails in good shape. As a resident of an ALF, Ms. McCormick noted that Resident 6 had the right to refuse nail care and decide whether her nails needed to be trimmed.

23. Ms. Lavigne informed staff that they needed to work with Resident 6 at her own pace, and to be careful not to make her combative. Ms. Lavigne treated Resident 6 for a wrist problem in mid-summer of 2011, when Resident 6 was in a splint for approximately six weeks, and received physical therapy. She described Resident 6's nails as "nice, round, nothing broken, nothing chipped. Every once in a while she's actually let staff

put nail polish on them but as far as cutting them down, it's like an act of Congress to get her to sit down enough to trim them." There is no evidence as to what could have been under Resident 6's nails when Ms. Endress saw her. However, the evidence establishes that Resident 6's nails were tended to by staff on a regular basis, and that her treating nurse was not aware of any problem with them.

24. Regarding facial hair, Ms. Lavigne never noticed any facial hair on Resident 6 other than having "a couple little whiskers here and there." Ms. Lavigne was Resident 6's treating nurse in the general time-period around the survey in question, and was never informed about any problems with Resident 6 regarding nails or facial hair, nor noticed any.

25. Ms. Endress classified the findings she made regarding Resident 6's nails and hair as a Class II violation because she perceived it as a "dignity issue because women do not like facial hair on them." Ms. McIntyre confirmed the class determined by Ms. Endress, although the record is not clear why.

Count II--cleanliness and maintenance

26. Count II of the Amended Administrative Complaint alleges that Kipling Manor failed to honor the rights of residents by not providing a safe and decent living environment to prevent the spread of disease for all residents. The Amended Administrative Complaint alleges in pertinent part as follows:

30. In an interview resident #3 on 7/12/11 at 9:00 am stated this place was not clean. He stated the cook will have gloves on his hands when he leaves the kitchen. The cook continues rolling the food down the hallway to the dining room while simultaneously rolling the open garbage container which is soiled. Without changing his gloves he will serve the food to the residents.[1/]

31. An observation of lunch on 7/12/11 at 12:00 pm revealed the cook serving turkey with gloved hands not using a utensil. Without changing his gloves he handled silver ware, moved a gallon of milk and was touching the dining room table. He was using the same gloved hand to serve corn bread.

32. While serving food he never changed his gloves between clean and dirty.

33. Other staff wearing gloves were serving lunch to residents and cleaning tables and pouring beverages without changing gloves. They were serving beverages touching the rims of glasses without changing clothes [sic].

34. During the survey, the following was seen:

a) Bathroom floor for room 9 on wing 1 was dirty with build-up of dirt in the corners.

b) Lounge area at the end of wing 1 had a broken recliner that was being used by a resident. The floor and furniture were soiled.

c) Room and bathroom #3 on wing 1 had dirty floors with build-up of dirt along baseboards and the toilet lid was too small for the tank. Vents were clogged with dust. The door was too short for the opening; wood was missing on door frame and the threshold had broken tile.

d) Dining room bathroom at the end of wing 2 had dirty floors with build-up of dirt along baseboards; around bottom of the toilet was black and the seal was cracked.

e) Dining room floors were dirty and walls had dried food on them.

f) Room 27 had filthy floors with build up along baseboards; dried spills were noted and the drywall had a hole in it.

g) Wing 2 had drywall that was pulling away from ceiling and the ceiling had brown water spots: soiled dirty walls; dirty baseboards with build up of dust; spills on walls and vents dusty.

h) Wing 2 had no baseboard near the shower; the cabinet had mildew on the outside surface; the wood was warped and peeling. The sink was soiled with dried brown substance. The door to the cabinet would not close. The baseboard wood near sink was split and the drywall had an indentation of the door knob.

i) Room 21 floors were filthy and smelled of urine. Soiled clothes laid on the floor with soiled underwear which were observed while medication technician was assisting resident. No action was taken by the medication technician.

j) Laundry room floors were filthy. There was no division between clean clothes and dirty clothes. Clothes were lying on the floor.[2/]

27. Based upon this complaint, Ms. Endress observed the dining room during a meal and toured the building. At hearing, Ms. Endress acknowledged that she did not see the cook touch the garbage pail or garbage and then touch food. She maintained,

however, that she observed the cook while wearing gloves, touch food then touch "dirty surfaces," then go back and touch food on plates and touch the rims on glasses. Ms. Endress did not specify at hearing what she meant by "dirty surfaces," but in her report which was the basis for the Amended Administrative Complaint, she noted that the cook would touch food and then touch surfaces such as moving a gallon of milk, touching the dining room table, and handling silver ware. She also testified that she saw other staff wearing gloves who were serving residents, cleaning tables, and serving beverages without changing their gloves.

