STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

BAYOU SHORES SNF, LLC, d/b/a
REHABILITATION CENTER OF
ST. PETE,

Petitioner,

vs. Case No. 15-0619

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.
_______________________________/
AGENCY FOR HEALTH CARE
ADMINISTRATION,

Petitioner,

vs. Case No. 15-5469

BAYOU SHORES SNF, LLC, d/b/a
REHABILITATION CENTER OF
ST. PETE,

Respondent.
_______________________________/

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this matter before Lynne A. Quimby-Pennock, Administrative Law Judge with the Division of Administrative Hearings (DOAH), on January 5 through 8, and February 22 and 23, 2016, in Saint Petersburg, Florida.

APPEARANCES

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STATEMENT OF THE ISSUES

The issues in these cases are whether the Agency for Health Care Administration (AHCA or Agency) should discipline (including license revocation) Bayou Shores SNF, LLC, d/b/a Rehabilitation Center of St. Pete (Bayou Shores) for the statutory and rule violations alleged in the June 10, 2014, Administrative Complaint, and whether AHCA should renew the nursing home license held by Bayou Shores.

PRELIMINARY STATEMENT

On June 10, 2014, AHCA issued an Administrative Complaint (AC) to Bayou Shores seeking to change Bayou Shores’ licensure status from standard to conditional for a three-month period;

imposing an administrative fine of $26,000.00; imposing survey fees of $12,000.00; and revoking Bayou Shores' license to operate. Bayou Shores timely executed an Election of Rights form contesting the factual basis for AHCA's allegations and filed a request for formal hearing (Petition) with AHCA. On September 29, 2015, AHCA referred the matter to DOAH, where it was designated DOAH Case No. 15-5469.[1/]

In January 2015, AHCA issued a notice of intent to deny (Notice) renewal of licensure to Bayou Shores. Bayou Shores timely requested a hearing, and on February 5, 2015, the matter was referred to DOAH, where it was designated DOAH Case No. 15-0619.

AHCA's Notice included alleged violations of sections 400.121(1)(a), (b), (c), and (d), and (3), Florida Statutes. During the hearing, AHCA's reference to sections 400.121(1), (b), (c), and (d), was corrected to sections 408.815(1)(b), (c), and (d), Florida Statutes. Section 400.121(1)(a) provides that the Agency may revoke, suspend or discipline an applicant or licensee for violating any "provision of this part, part II of chapter 408 or applicable rules." Section 408.815(1) provides in pertinent part:

> (b) An intentional or negligent act materially affecting the health or safety of a client of the provider;

(c) A violation of this part, authorizing statutes, or applicable rules;

(d) A demonstrated pattern of deficient performance.

Section 400.121(3)(d) provides that AHCA "shall revoke or deny a nursing home license for two class I deficiencies arising from separate surveys within a 30-month period."

On October 7, 2015, Bayou Shores moved to consolidate DOAH Case No. 15-5469 with DOAH Case No. 15-0619. AHCA did not object to the consolidation, and the two cases were consolidated on October 13, 2015.

At the final hearing, AHCA presented the testimony of Fadi Saba, M.D., medical director for Bayou Shores; Matthew Thompson, former Bayou Shores administrator; Carey Daniels, Jr., a certified nursing assistant (CNA) from Bayou Shores; Frances Thomason, former rehabilitation director for Bayou Shores; Janice Kicklighter, former social service director and risk manager for Bayou Shores; Bernard Hudson, a long-term care unit manager for AHCA; Deidre Wells, a registered nurse (RN), licensed health care risk manager and surveyor for AHCA; Susan Morton, a health facility evaluator II for AHCA; Kimberly Smoak, the bureau chief of Field Operations[2/] for AHCA; Timothy Selleck, administrator at Advanced Nursing and Rehabilitation Center (Advanced Center) (A sister facility to Bayou Shores), Clearwater, Florida; Katherine Benjamin, a health facility evaluator for AHCA;

Priscilla Bush, a licensed practical nurse (LPN) employed by Bayou Shores; and Charlene Cannedy, an LPN and unit manager of the second floor employed by Bayou Shores. AHCA's Exhibits I through III, VI through VIII[3/] were received in evidence. Over an objection registered during the hearing, AHCA's Exhibit III was taken under advisement and it is now admitted. Bayou Shores called Todd Martin, a licensed nursing home administrator at Gulf Shore Rehab and Nursing Center; Ann Essig, an RN and the current director of nursing (DON) at Bayou Shores; and Barbara Gamble, an LPN employed by Bayou Shores. Bayou Shores was allowed to cross-examine AHCA's witnesses beyond the scope of direct-examination as part of Bayou Shores' case-in-chief. Bayou Shores Exhibits 1 through 3 were received in evidence.

The first four volumes of the Transcript were filed on March 31, 2016, and the final two volumes were filed on April 1, 2016.[4/] On April 4, the parties were advised, via a Notice of Filing Transcript, that the proposed orders were to be filed on or before the close of business on May 16, 2016. On May 9, 2016, Bayou Shores filed a Motion for Extension of Time in which to file the proposed orders. The motion was granted, and the parties' proposed orders were to be filed by the close of business on May 20, 2016. The parties timely filed their Proposed Recommended Orders, which have been duly considered in the preparation of this Recommended Order.

