STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

WATER'S EDGE EXTENDED CARE,

Petitioner,

vs. Case No. 12-2188

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.
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RECOMMENDED ORDER

Pursuant to notice, a hearing was conducted in this case pursuant to sections 120.569 and 120.57(1), Florida Statutes (2012),[1/] before Jessica E. Varn, an Administrative Law Judge of the Division of Administrative Hearings ("DOAH"), on February 7, 2013, by video teleconference at sites in Port St. Lucie and Tallahassee, Florida.

APPEARANCES

For Petitioner: Thomas W. Caufman, Esquire
Sheila K. Nicholson, Esquire
Quintairos, Prieto, Wood and Boyer, P.A.
4905 West Laurel Street, Suite 200
Tampa, Florida 33607

For Respondent: Nelson E. Rodney, Esquire
Agency for Health Care Administration
8333 Northwest 53rd Street, Suite 300
Miami, Florida 33166

STATEMENT OF THE ISSUE

Whether Petitioner violated section 400.0255, Florida Statutes, by improperly discharging or transferring a resident such that Respondent correctly issued a Statement of Deficiencies against Petitioner.

PRELIMINARY STATEMENT

On May 14, 2012, the Agency for Health Care Administration (Agency) conducted a Complaint Survey (Survey) at Water's Edge Extended Care (Water's Edge) skilled nursing facility. As a result of the Survey, the Agency issued a Statement of Deficiencies, which was received by Petitioner on or about May 23, 2012. Water's Edge timely filed a Petition for Formal Administrative Hearing on or about June 1, 2012, and the matter was referred to the Division of Administrative Hearings for assignment of an Administrative Law Judge to conduct a hearing pursuant to sections 120.569 and 120.57(1).

The final hearing initially was set for August 27, 2012, but pursuant to the Agency's requests, was rescheduled for September 26, 2012, and then for December 6, 2012. Pursuant to Petitioner's request, the hearing again was rescheduled for February 7, 2013.

The final hearing was held on February 7, 2013. Water's Edge presented the testimony of Dr. Marie Cambronne, Dr. Michael Sherman, Martha Legere, and Christine Cerny and offered

Petitioner's Exhibits 1 through 4, which were admitted into evidence without objection. The Agency presented the testimony of Alexandra Pellan, Martha Lederman, Susan Grofic, and David Grofic and offered Respondent's Exhibits 1, 3, 4, 7, 8, 11, 20-32, 34, 35, 37-47, 49, 97, 99, 103, and A into evidence. Respondent's Exhibits 50, 51, 52, and 53 were admitted into evidence over objection.

The two-volume Transcript was filed on March 8, 2013, and the parties were given until April 8, 2013, to file their proposed recommended orders. On May 23, 2013, the undersigned issued an Order notifying the parties that Respondent's Exhibit 29 was missing from Respondent's Evidence Notebook and allowing Respondent to indicate whether this was done in error, or if Exhibit 29 was intended to be omitted. Respondent promptly filed Exhibit 29. Petitioner was given until June 10, 2013, to object to the admission of Exhibit 29 if necessary. No objection was made by Petitioner to Exhibit 29, and it was therefore admitted into evidence. Each party timely filed its Proposed Recommended Order, and both were duly considered in preparing this Recommended Order.

FINDINGS OF FACT

1. Petitioner is a 36-bed skilled nursing facility located on the campus of Sand Cove Hills, a retirement community in Palm City, Florida. Sand Cove Hills is a continuing care retirement community containing 255 independent living units, 36 skilled nursing units, and 20 assisted living beds. The assisted living

beds and skilled nursing units are separately licensed by the Agency.

2. M.M. became a resident of Water's Edge on February 25, 2012, after being referred to the facility from Martin Memorial Hospital for rehabilitation. She was 90 years old.

3. During M.M.'s residency at Water's Edge, Heather Furlong served as the administrator, Martha Legere served as the director of nursing, Dr. Michael Sherman served as the medical director, Althea Armstrong served as a charge nurse, Christine Cerny served as a licensed practical nurse (LPN) who provided direct care to M.M., and Deneas Morris served as a certified nursing assistant (CNA) who also provided direct care to M.M.

4. From March 3, 2012, until March 11, 2012, M.M. was hospitalized and diagnosed with right lower lobe pneumonia. When she arrived at Water's Edge, she was admitted by Dr. Sherman, an internist.

5. Dr. Marie Cambronne was M.M.'s psychiatrist and first saw M.M. on April 10, 2012. She found M.M. to be very agitated and paranoid. Dr. Cambronne diagnosed her as suffering from dementia and psychosis and prescribed Risperdal for paranoia, delusion, and psychosis. Dr. Cambronne believed that an involuntary examination under the Baker Act might be appropriate because M.M. was very territorial, but opted to wait and see if medicine would alleviate the symptoms.

6. On or about April 14, 2012, Nurse Cerny noticed that M.M. was exhibiting troubling behavior. She had periods of paranoia, believing that Water's Edge staff and other residents were trying to hurt her.