28. Deborah Jackson is a personal care assistant (PCA), food server, and laundry worker at Kipling Manor. Ms. Jackson and one other PCA serve meals for about 60 residents. She received training in food service. She was working at Kipling Manor the days Ms. Endress was there for the survey.

29. Ms. Jackson always wears gloves when serving the residents. If she touches anything besides food she changes gloves. For example, if she moves chairs, she changes gloves before resuming food service. She has never seen the other PCA touch other items then serve food. She was trained never to touch the rims of the glasses but to pick up glasses and cups from the side. She goes through "probably a whole box" of gloves in a day.

30. According to Ms. Jackson, the cook stands behind the area and puts the food on the plates, preparing two plates at a time. She watches him prepare the plates of food. She and the other PCA then serve the food to the residents. The garbage can is kept in the back, not where food is being served. She has never seen the cook touch the garbage can then prepare plates of food. When he has finished, he takes all "his stuff" out on a cart, while the PCAs clean up. If a resident spilled food, the PCAs, not the cook, would clean it up.

31. L.N. was the cook at the time of the survey inspection. L.N. was hired in April 2011 and received training in infectious control and food service sanitation. L.N. no longer works for Kipling Manor.[3/]

32. Billie Williams, as administrator of Kipling Manor, confirmed Ms. Jackson's description of the cook's role in serving dinner. That is, that the cook prepared plates of food and the PCAs then served the residents.

33. At hearing, Ms. Endress essentially reiterated her findings regarding the other allegations in count II dealing with the cleanliness and condition of the facility. No further proof was offered regarding these or any other allegations in the Amended Administrative Complaint.

34. Mr. Williams' testimony contradicted much of what Ms. Endress described regarding the cleanliness and condition of the facility. Specifically, Mr. Williams noted that on the day of the survey inspection, maintenance men were repairing a ceiling leak. The ceiling leak was the cause of the "drywall pulling away from the ceiling" and the "brown water spots" on the ceiling cited in the Amended Administrative Complaint. These conditions were the result of the water leak and were in the process of being repaired at the time of the survey. The workers arrived early in the morning and cut drywall from the ceiling where the water dripped down on it. They necessarily used a ladder to do the ceiling repair work. A maintenance man stood at the bottom of the ladder and, if a resident approached, would escort the resident around the ladder.

35. Regarding the issues of cleanliness, Mr. Williams has two housekeepers, a person who does the laundry, and two maintenance men. Mr. Williams acknowledged that there may be a small wax buildup along baseboards or on the inside corner of a door. However, the two maintenance men wax, strip, and buff the floors throughout the building. The floors are swept and buffed every day. The baseboards (wall to floor) are dust mopped twice a day.

36. Regarding the allegation that there was black around the bottom of the toilet and the seal was cracked in the bathroom off the dining room area, Mr. Williams went to that room with the maintenance men to personally inspect it. He observed some discoloration on the floor where the toilet may have overflowed at some time and got underneath the tile. The maintenance men cleaned this immediately and replaced the tile.

37. Regarding the allegation that there was mildew on a bathroom cabinet, Mr. Williams inspected the black mark and found it to be a tire mark from a wheelchair. He found no mold or mildew. The black mark was removed.

38. There is a separate laundry room where washers and dryers are located. Any clothes on the floor are for sorting or separating by color or other reason prior to washing. Once clothes are washed, they are taken back to the residents' rooms immediately. Clean sheets, towels, and wash cloths are placed on wooden shelves that were built for that purpose. There is no evidence that establishes that clean and dirty clothes were mixed on the floor.

39. Mr. Williams also inspected the recliner. The recliner has snap-on armrests and one had been snapped off. The maintenance men snapped the armrest back on the chair, and it was easily repaired.