Unless otherwise stated, all statutory references are to the 2014 codification of the Florida Statutes, which reflects the statutes in effect at the time of the alleged violations.

All rule references are to the Florida Administrative Code Rules in effect at the time of the alleged violations.

Prior to the hearing, each party submitted a unilateral statement containing facts that they believed were not in dispute in this case. To the extent that any fact statements were in agreement and relevant, those facts may be found below.

FINDINGS OF FACT

1. Bayou Shores is a 159-bed licensed nursing facility under the licensing authority of AHCA, located in Saint Petersburg, Florida. Bayou Shores was at all times material hereto required to comply with all applicable rules and statutes.

2. Bayou Shores was built in the 1960s as a psychiatric hospital. In addition to long-term and short-term rehabilitation residents, Bayou Shores continues to treat psychiatric residents and other mental health residents.

3. AHCA is the state regulatory authority responsible for licensure of nursing homes and enforcement of applicable federal regulations, state statutes, and rules governing skilled nursing facilities, pursuant to the Omnibus Reconciliation Act of 1987, Title IV, Subtitle C (as amended) chapters 400, Part II, and 408,

Part II, Florida Statutes, and Florida Administrative Code Chapter 59A-4.

4. AHCA is responsible for conducting nursing homes surveys to determine compliance with Florida statutes and rules. AHCA completed surveys of Bayou Shores' nursing home facility on or about February 10, 2014;[5/] March 20, 2014; and July 11, 2014. Surveys may be classified as annual inspections or complaint investigations.

5. Pursuant to section 400.23(8), Florida Statutes, AHCA must classify deficiencies according to their nature and scope when the criteria established under section 400.23(2) are not met. The classification of the deficiencies determines whether the licensure status of a nursing home is "standard" or "conditional" and the amount of the administrative fine that may be imposed, if any. AHCA surveyors cited deficiencies during the three surveys listed above (paragraph 4).

6. Prior to the alleged events that prompted AHCA's actions, Bayou Shores had promulgated policies or procedures for its operation. Specifically, Bayou Shores had policies or procedures in place governing:

> A) (Resident) code status, involving specific life-saving responses (regarding what services would be provided when or if an untoward event occurred, including a resident's end of life decision);

B) Abuse, neglect, exploitation, misappropriation of property; and

C) Elopements.

A. CODE STATUS

7. Bayou Shores’ policy on code status orders and the response provided, in pertinent part, the following:

> Each resident will have the elected code status documented in their medical record within the Physician’s orders & on the state specific Advanced Directives form kept in the Advanced Directives section of the medical record.

8. Bayou Shores’ procedure on code status orders and the response also provided that the “Physician & or Social Services/Clinical Team” would discuss with a “resident/patient or authorized responsible party” their wishes regarding a code status as it related to their current clinical condition. This discussion was to include an explanation of the term “'Do Not Resuscitate’ (DNR) and/or ‘Full Code.’” Bayou Shores personnel were to obtain a written order signed by the physician indicating which response the resident (or their legal representative) selected. In the event a resident was found unresponsive, the procedure provided for the following staff response:

> 3 Response:
>
> a. Upon finding a resident/patient unresponsive, call for help.
>
> b. Evaluate for heartbeat, respirations, & pulse.

c. The respondent to the call for help will immediately overhead page a "CODE BLUE" & indicate the room number, or the location of the resident/patient & deliver the Medical Record & Emergency Cart to the location of the CODE BLUE.

d. If heartbeat, respirations, & pulse cannot be identified, promptly verify Code Status - Respondent **verifies Code Status by review of the resident's/patient's Medical Record.**

e. If Code Status is "DNR" – **DO NOT initiate CPR** (Notify Physician, Supervisor & Family).

f. If Code Status includes CPR & respondent is CPR certified, **BEGIN** Cardio Pulmonary Resuscitation.

i. If respondent is not CPR certified, STAY with the RESIDENT/PATIENT – Continue to summon assistance.

ii. The first CPR certified responder will initiate CPR.

g. If code status is not designated, the resident is a FULL CODE & CPR will be initiated.

h. A scribe will be designated to record activity related to the Code Blue using the **"Code Blue Worksheet."**

i. **The certified respondent will continue CPR until:** Relieved by EMS, relieved by another CPR certified respondent, &/or Physician orders to discontinue CPR.

j. A staff member will be designated to notify the following person(s) upon initiation of CPR.

i. EMS (911)

ii. Physician

iii. Family/Legal Representative

* * *

5) Review DNR orders monthly & with change in condition and renew by Physician's signature on monthly orders. (Emphasis supplied).

9. Bayou Shores' "Do Not Resuscitate Order" policy statement provides:

> Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a *Do Not Resuscitate Order* in effect.

Further, the DNR policy interpretation provides:

> 1. Do not resuscitate order must be signed by the resident's Attending Physician on the physician's order sheet maintained in the resident's medical record.
>
> 2. A *Do Not Resuscitate Order (DNRO)* form must be completed and signed by the Attending Physician and resident (or resident's legal surrogate, as permitted by State law) and placed in the front of the resident's medical record. (Note: Use only State approved DNRO forms. If no State form is required use facility approved form.)
>
> 3. Should the resident be transferred to the hospital, a photocopy of the DNRO form must be provided to the EMT personnel transporting the resident to the hospital.
>
> 4. Do not resuscitate orders (DNRO) will remain in effect until the resident (or legal surrogate) provides the facility with a signed and dated request to end the DNR order. (Note: Verbal orders to cease the DNRO will be permitted when two (2) staff members witness such request. Both witnesses

must have heard and both individuals must document such information on the physician's order sheet. The Attending Physician must be informed of the resident's request to cease the DNR order.)