7. CNA Morris recalled M.M. being difficult; M.M. hit Ms. Morris on more than one occasion, ate other residents' meals, took other residents' possessions, and argued with other residents. Ms. Morris believed that other residents were afraid of M.M.

8. Nurse Cerny recalled that M.M. was confused, agitated, went into other residents' rooms, changed her clothes often, and would go through her roommate's belongings. M.M. was calmer when her daughter was present, but when alone, would sometimes pack and unpack her own belongings. She had periods of forgetfulness and hallucinations.

9. Water's Edge is not a locked-down unit; therefore, some residents, like M.M., were fitted with a "WanderGuard" to keep them from wandering out of the facility. The WanderGuard is a bracelet which activates an alarm if a resident wearing it attempts to open an exterior door. The door becomes locked for 15 seconds, to allow time for the staff to redirect the resident.

10. M.M. cut off her WanderGuard twice while she resided at Water's Edge.

11. On or about April 30, 2012, M.M. pushed a roommate's wheelchair (while the roommate was seated in the wheelchair) out of their room and into the hallway, and then slammed the door shut.

12. Dr. Sherman ran tests to rule out an organic cause for M.M.'s spiraling psychiatric issues; he found none.

13. On May 1, 2012, Dr. Cambronne once again saw M.M. M.M. explained to Dr. Cambronne that she believed her roommate had fooled around with her husband, which is why she had kicked her roommate out of the room. Dr. Cambronne noted that M.M. was angry, obsessed with her roommate, confused, and paranoid. She prescribed Ativan to calm M.M. down. While she considered initiating a Baker Act transfer, she was informed by the staff that Dr. Sherman was running tests to rule out an organic cause for M.M.'s psychiatric symptoms.

14. On May 2, 2012, Nurse Cerny noted that M.M. was getting more aggravated at night and was wandering into other resident's rooms. The staff began conducting 15-minute safety checks on M.M. On the morning of May 3, 2012, Nurse Cerny noted that M.M. had continued to enter other residents' rooms through the night and had been found wearing her undergarments over her clothes.

15. On May 3, 2012, M.M. left with her daughter to have some lab work done. When M.M. returned to Water's Edge, and her

daughter left, M.M. required one-on-one care due to her high level of agitation. Nurse Cerny provided that care.

16. On that same day, Dr. Cambronne received a call from Water's Edge, letting her know that the Ativan was not working, that Dr. Sherman had ruled out any organic cause for the psychiatric symptoms, and that M.M. was becoming increasingly agitated. She was informed that M.M. was continuing to bother the other residents, and, in particular, M.M. was bothering the resident whom she had delusions about.

17. Dr. Cambronne decided to involuntarily commit M.M. to a facility that received Baker Act patients, because the Ativan was not working, and M.M. was terrorizing another resident. Dr. Cambronne was concerned that M.M. was a threat to the other residents.

18. Because Dr. Cambronne was busy at a hospital, she asked Water's Edge staff to bring the Baker Act form to her at the hospital so that she could fill it out. Director of Nursing Legere brought the form to Dr. Cambronne and waited until Dr. Cambronne was able to see her. The Baker Act form was completely filled out by Dr. Cambronne.

19. On the Baker Act form, Dr. Cambronne checked the boxes that indicated the patient was likely to suffer from neglect or would pose a threat to herself by refusing to take care of herself and that there was a substantial likelihood that she

would pose a threat. Dr. Cambronne failed to check the next box, which indicated whether that threat was to M.M. or others, but she credibly testified that the threat was to both.

Dr. Cambronne wrote the following as her observations:

> Pt. [sic] is combative with staff [sic] push [sic] other resident on her wheelchair and closed door, entering into other residents room [sic], confused, disorganized, psychotic [sic] not following redirection, exit seeking[.]

20. Martha Lenderman, an expert in the Baker Act, reviewed the Baker Act form and found it deficient because Dr. Cambronne had not personally observed M.M. on the date the form was filled out, the form was not filled out based solely on Dr. Cambronne's observations, and Dr. Cambronne had left a box empty which asked for "other information."

21. Dr. Cambronne explained that she had personally observed M.M.'s obsession with her roommate, her confusion, and her psychosis. Dr. Cambronne had been informed of M.M.'s combativeness with staff and her exit seeking behavior. Since Dr. Cambronne was not providing one-on-one care to M.M., she had to rely on the reports from the staff, coupled with her own observations and diagnosis.

22. The undersigned finds Dr. Cambronne's testimony credible and reasonable; any omissions on the form were harmless.

23. Water's Edge held a bed open for M.M., paid for by M.M.'s family, should she return to the facility that same night, or at any later date. Dr. Sherman was in complete agreement with M.M.'s involuntary commitment, finding it an appropriate course of action.