40. Regarding the allegation that the drywall in a bathroom had an indentation of the door knob, Mr. Williams inspected that and found that the doorstop on the bottom had broken off. There was an indentation in the wall the size of a doorknob where the door had been opened hard. This was repaired by the maintenance men.

41. Regarding the allegation of vents being clogged with dust in a room and bathroom, Mr. Williams found "a little" dust on a vent which was cleaned immediately by staff. He then instructed staff to check the vents daily for dust build-up.

42. Mr. Williams could not find a door that was too short for the opening, and noted that this would be a fire code violation. Kipling Manor is current on fire and health safety inspections.

43. In general response to the allegations regarding cleanliness and maintenance and to a question asking whether he keeps a well-maintained building, Mr. Williams stated:

> We try our best. I mean, I have--you know, when you have incontinent residents who are demented, who are bipolar or suffering from depression, they will do things. And, yes, they do. And like, I think in one of the reports she wrote up, there was wet clothes on the floor. Well, if a resident, some of them are semi-independent, too. I mean, they take care of their own needs. If they had an incontinent issue that morning, and they took their clothes off and left it there on the floor, you know, they expect the staff to pick it up and take it to a

> laundry room when they come through. You know, we do, I think, we do a darn good job given the -- a lot of my residents have been homeless, have never had any structured living. Nobody else in town takes them, but I have.

44. Ms. Endress classified the alleged violations in Count II as Class II "because of the potential for harm to residents which could occur from an unsafe environment and potential spread of infection." Ms. McIntyre agreed with Ms. Endress that "the totality of all the findings are what drove the deficiency to be considered a Class II."

Count III--Resident 4 medications

45. Count III alleges that Kipling Manor failed to administer medications according to the medication observation record (MOR) for 1 out of 9 sampled residents (Resident 4).

46. During lunch, Ms. Endress observed Resident 4 become agitated, rub his face, and complain loudly in the dining room. Following an observation of this resident and a conversation with him, Ms. Endress reviewed Resident 4's medication observation record (MOR) and health assessment.

47. Ms. Endress determined that Resident 4 had not been given one of his medications, Interferon, when scheduled. The MOR shows a time for administration as 8 a.m. According to Ms. Endress, on the date this took place, July 12, 2011, the MOR was blank in the box that should be initialed when the

medication was administered. The MOR in evidence, however, reflects initials in that box (i.e., it is not blank). When a drug is self-administered, the staff member initials the box for that day. Erica Crenshaw recognized and identified the initials in the box for that day as those of former unit manager Tekara Levine, who trained Ms. Crenshaw. According to Mr. Williams, Ms. Levine, was certified in the self-administration of medications and was a trustworthy employee.

48. Ms. Endress observed Resident 4 wheel himself from the dining room to the medication room and self-administer his medication. This occurred around noon that day.

49. Ms. Endress determined this to be a Class II violation as she believed it directly threatened the resident emotionally. She based this in part on the resident's demeanor before the medication and afterwards, and the comments the resident made to her.

50. Resident 4 is one of Nurse Lavigne's patients. Resident 4 has a diagnosis of MS, major depression, post traumatic stress disorder, a paranoid psychosis, and anxiety and affective disorder. He receives Interferon for his MS. It is injectable and he self-administers it every other day.

51. According to Nurse Lavigne, there is no doctor's order stating that the Interferon must be given at 8 a.m. or any other particular time. The injection can be administered at any time

during the day. Resident 4 sometimes gets confused about his medications. He gets extremely upset if he thinks he has not gotten his medications. He will sometimes tell her (Nurse Lavigne) that he did not receive a particular medication when he, in fact, did receive it. Once he is shown the MOR indicating that he has received his medication, he visibly calms down. He does not like to leave his room because he thinks somebody is changing stations on his TV. Regarding his once-a-day medications, staff will wait until he is ready to come out of his room because he can get agitated. He sometimes gets upset if there are a lot of people around him, such as in the dining room.

52. Nurse Lavigne does a full assessment when she sees Resident 4. She was not aware of any problems with Resident 4 during that time period regarding his medications.