5. The Interdisciplinary Care Planning Team will review advance directives with the resident during quarterly care planning sessions to determine if the resident wishes to make changes in such directives.

6. Inquiries concerning do not resuscitate orders/requests should be referred to the Administrator, Director of Nursing Services, or to the Social Services Director.

10. Bayou Shores' advance directives policy statement provides: "Advance Directives will be respected in accordance with state law and facility policy." In pertinent part, the Advance Directives policy interpretation and implementation provides:

* * *

4. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

5. In accordance with current OBRA definitions and guidelines governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to:

* * *

b. **Do Not Resuscitate** – Indicates that, in case of respiratory or cardia failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that

> **no** cardiopulmonary resuscitation (CPR) or other life-saving methods are to be used.
>
> * * *
>
> 8. Changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new documents if changes are extensive. The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan.
>
> 9. The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. (Emphasis supplied).

11. A DNR order is an advance directive signed by a physician that nursing homes are required to honor. The DNR order is on a state-mandated form that is yellow/gold ("goldenrod") in color. The DNR order is the only goldenrod form in a resident's medical record/chart.[6/] The medical record itself is kept at the nursing station.

12. DNR Orders should be prominently placed in a resident's medical record for easy access. When a resident is experiencing a life-threatening event, care-givers do not have the luxury of time to search a medical record or chart to determine whether the resident has a DNR order or not. Cardiopulmonary resuscitation should be started as soon as possible, provided the resident did not have a DNR order.

13. Bayou Shores had a policy and procedure regarding DNR orders and the implementation of CPR in place prior to the February 2014 survey. The policy and procedure required that DNR orders be honored, and that each resident with a DNR order have the DNR order on the state-mandated goldenrod form in the "Advanced Directives" section of the resident's medical record.

B. ABUSE, NEGLECT, EXPLOTATION, AND MISAPPROPRIATION OF PROPERTY PREVENTION, PROTECTION AND RESPONSE POLICY AND PROCEDURES

14. Bayou Shores' "Abuse, Neglect, Exploitation, and Misappropriation of Property Prevention, Protection and Response" policy provided in pertinent part:

> Abuse, Neglect, Exploitation, and Misappropriation of Property, collectively known and referred to as ANE and as hereafter defined, will not be tolerated by anyone, including staff, patients, volunteers, family members or legal guardians, friends or any other individuals.
>
> The health center **Administrator** is responsible for assuring that patient safety, including freedom from risk of ANE, hold the highest priority. (Emphasis supplied).

15. Bayou Shores' definition of sexual abuse included the following:

> **Sexual Abuse**: includes but is not limited to, sexual harassment, sexual coercion, or sexual assault. (Emphasis supplied).

16. Bayou Shores' ANE prevention issues policies included in pertinent part:

> The center will provide supervision and support services designed to reduce the likelihood of abusive behaviors. Patients with needs and behaviors that might lead to conflict with staff or other patients will be identified by the Care Planning team, with interventions and follow through designed to minimize the risk of conflict.

17. Bayou Shores' procedure for prevention issues involving residents identified as having behaviors that might lead to conflict included, in part, the following:

> a. patients with a history of aggressive behaviors,
>
> b. patients who enter other residents rooms while wandering.
>
> * * *
>
> e. patients who require heavy nursing care or are totally dependent on nursing care will be considered as potential victims of abuse.

18. Bayou Shores' interventions designed to meet the needs of those residents identified as having behaviors that might lead to conflict included, in part:

> a. Identification of patients whose personal histories render them at risk for abusing other patients or staff,
>
> b. assessment of appropriate intervention strategies to prevent occurrences,

19. Bayou Shores' policy regarding ANE identification issues included the following:

Any patient event that is reported to any staff by patient, family, other staff or any other person will be considered as possible ANE if it meets any of the following criteria:

* * *

f. Any complaint of sexual harassment, sexual coercion, or sexual assault. (Emphasis supplied).

20. Bayou Shores' ANE procedure included the following:

Any and all staff observing or hearing about such events will report the event immediately to the ABUSE HOTLINE AT 1-800-962-2873. The event will also be reported immediately to the immediate supervisor, AND AT LEAST ONE OF THE FOLLOWING INDIDUALS, Social Worker (ANE Prevention Coordinator), Director of Nursing, or Administrator.

Any and all employees are empowered to initiate immediate action as appropriate. (Emphasis supplied).

21. Bayou Shores' policies regarding ANE investigative issues provided the following:

Any employee having either direct or indirect knowledge of any event that might constitute abuse must report the event promptly.

* * *

All events reported as possible ANE will be investigated to determine whether ANE did or did not take Place [sic].

22. Bayou Shores' procedures regarding ANE investigative issues included the following:

Any and all staff observing or hearing about such events must report the event immediately

to the **ANE Prevention Coordinator or Administrator.** The event should also be reported immediately to the employee's supervisor.