24. Dr. Cambronne was fairly certain that M.M. would be brought by law enforcement to the St. Lucie Medical Center, which is the hospital where she was working that day, because it is the closest Baker Act facility to Water's Edge.

25. Ms. Lenderman testified that once a Baker Act involuntary examination is initiated, the patient must be taken to a receiving facility or hospital. Law enforcement is the designated authority to transport a patient, and law enforcement has no discretion to ignore the Baker Act order. Ms. Lenderman also testified that, if a Baker Act order is improperly issued, an affected person can file a Petition for Writ of Habeas Corpus to have the individual released from the receiving facility.

26. No evidence was presented indicating that a Petition for a Writ of Habeas Corpus was ever filed in the instant case, or that any disciplinary action was initiated as to Dr. Cambronne's medical license.

27. Water's Edge, having received a Baker Act initiation form from M.M.'s treating psychiatrist, contacted law enforcement for a proper transfer. M.M. was brought by law enforcement to

the St. Lucie Medical Center, and Dr. Cambronne treated her there.

28. M.M.'s transfer from Water's Edge to St. Lucie Medical Center was initiated by Dr. Cambronne, and not by Water's Edge. Water's Edge only complied with M.M.'s treating psychiatrist's Baker Act order, arranging transportation without delay.

29. M.M. received 24-hour care at St. Lucie Medical Center and, in Dr. Cambronne's opinion, received good care. During M.M.'s stay at St. Lucie Medical Center, M.M.'s family did not request that M.M. return to Water's Edge.

30. After eight to ten days had passed, M.M.'s family asked Water's Edge to release the bed hold for M.M. M.M. was later moved to another facility and eventually passed away in January of 2013.

CONCLUSIONS OF LAW

31. DOAH has jurisdiction over the subject matter of this proceeding and of the parties hereto pursuant to chapter 120.

32. As the party asserting the affirmative of an issue, the Agency has the burden of proof and must prove the material allegations by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 679 So. 2d 932 (Fla. 1996).

33. Regarding the standard of proof, in Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983), the court held that:

> [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking 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.

Id. The Florida Supreme Court later adopted the Slomowitz court's description of clear and convincing evidence. See In re Davey, 645 So. 2d 398, 404 (Fla. 1994). The First District Court of Appeal also has followed the Slomowitz test, adding that "[a]lthough this standard of proof may be met where the evidence is in conflict, . . . it seems to preclude evidence that is ambiguous." Westinghouse Elec. Corp. v. Shuler Bros., Inc., 590 So. 2d 986, 988 (Fla. 1st DCA 1991), rev. denied, 599 So. 2d 1279 (Fla. 1992)(citation omitted).

34. Section 400.0255, which is the statutory authority cited by the Agency for the alleged deficiency, contains various provisions that deal with nursing home resident transfers or discharges that are initiated by the nursing home facility. Specifically, section 400.0255(17) states as follows:

> The provisions of this section apply to transfers or discharges that are initiated by the nursing home facility and not by the resident or by the resident's physician or legal guardian or representative.

35. The statutory provision cited by the Agency in the Statement of Deficiencies is wholly inapplicable in the instant case. The Baker Act transfer was initiated by Dr. Cambronne, and not by Water's Edge.

36. As to the involuntary examination of M.M., section 394.463(2)(a)3., Florida Statutes, states as follows:

> A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest receiving facility for involuntary examination.

37. Here, Dr. Cambronne executed a certificate on May 3, after having examined M.M. on May 1. The certificate indicated that M.M. met the criteria for involuntary examination, and Dr. Cambronne wrote her observations which were the basis for her conclusion. The form meets all the statutory requirements. As further required by the statute, law enforcement was notified by Water's Edge, and M.M. was properly transferred to the nearest receiving facility.

38. As Ms. Lenderman explained, the nursing home administrator must follow a Baker Act order and must do so without delay.

39. No statute, rule, or policy has been cited by the Agency to support its argument that Water's Edge could exercise discretion when a physician issues a Baker Act order.

40. The Agency failed to establish that Waters' Edge violated section 400.0255, by improperly discharging or transferring M.M.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration dismiss the Statement of Deficiencies issued to Water’s Edge.

DONE AND ENTERED this 24th day of June, 2013, in Tallahassee, Leon County, Florida.

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

Filed with the Clerk of the
Division of Administrative Hearings
this 24th day of June, 2013.

ENDNOTE

[1/] Unless otherwise indicated, all statutory references are to the 2012 codification of Florida Statutes, which was in effect at the time of the alleged deficiency.

COPIES FURNISHED:

Nelson E. Rodney, Esquire
Agency for Health Care Administration
8333 Northwest 53rd Street, Suite 300
Miami, Florida 33166

Thomas W. Caufman, Esquire
Sheila K. Nicholson, Esquire
Quintairos, Prieto, Wood and Boyer, P.A.
4905 West Laurel Street, Suite 200
Tampa, Florida 33607

Elizabeth Dudek, Secretary
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 1
Tallahassee, Florida 32308

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

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

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.