53. While the record is unclear as to why Resident 4's MOR shows an administration time of 8 a.m., the evidence established, through Nurse Levine, his treating nurse, that there is no doctor's order requiring that the drug be administered at that particular time. The evidence also established that Resident 4 self-administered his medication at noon on July 14, and that this was initialed by a staff member on his MOR.

Count IV--Resident 1 medications

54. As a result of a complaint received, Ms. Endress interviewed residents about their medications and spoke to a new staff member. Based upon these interviews, Ms. Endress determined that one of Resident 1's medications (Flexeril) had not been available for one dose on July 13, 2011, and another of this resident's medications (Visteril) had not been available from June 23 until July 12, 2011). Ms. Endress classified this alleged violation as a Class II because she determined that that it directly affected the resident psychologically and physically.

55. Resident 1 had a diagnosis of COPD and has an anxiety disorder. She is alert and oriented. Resident 1 was prescribed Flexeril to be administered every evening, and Vistaril and Ativan for anxiety. She is to receive Ativan twice a day and PRN (as needed) and Visteril before bed and PRN.

56. Each day a medication is administered, the residents' MORs are initialed by staff in a box indicating each day of the month. However, if the resident runs out of a drug, the staff member will put a circle in the box representing that day and makes a note on the back of the MOR. No circles or notes appear on Resident 1's MOR indicating that either drug was not available.

57. Resident 1 is a patient of Nurse McCormick. Resident 1 becomes anxious or agitated if she does not receive her medication for her anxiety disorder. Nurse McCormick considered Resident 1's anxiety disorder well controlled by the medications.

58. Resident 1's MOR reflects that she received Visteral from June 1 through 30 at night as ordered and received it PRN several times prior to June 23, 2011, but did not receive it PRN the rest of the month of June or July 1 through 14. She also received Ativan twice a day routinely in June and July and five times PRN during the period June 23 through 30, 2011, and four times during the period July 1 through 14. According to Nurse McCormick, either medication was appropriate for controlling Resident 1's anxiety disorder.

59. Resident 1's MOR reflects that she received Flexeril on June 30, 2011.

60. Nurse McCormick was not made aware at any time that Resident 1 was not receiving any of her medications. As the treating and prescribing nurse, missed or unavailable medications would have come to Nurse McCormick's attention. Resident 1 was not anxious, nervous or agitated when interviewed by Ms. Endress on July 12, 2011.

61. There is no competent evidence that Resident 1 displayed any signs of anxiety, nervousness or agitation during the survey or during the times that the Amended Administrative Complaint alleges that she did not receive her medication.

62. Nurse McCormick found the staff of Kipling Manor to be careful with all residents. She has been to the facility at various times of the day from early in the morning to late into the evening. Nurse McCormick is of the opinion that the staff takes care of all its residents and provides them with dignity. Despite Kipling Manor's resident population of seriously mentally ill residents, Nurse McCormick is of the opinion that the facility manages its residents with dignity and care.

Count V--Background Check

63. The Amended Administrative Complaint alleges that one staff member of Kipling Manor, the cook, had not been background screened.

64. Based upon record review and staff interview, Ms. Endress determined that the facility did not complete a level 2 background check for 1 out of 8 sampled staff members. A record review revealed that this employee had been hired in April 2011.

65. On April 26, 2011, the employee in question signed an Affidavit of Compliance with Background Screening Requirements, using AHCA form #3100-0008. By signing this form, the employee

attested to never having been arrested for, pled nolo contendere to, or convicted of certain disqualifying offenses.

66. Mr. Williams did not complete a background check on the cook because he did not think the cook was covered under the law. That is, he did not think the law applied to the cook because of the lack of personal contact with the residents.

67. The cook is present during meal times serving plates of food to the dining workers who then directly serve the residents. The living areas are accessible to the cook.

68. This employee no longer works at Kipling Manor. The record is not clear as to when he stopped working there.

69. Ms. Endress determined that this constituted a Class II deficiency as she believed that it could potentially lead to harm to residents of the facility. According to Ms. McIntyre, AHCA always imposes a Level II deficiency for failure to have a level 2 background screening for employees.