All employees are encouraged and empowered to contact the ABUSE HOTLINE AT 1-800-962-2873. [sic] if they witness such event or have reasonable cause to suspect such an event has indeed occurred.

THE ANE PREVENTION COORDINATOR will initiate investigative action.

The Administrator of the center, the Director of Nurses and/or the Social Worker (ANE PREVENTION COORDINATOR) will be notified of the complaint and action being taken as soon as practicable. (Emphasis supplied).

23. Bayou Shores' policy regarding ANE reporting and response issues included the following:

All allegations of possible ANE will be immediately reported to the Abuse Hotline and will be assessed to determine the direction of the investigation.

24. Bayou Shores' procedures regarding ANE reporting and response issues included the following:

Any investigation of alleged abuse, neglect, or exploitation will be reported immediately to the Administrator and/or the ANE coordinator. It will also be reported to other officials, in accordance with State and Federal Law.

A. THE IMMEDIATE REPORT

All allegations of abuse, neglect, . . . must be reported immediately. This allegation must be reported to the **Abuse Hotline** (Adult Protective Services) within twenty-four hours whenever an allegation is made.

The ANE Prevention Coordinator will also submit **The Agency for Health Care Administration AHCA Federal Immediate/5-Day Report and send it to:**

Complaint Administration Unit
Phone: 850-488-5514
Fax: 850-488-6094
E-Mail: fedrep@ahca.myflorida.com

B. THE REPORT OF INVESTIGATION (Five Day Report):

The facility ANE Prevention Coordinator will send the result of facility investigations to the State Survey Agency within five working days of the incident. This will be completed using the same AHCA Federal/Five Day Report, and sending it to the Complaint investigation Unit as noted above.

C. DESIGNATED REPORTERS:

Shall immediately make a report to the State Survey Agency, by fax, e-mail, or telephone.

All necessary corrective actions depending on the result of the investigation will be taken.

Report any knowledge of actions by a court of law against any employee, which would indicate an employee is unfit for service as a nurse aide or other facility staff to the State nurse aide registry or other appropriated [sic] licensing authorities.

Any report to Adult Protective Services will trigger an internal investigation following the protocol of the Untoward Events Policy and Procedure. (Emphasis supplied).

25. Bayou Shores' abuse investigations policy statement provides the following:

> All reports of resident abuse, . . . shall be promptly and thoroughly investigated by facility management.

26. Bayou Shores' abuse investigations interpretation and implementation provides, in pertinent part, the following:

> 1. Should an incident or suspected incident of resident abuse, . . . be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident.
>
> 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation.
>
> 3. The individual conducting the investigation will, as a minimum:
>
> a. Review the completed documentation forms;
>
> b. Review the resident's medical record to determine events leading up to the incident;
>
> c. Interview the person(s) reporting the incident;
>
> d. Interview any witnesses to the incident;
>
> e. Interview the resident (as medically appropriate);
>
> f. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition;
>
> g. Interview staff members (on all shifts) who have had contact with the resident during the period of the allege incident;
>
> h. Interview the resident's roommate, family members, and visitors;

i. Interview other residents to whom the accused employee provides care or services; and

j. Review all events leading up to the alleged incident.

4. The following guidelines will be used when conducting interviews;

a. Each interview will be conducted separately and in a private location;

b. The purpose and confidentiality of the interview will be explained thoroughly to each person involved in the interview process; and

c. Should a person disclose information that may be self-incriminating, that individual will be informed of his/her rights to terminate the interview until such time as his/her rights are protected (e.g., representation by legal counsel).

5. Witness reports will be obtained in writing. Witnesses will be required to sign and date such reports.

6. The individual in charge of the abuse investigation will notify the ombudsman that an abuse investigation is being conducted. The ombudsman will be invited to participate in the review process.

7. Should the ombudsman decline the invitation to participate in the investigation, that information will be noted in the investigation record. The ombudsman will be notified of the results of the investigation as well as any corrective measures taken.

*   *   *

10. The individual in charge of the investigation will consult daily with the

Administrator concerning the progress/findings of the investigation.

11. The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation.

12. The results of the investigation will be recorded on approved documentation forms.

13. The investigator will give a copy of the completed documentation to the Administrator within ___ working days of the reported incident.

14. The Administrator will inform the resident and his/her representative (sponsor) of the results of the investigation and corrective action taken within ___ days of the completion of the investigation.

15. The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency, the local police department, the ombudsman, and others as may be required by state or local laws, within five (5) working days of the reported incident.

16. Should the investigation reveal that a false report was made/filed, the investigation will cease. Residents, family members, ombudsmen, state agencies, etc., will be notified of the findings. (Note: Disciplinary actions concerning the filing of false reports by employees are outlined in our facility's personnel policy manual.)

17. Inquiries concerning abuse reporting and investigation should be referred to the Administrator or to the Director of Nursing Services.

27. Bayou Shores' reporting abuse to facility management policy statement provides the following:

> It is the responsibility of our employees, facility consultants, Attending Physicians, family members visitors etc., to promptly report any incident or suspected incident of . . . resident abuse . . . to facility management.

28. Bayou Shores' reporting abuse to facility management policy interpretation and implementation provides the following:

> 1. Our facility does not condone resident abuse by anyone, including staff members, . . . other residents, friends, or other individuals.
>
> 2. To help with recognition of incidents of abuse, the following definitions of abuse are provided:
>
> * * *
>
> c. **Sexual abuse is** defined as, but not limited to, sexual harassment, sexual coercion, or sexual assault.
>
> 3. All personnel, residents, family members, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or its staff.
>
> 4. Employees, facility consultants and /or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Director of Nursing Services. In the absence of the Director of Nursing Services such reports may be made to the Nurse Supervisor on duty.
>
> 5. Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing Services. The following information should be reported:

a. The name(s) of the resident(s) to which the abuse or suspected abuse occurred;

b. The date and time that the incident occurred;

c. Where the incident took place;

d. The name(s) of the person(s) allegedly committing the incident, if known;

e. The name(s) of any witnesses to the incident;

f. The type of abuse that was committed (i.e., verbal, physical, . . . sexual, . . .); and

g. Any other information that may be requested by management.

6. Any staff member or person affiliated with this facility who . . . believes that a resident has been a victim of . . . abuse, . . . shall immediately report, or cause a report to be made of, the . . . offense. Failure to report such an incident may result in legal/criminal action being filed against the individual(s) withholding such information.

* * *

8. The Administrator or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident.

9. When an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred. Reporting procedures

> should be followed as outlined in this policy.
>
> 10. Upon receiving reports of . . . sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record. (Note: If sexual abuse is suspected, DO NOT bathe the resident or wash the resident's clothing or linen. Do not take items from the area in which the incident occurred. Call the police immediately.) (Emphasis supplied).

C. <u>ELOPEMENT A/K/A EXIT SEEKING</u>

29. Bayou Shores' elopement policy statement provides the following:

> Staff shall investigate and report all cases of missing residents.

30. Bayou Shores' elopement policy interpretation and implementation provides the following:

> 1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.
>
> * * *
>
> 4. If an employee discovers that a resident is missing from the facility, he/she shall:
>
> a. Determine if the resident is out on an authorized leave or pass;
>
> b. If the resident was not authorized to leave, initiate a search of the building(s) and premises;
>
> c. If the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative

(sponsor), the Attending Physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., Emergency Management, Rescue Squads, etc.);

d. Provide search teams with resident identification information; and

e. Initiate an extensive search of the surrounding area.

5. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall:

a. Examine the resident for injuries;

b. Contact the Attending Physician and report findings and conditions of the resident;

c. Notify the resident's legal representative (sponsor);

d. Notify search teams that the resident has been located;

e. Complete and file an incident report; and

f. Document relevant information in the resident's medical record.

FEBRUARY 2014 SURVEY

31. A patient has the right to choose what kind of medical treatment he or she receives, including whether or not to be resuscitated.

32. At Bayou Shores there may be multiple locations in a resident's medical record for physician orders regarding a resident's DNR status. A physician's DNR order should be in the resident's medical record. When a resident is transported from a

facility to another health care facility, the goldenrod form is included with the transferring documentation. If there is not a DNR, a full resuscitation effort would be undertaken.

33. In late January, early February 2014, AHCA conducted Bayou Shores' annual re-licensure survey. During the survey, Bayou Shores identified 24 residents who selected the DNR status as their end-of-life choice. Of those 24 residents, residents numbered 35,[7/] 54 and 109, did not have a completed or current "Do Not Resuscitate Order" in their medical records maintained by Bayou Shores.[8/]

34. As the medical director for Bayou Shores, Dr. Saba completed new DNR orders for patients during or following the February survey. In one instance, a particular DNR order did not have a signature of the resident or the representative of the resident, confirming the DNR status. Without that signature, the DNR order was invalid. In another instance, a verbal authorization was noted on the DNR forms, which such is not sufficient to control a DNR status.

35. A medication administration record (MAR) is not an order; however, it should reflect orders. In one instance, a resident's MAR reflected a full code status, when the resident had a DNR order in place.

36. During the survey, Bayou Shores was in the midst of changing its computer systems and pharmacies. At the end of each

month, orders for the upcoming month were produced by the pharmacy, and inserted into each resident's medical record. Bayou Shores' staff routinely reviewed each chart to ensure the accuracy of the information contained therein. Additionally, each nurse's station was given a list of those residents who elected a DNR status over a full-code status.

37. Conflicting critical information could have significant life or death consequences. The administration of cardio-pulmonary resuscitation (CPR) to a resident who has decided to forgo medical care could cause serious physical or psychological injuries.

38. As the February survey progressed, and Bayou Shores was made aware of the DNR order discrepancies, staff contacted residents or residents' legal guardians to secure signatures on DNR orders so that resident's last wishes would be current and correct. Bayou Shores had a redundant system in place in an effort to ensure that a resident's last wishes were honored; however, the systems failed.

MARCH 2014 SURVEY

39. On March 20, 2014, AHCA conducted a complaint survey and a follow-up survey to the February 2014 survey. During the March 2014 survey, Janice Kicklighter served as the ANE prevention coordinator for Bayou Shores.

40. On February 13, 2014,[9/] Resident BJ was admitted to Bayou Shores from another health care facility. Sometime after BJ was admitted, paperwork indicating BJ's history as a sex offender was provided to Bayou Shores. Exactly when this information was provided and to whom is unclear.