70. Both Ms. Endress and Ms. McIntyre testified at hearing regarding what constitutes Class II and Class III deficiencies. In several instances, Ms. Endress classified a violation or deficiency that could potentially result in harm to a resident as a Class II. Ms. McIntyre testified that "a potential harm to a resident could be a class II deficiency." She described a Class III as one that "indirectly threatens the physical,

emotional health or safety of a resident. . . . indirectly or potentially."

71. The Agency provided a mandatory correction date of August 1, 2011, for all five counts in the Administrative Complaint.

CONCLUSIONS OF LAW

72. The Division of Administrative Hearings has jurisdiction over the parties and subject matter in this case. §§ 120.569 and 120.57, Fla. Stat. (2011). This proceeding is de novo. § 120.57(1)(k), Fla. Stat.

73. The burden of proof in this proceeding is on the agency. Because of the proposed penalties in the Amended Administrative Complaint, the agency is required to prove the allegations against Respondent by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996).

73. The clear and convincing standard of proof has been described by the Florida Supreme Court:

> Clear 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.

In re Davey, 645 So. 2d 398, 404 (Fla. 1994) (quoting Slomowitz v. Walker, 429 So. 2d 797,800 (Fla. 4th DCA 1983)).

74. "[W]here a statute provides for revocation of a license the grounds must be strictly construed because the statute is penal in nature. No conduct is to be regarded as included within a penal statute that is not reasonably proscribed by it; if there are any ambiguities included, they must be construed in favor of the licensee." McClung v. Crim. Just. Stds. & Training Comm'n, 458 So. 2d 887, 888 (Fla. 5th DCA 1984).

75. Count I of the Amended Administrative Complaint alleges a violation of Florida Administrative Code Rule 58A-5.0182, which reads in pertinent part as follows:

> 58A-5.0182 Resident Care Standards
>
> An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.
>
> (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following:
>
> * * *
>
> (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual.

76. Count II of the Amended Administrative Complaint alleges a violation of section 429.28(1) (a) and (b), Florida Statutes, which reads as follows:

> 429.28 Resident bill of rights.-
> (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
> (a) Live in a safe and decent living environment, free from abuse and neglect.
>
> (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

77. Counts III and IV of the Amended Administrative Complaint allege violations of Florida Administrative Code Rule 58A-5.0185, which reads in pertinent part as follows:

> 58A-5.0185 Medication Practices.
>
> Pursuant to Sections 429.255 and 429.256, F.S., and this rule, licensed facilities may assist with the self-administration or administration of medications to residents in a facility. A resident may not be compelled to take medications but may be counseled in accordance with this rule.
>
> (1) SELF ADMINISTERED MEDICATIONS
> (a) Residents who are capable of self-administering their medications without assistance shall be encouraged and allowed to do so.
>
> * * *

(5) MEDICATION RECORDS.

* * *

(b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known allergies the resident may have; the name of the resident's health care provider, the health care provider's telephone number; the name, strength and directions for each use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered.

* * *

(7) MEDICATION LABELING AND ORDERS

* * *

(f) The facility shall make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.

78. Count V alleges a violation of the background screening statutes. Section 429.174, Florida Statutes, requires level 2 background screening for personnel as required in section 408.809(1)(e) and pursuant to chapter 435. Section 408.809(1)(e) requires level 2 background screening to the following employees:

> (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; . . .

79. Section 435.04(1)(a), Florida Statutes, requires all employees required by law to be screened pursuant to this section must undergo security background checks as a condition of employment. The mandatory background screening prior to employment became effective on August 1, 2010, the effective date of significant amendments to the background screening statutes pursuant to chapter 2010-114, Laws of Florida.

80. AHCA has alleged that the violations more fully described above all fall under the classification of "Class II." "The entire statutory scheme is based on a classification of deficiencies, with the deficiencies being classified according to the level of harm that might or did result from the deficiency. . . . Accordingly, the Agency has the burden to prove harm or the potential for harm upon a resident in order to substantiate its classification of any deficiency." Beverly Healthcare of Kissimmee v. Ag. For Health Care Admin., 870 So. 2d 208, 212 (Fla. 5th DCA 2004).