41. Once BJ was assigned to a floor, CNA Daniels was assigned to assist BJ, and tasked to give BJ a shower. CNA Daniels observed that BJ was unable to transfer from his bed to the wheelchair without assistance; however, CNA Daniels, with assistance, was able to transfer him, and took him to the shower via a wheelchair. It is unclear if CNA Daniels shared his observation with any other Bayou Shores staff.

42. Several hours after BJ's admission, Mr. Thompson, Bayou Shores' then administrator, was informed that BJ had been admitted. Mr. Thompson conferred with the director of nursing (DON) and the director of therapy (director). The director immediately assessed BJ that evening. The director then advised Mr. Thompson and the DON that her initial contact with BJ was less than satisfactory. BJ declined to cooperate in the assessment, and the director advised Mr. Thompson and the DON that BJ could not get out of bed without assistance.

43. Mr. Thompson, the DON and the director did not provide any further care instructions or directions to Bayou Shores staff

regarding BJ’s care or stay at that time. A failure to cooperate does not ensure safety for either BJ or other residents.

44. The day after his admission, BJ was assessed by a psychiatrist. Thereafter, Mr. Thompson notified nearby schools and BJ’s roommate (roommate) that BJ was a sexual offender.

45. Shortly after his conversation with the roommate, Mr. Thompson directed that a “one-on-one” be established with BJ, which means a staff member was to be with BJ at all times. BJ was evaluated again and removed from the facility.

46. Bayou Shores did not immediately implement its policy and procedures to ensure its residents were free from the risk of ANE.

47. Hearsay testimony was rampant in this case. Mr. Thompson testified that he spoke with BJ’s roommate about an alleged sexual advance. However, the lack of direct testimony from the alleged victim (or other direct witness) fails to support the hearsay testimony and thus there is no credible evidence needed to support a direct sexually aggressive act. Rather, the fact that Mr. Thompson claims that he was made aware of the alleged sexual attempt, yet failed to institute any of Bayou Shores policies to investigate or assure resident safety is the violation.

JULY 2014 COMPLAINT SURVEY

48. In June 2015, Resident JN left the second floor at Bayou Shores without any staff noticing. A complaint was filed.

49. At the time of the June 2014 incident (the basis for the July Survey), Bayou Shores' second floor was a limited access floor secured through a key system. Some residents on the second floor had medical, psychiatric, cognitive or dementia (Alzheimer) issues, while other residents choose to live there.

50. There are two elevators that service the second floor; one, close to the nurses' station, and the second, towards the back of the floor. There was no direct line of sight to the nurses' station from either elevator. To gain access to the second floor, a visitor obtained an elevator key from the lobby receptionist, inserted the key into the elevator portal which brought the elevator to the lobby, the elevator doors opened, the visitor entered the elevator, traveled to the second floor, exited the elevator, and the elevator doors closed. To leave the floor, the visitor would use the same system in reverse.

51. At the time of the June incident, visitors could come and go to the second floor unescorted. Additionally, Bayou Shores had video surveillance capabilities in the elevator area, but no staff member was assigned to monitor either elevator.

52. Mr. Selleck, Advanced Center's administrator, sought JN's placement at Bayou Shores because he thought Bayou Shores

offered a more secure environment than Advanced Center. Advanced Center was an unlocked facility and the only precaution it had to thwart exit-seeking behavior was by using a Wander Guard.[10/]

53. JN was admitted to Bayou Shores on Friday evening, June 20, 2014, from Advanced Center. Based upon JN's admitting documentation, Bayou Shores knew or should have known of JN's exit-seeking behavior.

54. JN slept through his first night at Bayou Shores without incident. On June 21, his first full day at Bayou Shores, JN had breakfast, walked around the second floor, spoke with staff on the second floor and had lunch.

55. At a time unknown, on June 21, JN left the second floor and exited the Bayou Shores facility. JN did not tell staff that he was leaving or where he was going. Upon discovering that JN was missing, Bayou Shores' staff thoroughly searched the second floor. When JN was not found there, the other floors were also searched along with the smoking patio. JN was not found on Bayou Shores' property. Thereafter, Bayou Shores' staff went outside the facility and located JN at a nearby bus stop.

56. The exact length of time that JN was outside Bayou Shores' property remains unknown. Staff routinely checks on residents. However, there was no direct testimony as to when JN left the second floor; just that he went missing. Staff instituted the policy and procedure to locate JN, and did so, but

failed to undertake any investigation to determine how JN left Bayou Shores without any staff noticing.

NOTICE OF INTENT TO DENY

57. AHCA's Notice was issued on January 15, 2015. Bayou Shores was cited for alleged Class I deficient practices in each of the three conducted surveys: failure to have end-of-life decisions as reflected in a signed DNR order; failure to safeguard residents from a sexual offender; and failure to prevent a resident from leaving undetected and wandering outside the facility.

CONCLUSIONS OF LAW

58. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding pursuant to sections 120.569 and 120.57(1), Florida Statutes.

59. This case combines the denial of an application to renew a nursing home license on various grounds (DOAH Case No. 15-0619) and an AC to discipline the facility on some of the same grounds (DOAH Case No. 15-5469).

BURDEN OF PROOF

60. The burden in DOAH Case No. 15-5469 is on AHCA to prove the allegations in its AC by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

61. The Supreme Court has stated:

> 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 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 Henson, 913 So. 2d 579, 590 (Fla. 2005)(quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)).

62. AHCA's action in stating its intention to deny the renewal of Bayou Shores' license is tantamount to revoking the license. See Wilson v. Pest Control Comm'n, 199 So. 2d 777, 781 (Fla. 4th 1967). Accordingly, AHCA bears the ultimate burden of persuasion on this issue by clear and convincing evidence. See also Coke v. Dep't of Child. & Fam. Servs., 704 So. 2d 726 (Fla. 5th DCA 1998); Dubin v. Dep't of Bus. Reg., 262 So. 2d 273, 274 (Fla. 1st DCA 1972); Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., supra, at 933-34 (Fla. 1996).

LICENSE RENEWAL

63. An applicant for renewal of a nursing home license must demonstrate compliance with the authorizing statutes and applicable rules during an inspection pursuant to section

408.811, Florida Statutes, as required by authorizing statutes. § 408.806(7)(a), Fla. Stat.

64. The February 2014 survey was in conjunction with Bayou Shores' renewal application. The deficiencies noted in the February 2014 survey were corrected or being corrected as the survey was completed. Less than a month later, AHCA was called to Bayou Shores on a complaint and an investigation was opened regarding the sex offender issue. Three months later, another complaint investigation was opened regarding the elopement issue. It could not be concluded that Bayou Shores was in compliance with part II, authorizing statutes, and applicable rules until those investigations were completed.

65. Holding a standard license in Florida requires that the facility has no Class I or Class II deficiencies and has corrected all Class III deficiencies within the time established by the agency. § 400.23(7)(a), Fla. Stat. A license will convert to conditional status due to the presence of one or more Class I or II deficiencies, or any Class III deficiencies not corrected within the time established by the agency.

66. Section 400.102, Florida Statutes, provides:

> Action by agency against licensee; grounds. — In addition to the grounds listed in part II of chapter 408, any of the following conditions shall be grounds for action by the agency against a licensee:

(1) An intentional or negligent act materially affecting the health or safety of residents of the facility;

(2) Misappropriation or conversion of the property of a resident of the facility;

(3) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a nursing home resident; or

(4) Fraudulent altering, defacing, or falsifying any medical or nursing home records, or causing or procuring any of these offenses to be committed.

67. Section 400.121(3) provides in pertinent part:

(3) The agency shall revoke or deny a nursing home license if the licensee or controlling interest operates a facility in this state that:

* * *

(d) Is cited for two class I deficiencies arising from separate surveys or investigations within a 30-month period.

The licensee may present factors in mitigation of revocation, and the agency may make a determination not to revoke a license based upon a showing that revocation is inappropriate under the circumstances.

68. Section 400.23(7)(a) provides:

(7) The agency shall, at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a licensure status to that facility. The agency shall base its evaluation on the most recent inspection

> report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. In addition to license categories authorized under part II of chapter 408, the agency shall assign a licensure status of standard or conditional to each nursing home.
>
> (a) A standard licensure status means that a facility has no class I or class II deficiencies and has corrected all class III deficiencies within the time established by the agency.

69. Florida Administrative Code Rule 59A-4.107(5) provides:

> All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift.

JUNE 2014 ADMINISTRATIVE COMPLAINT

The June 2014 AC consists of eight counts:

70. Count I alleges that Bayou Shores failed to follow its own policy and procedures regarding the use of DNR orders, in violation of section 400.022(1)(l), Florida Statutes. Section 400.022 provides in pertinent part as follows:

> (1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:
>
> * * *
>
> (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned

> recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

71. Count I involved an alleged failure to maintain "current, accurate, and accessible information regarding end of life choices placing the residents at risk for failure to honor their advance directives." It was also alleged that Bayou Shores' "deficient practice presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility."

72. AHCA cited this alleged deficiency as a Class I deficiency, which is defined in section 400.23(8)(a) as follows:

> A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction. A class I deficiency is subject to a civil penalty of $10,000 for an isolated deficiency, $12,500 for a patterned deficiency, and $15,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was

> previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection. A fine must be levied notwithstanding the correction of the deficiency.

The failure to have the medical records current and correct is a Class I deficiency.

73. Count II alleges that the cited Class I deficiency subjected Bayou Shores to the "assignment of a conditional licensure status under § 400.23(7)(a)." Section 400.23(7)(a) provides:

> The agency shall, at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a licensure status to that facility. The agency shall base its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. In addition to license categories authorized under part II of chapter 408, the agency shall assign a licensure status of standard or conditional to each nursing home.
>
> (a) A standard licensure status means that a facility has no class I or class II deficiencies and has corrected all class III deficiencies within the time established by the agency.