81. Section 408.813(2), Florida Statutes, sets forth the four classifications of deficiencies in pertinent part as follows:

> (2) Violations of this part, authorizing statutes, or applicable rules shall be classified according to the nature of the violation and the gravity of its probable effect on clients. . . .
>
> (b) Class "II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. The agency shall impose an administrative fine as provided by law for a cited class II violation. A fine shall be levied notwithstanding the correction of the violation.
>
> (c) Class "III" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than class I or class II violations. The agency shall impose an administrative fine as provided in this section for a cited class III violation. A citation for a class III violation must specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, a fine may not be imposed.
> (emphasis added)

82. The Amended Administrative Complaint seeks to impose fines in the total amount of $12,500. Part I of chapter 429, Florida Statutes, is entitled The Assisted Living Facilities Act. Section 429.19 imposes fines for violations according to its classification and reads in pertinent part as follows:

> (2) Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents. The agency shall indicate the classification on the written notice of the violation as follows:
>
> (b) Class "II" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class II violation in an amount of $1,000 and not exceeding $5,000 for each violation.
>
> (c) Class "III" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class III violation in an amount not less than $500 and not exceeding $1,000 for each violation;

83. Count I of the Amended Administrative Complaint alleged that the facility failed to provide incontinent care for 1 of 9 sampled residents (Resident 8) which resulted in harm. Count I also contains allegations regarding Resident 6 having long facial hair and long, dirty fingernails. AHCA failed to prove the allegations in Count I. The evidence established that Resident 8 did not have a diagnosis of incontinence, but was on a 2-hour toileting schedule.

84. The evidence further established that her treating nurses were not aware of any skin breakdown or infection. While certainly sitting in urine for that period of time is not desirable, at most it constitutes a potential for harm. Resident 8 was checked for toileting every two hours, approximately the amount of time the resident was observed by

the surveyor. As for Resident 6's facial hair and fingernails, both of her treating nurses were of the opinion that staff worked with Resident 6 to keep her nails in good shape, and that it was like "an act of Congress" to get Resident 6 to sit down and allow someone to trim her nails. Regarding the chin hair, Ms. Lavigne, did not observe anything extreme. There is no evidence that Resident 6's nails or chin hair resulted in harm to Resident 6. The record is silent as to what could have been under Resident 6's nails when Ms. Endress saw her. Significantly, neither Ms. Lavigne nor Ms. McIntyre, who provided health care to each of these residents, did not see any evidence of harm. The evidence does not support a violation of rule 58A-5.0182, as the Respondent did "offer personal supervision as appropriate" including "daily observation" and awareness of "the general health, safety, and physical and emotional well-being of the individual."

85. Count II of the Amended Administrative Complaint charges Respondent with a violation of section 429.28, in that Respondent failed to honor the rights of its residents by not providing a safe and decent living environment to prevent the spread of disease for all residents. Count II alleges, among other things, that the cook wears gloves on his hands when he leaves the kitchen; that he then rolls the food cart down the hallway to the dining room, while simultaneously rolling the

open garbage container which is soiled, without changing gloves. The evidence simply does not support this allegation.

86. Count II contains other allegations concerning gloves and food service. While Ms. Endress' testimony regarding her dining room observations is accepted as credible, so is the testimony of Ms. Jackson who established that staff members are trained to change gloves when doing anything besides touching food; that she was trained never to touch the rims of glasses; that if a resident spills food, the PCAs clean it up, not the cook. Moreover, the cook observed by Ms. Endress no longer works there.

87. Count II also alleged many items concerning lack of cleanliness and maintenance. In many instances as more fully detailed in the Findings of Fact, the matters were minor maintenance matters which were either in the process of being repaired at the time of the inspection (i.e., the ceiling leak) or immediately repaired (i.e., the recliner arm and tile around the toilet stained from a water leak.)

88. Applying the language in section 408.813(2), and considering the "nature of the violation and the gravity of its probable effect on clients," it is determined that any violation cited in Count II was minor and isolated in nature, and only indirectly or potentially threatened the health of the

residents. Therefore, it is concluded that this deficiency is in the nature of a Class III.