74. Count III alleges that Bayou Shores has been cited for two state Class I deficiencies and is subject to a six-month

survey cycle for a two-year period and a fee, pursuant to section 400.19(3), Florida Statutes. Section 400.19(3) provides:

> The agency shall every 15 months conduct at least one unannounced inspection to determine compliance by the licensee with statutes, and with rules promulgated under the provisions of those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of residents. The survey shall be conducted every 6 months for the next 2-year period if the facility has been cited for a class I deficiency, has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency. In addition to any other fees or fines in this part, the agency shall assess a fine for each facility that is subject to the 6-month survey cycle. The fine for the 2-year period shall be $6,000, one-half to be paid at the completion of each survey. The agency may adjust this fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional surveys. The agency shall verify through subsequent inspection that any deficiency identified during inspection is corrected. However, the agency may verify the correction of a class III or class IV deficiency unrelated to resident rights or resident care without reinspecting the facility if adequate written documentation has been received from the facility, which provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person shall constitute cause for suspension of not fewer than 5 working days according to the provisions of chapter 110.

75. Count IV was the result of a "re-visit to a re-licensure survey and a complaint survey" of Bayou Shores. This count alleges another violation of section 400.022(1)(l) involving failure to follow its own policy and procedures by neglecting "to ensure the protection of a resident with a known history of sexual offenses or predatory activity from himself or others, failure to ensure that no residents were subjected to inappropriate sexual behavior after the discovery of such activity by the resident, and failure to assess and or provide treatment to a resident known to have been the subject of attempted inappropriate sexual behaviors." § 400.022(1)(l), Fla. Stat. (quoted in paragraph 68 above). Bayou Shores failure to follow its own policies and procedures regarding the safety of its residents is a Class I deficiency.

76. Count V detailed conditions found at Bayou Shores regarding alleged failures "to maintain a complete, comprehensive, and accurate care plan and or fail[ure] to review a resident's care plan after a significant change of condition and revised as appropriate to ensure the continued accuracy as the same relates to the use of restraints."

77. Count VI alleged that the one cited state Class I deficiency in Count V, that "was not in substantial compliance at the time of the survey," subjects Bayou Shores to the "assignment of a conditional licensure status under § 400.23(7)(a)."

78. AHCA failed to establish any facts to support Counts V and VI.[11/]

79. Count VII alleges that Bayou Shores has been cited for two state Class I deficiencies and is subject to a six-month survey cycle for a two-year period and a fee, pursuant to section 400.19(3). (As found in paragraph 72 above.)

80. Count VIII alleges that Bayou Shores has been cited for two isolated state Class I deficiencies. Based on these allegations, AHCA seeks to revoke Bayou Shores' nursing home license.

81. AHCA presented clear and convincing evidence that despite Bayou Shores' seemingly redundant system to ensure residents' DNR orders were well documented, the system was inadequate to safeguard the residents' health, safety and welfare. AHCA also presented clear and convincing evidence that Bayou Shores failed to safeguard its residents when it failed to follow its own policies and procedures. AHCA presented clear and convincing evidence that a resident left the Bayou Shores facility without its staff knowing.

82. AHCA presented clear and convincing evidence that Bayou Shores committed three Class I violations within six months.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care

Administration enter a final order revoking Bayou Shores license to operate a nursing home; and denying its application for licensure renewal.

DONE AND ENTERED this 21st day of July, 2016, in Tallahassee, Leon County, Florida.

LYNNE A. QUIMBY-PENNOCK
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Filed with the Clerk of the
Division of Administrative Hearings
this 21st day of July, 2016.

ENDNOTES

[1/] On September 28, 2015, AHCA's Agency Clerk issued an order referring the matter to DOAH and directing that AHCA "may only pursue the revocation of Respondent's license and the imposition of a conditional licensure for the time period of February 10, 2014, through May 13, 2014."

[2/] During the survey period, Ms. Smoak was the manager of the survey and certification support branch for AHCA. This support branch is responsible for training all the surveyors on quality assurance activities in Florida.

[3/] AHCA's Exhibit VIII was received into evidence over objections based on relevance and authentication. Upon review of the hearing Transcript, the person who allegedly authored the document testified and was excused from the hearing without authenticating the document. Exhibit VIII was not properly

introduced or authenticated and no direct testimony was received concerning it. Exhibit VIII was not considered.

[4/] Two different court reporters were engaged to provide the hearing Transcripts. The final two volumes were provided via volume 1A (consisting of pages 1 through 90), volume 1B (consisting of pages 91 through 195), and volume 2A (consisting of pages 196 through 241).

[5/] This survey started in late January 2014, and concluded in February. It will be referred to simply as the February survey.

[6/] Medical record and medical chart were used interchangeably during the hearing. For ease of reference medical record will be used in this Order.

[7/] The AC contains an error found on page 9, paragraph 18, e. iv.; "March 3, 3018," a date that has not yet occurred.

[8/] Bayou Shores' "Petitioner's pre-hearing stipulation," page 9, paragraph 5, and AHCA's "Unilateral Response to Pre-hearing Instructions," page 8, paragraph 5.

[9/] The AC contains an error found on page 25, paragraph 43, "On February 13, 2014, at approximately 10:00 a.m.;" According to all the testimony, BJ had not been admitted to Bayou Shores by that time.

[10/] A Wander Guard device is an electronic band worn by a resident. If the Wander Guarded resident moves toward an exit door sensor, the sensor will sound and the door will lock for a few minutes.

[11/] Count V allegations centered on an alleged failure to ensure specific care plans were created, maintained, revised as necessary, and followed for individual residents identified by numbers 113, 118, and 20.

Count VI allegations encompassed the allegations in Count V, and were not proven.

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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.