89. Count III alleges a violation of rule 58A-5.0185(5), alleging that Respondent failed to administer medications according to Resident 4's MOR. The evidence established that while the MOR stated "8 a.m." as the time of administration, Ms. Lavigne, his treating nurse, explained that there is no doctor's order that Resident 4 must be given at 8 a.m. or at any other specific time of day. The medicine can be administered at any time of day. Resident 4 can receive the medication in question anytime of the day, every other day. Further, the evidence established that this Resident often complained of not receiving his medication, when he, indeed, had. Accordingly, it is determined that there is no violation of rule 58A-5.0185(5) as alleged in Count III.

90. Count IV alleges that Respondent failed to have medication available for administration for Resident 1 in violation of rule 58A-0185(7). AHCA did not prove this alleged violation. The Resident's MOR reflects that she did indeed receive Flexeril on June 30 as ordered, and received Vistaril every night as ordered for anxiety (as well as Ativan for the same condition.) Resident 1's treating and prescribing nurse considered Resident 1's condition well controlled and observed no indications of anxiety during the days in question. The

lack of documentation of PRN administration of Visteril, which she received every day as ordered, does not clearly and convincingly establish that the drug was unavailable. While Ms. Endress relied on representations made by a new staff member and the resident, the evidence does not support these allegations.

91. Count V of the Amended Administrative Complaint alleges that Respondent failed to conduct a background screening check on one of 8 sampled staff members "which could potentially lead to harm for residents in the facility."

92. The evidence established that one employee, the cook, had not been background screened. Respondent, in good faith, interpreted the law to not include the cook, because of the limited nature of contact with residents. Notwithstanding Respondent's interpretation of the applicable law, the cook had access to client living areas as referenced in section 408.908(1)(e). Accordingly, the cook, who was hired after the substantial amendments to the background screening statutes in 2010, should have been background screened.

93. AHCA asserts that this is a Class II violation. Despite Ms. McIntyre's testimony that AHCA always classifies this as a Class II deficiency, no rule has been cited as authority for this purported agency policy. § 120.57(1)(e), Fla. Stat. Moreover, its own allegations in paragraph 90 of

the Amended Administrative Complaint state that this "could potentially lead to harm for residents in the facility." This fits within the definition of a Class III violation, and is more appropriately classified as such.[4/]

94. AHCA proved two Class III deficiencies. Applying section 429.19, each deficiency warrants a fine of a maximum of $1,000 for a total of $2,000.

95. AHCA seeks to impose a survey fee of $500. Section 429.19(7), Florida Statutes authorizes AHCA to assess a survey fee equal to the lesser of one half of the facility's biennial license and bed fee or $500 to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint. The violation(s) found herein are the result of a complaint investigation. Accordingly, the $500 survey fee sought by AHCA to be imposed pursuant to section 429.19(7) is appropriate.

96. Finally, AHCA seeks to revoke Respondent's license. Section 429.14(1)(e), Florida Statutes, authorizes AHCA to deny, revoke, or suspend the license of a facility having three or more class II deficiencies. No Class II deficiencies were proven. Revocation is not supported by the evidence nor required by law.

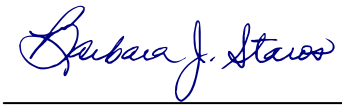
RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law set forth herein, it is

RECOMMENDED:

That the Agency for Health Care Administration enter a final order imposing a fine of $2,000, imposing a survey fee of $500, and dismissing the remaining allegations of the Amended Administrative Complaint against Respondent, Kipling Manor.

DONE AND ENTERED this 1st day of May, 2012, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 1st day of May, 2012.

ENDNOTES

[1/] The allegations of Resident 3 have not been considered as they are hearsay and there is insufficient proof that they meet the requirements of section 90.803(24), Florida Statutes, as an exception to the hearsay rule. This allegation, however, is a component of the Amended Administrative Complaint and will be addressed as such.

[2/] All allegations in Count II of the Amended Administrative Complaint regarding Resident 2 were withdrawn at hearing by AHCA.

[3/] The cook's initials are being used because a family member by the same last name was a resident at Kipling Manor.

[4/] It is noted that AHCA has on at least one occasion classified this as a Class III violation. See Ag. for Health Care Admin. v. Delta Health Group, Inc., Case No. 03-1655 (Fla. DOAH Nov. 25, 2003) (AHCA May 19, 2003) (Administrative Complaint charged facility with Class III deficiency for failure to perform background screening on two staff members).

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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.