STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Petitioner,

vs. Case No. 15-1098

1351 GOLDEN, LLC, d/b/a CROSS
TERRACE REHABILITATION CENTER,

Respondent.
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RECOMMENDED ORDER

A final hearing was held in this matter before Robert S. Cohen, Administrative Law Judge with the Division of Administrative Hearings, on June 23 and 24, 2015, in Tampa, Florida.

APPEARANCES

For Petitioner: John E. Bradley, Esquire
Agency for Health Care Administration
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For Respondent: Michael Brett Kornhauser, Esquire
Christopher M. David, Esquire
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STATEMENT OF THE ISSUES

The issues are whether Respondent provided adequate and appropriate care and treatment for Resident No. 80, and whether

Respondent implemented a plan of care to treat Resident No. 80's skin condition. The ultimate issue is whether these two deficiencies should result in a fine being imposed upon Respondent and changing its license to a conditional status.

PRELIMINARY STATEMENT

Petitioner, the Agency for Health Care Administration ("Petitioner" or "AHCA"), conducted an annual survey at Respondent's skilled nursing facility, known as Cross Terrace Rehabilitation Center, from July 21 through 24, 2014. Petitioner issued an Administrative Complaint against Respondent on January 7, 2015, seeking to impose upon Respondent a $5,000 administrative fine based upon two Class II deficiencies discovered during the July survey inspection, and to change the facility's status to a conditional license beginning July 24 and ending August 24, 2014.

Respondent timely executed an Election of Rights form contesting the factual basis for AHCA's allegations and filed a Request for Formal Hearing (Petition) with Petitioner. That Petition was forwarded to the Division of Administrative Hearings for assignment of an administrative law judge. The matter was originally scheduled for hearing on May 11 and 12, 2015, but after a continuance requested by Respondent, the matter proceeded to hearing on June 23 and 24, 2015.

At the hearing, Petitioner presented the testimony of D█ W█; Carlos Arruda; Jillian Allane, a health facility evaluator; Kathryn Hill, R.N.; Pankaj Joshi, M.D.; Deirdre Wells, R.N.; and Patricia Freed, R.N. Nurses Hill and Freed were accepted as experts in the field of nursing. Petitioner also offered five exhibits (Exhibit Nos. 1, 3, and 8-10), which were admitted into evidence. Respondent presented the testimony of Dona Conde, R.N., its director of nursing; Donna Gallant, R.N., its MDS coordinator; and Pankaj Joshi, M.D., its medical director, and offered 17 exhibits (Exhibits A-N, Q, R, and V), all of which were admitted into evidence, except Exhibit K.

A four-volume Transcript of the final hearing was filed on July 20, 2015. Petitioner and Respondent filed their proposed Findings of Fact and Conclusions of Law on August 31, 2015.

References to statutes are to Florida Statutes (2014), unless otherwise noted.

FINDINGS OF FACT

1. Petitioner is the regulatory agency responsible for licensure of nursing homes and enforcement of applicable federal regulations, state statutes, and rules governing skilled nursing facilities pursuant to the Omnibus Budget Reconciliation Act of 1987, Title IV, Subtitle C (as amended); part II of chapters 400 and 408, Florida Statutes; and Florida Administrative Code Chapter 59A-4.

2. Respondent operates a skilled nursing facility with 104 beds, known as Cross Terrace Rehabilitation Center, which is located at 1351 San Christopher Drive, Dunedin, Florida 34698. Its license number is 11300961.

3. On January 7, 2015, Petitioner filed an Administrative Complaint against Respondent alleging that Respondent failed to provide adequate and appropriate care and treatment for Resident No. 80 (the Resident) and failed to implement a "plan of care" to treat the Resident's skin condition.

4. Petitioner cited both deficiencies as Class II deficiencies as defined by section 400.23(8)(b). As a result, Respondent sought to impose a fine in the amount of $5,000 and assign Respondent conditional licensure status.

Count I: Adequate and Appropriate Care

5. A central issue concerning whether the Resident received the appropriate care is whether an appropriate "resident care plan" existed for the Resident's well-being and treatment.

6. According to the Resident's dermatologist, Kathleen Soe, M.D., the Resident suffered from neurodermatitis pruritus, a psychogenic condition caused by the brain sending a signal for the individual to itch, pick, scratch, dig, or otherwise mutilate the skin, even though there is no physical cause for or need to engage in such conduct. Dr. Soe stated that several services would be helpful to maintain the Resident's physical well-being:

educating the Resident regarding the cause and symptoms of the skin condition, limiting the ability to irritate the affected skin area through scratching, keeping the Resident's nails trimmed, using Geri-Sleeves to cover the affected area to prevent exposure and scratching, and applying appropriate lotions or creams to the affected areas as needed. The Resident suffered from diabetes which prevented the use of steroidal medications.

7. The AHCA nurses testifying at the hearing, as well as Respondent's medical director, Dr. Joshi, agreed that the recommended treatments for the Resident's skin condition were appropriate.

Count II: Resident Care Plan

8. Rule 59A-4.109(1) states, in part, as follows:

> (1) Each resident admitted to the nursing home facility shall have a plan of care. The plan of care shall consist of:
> (a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential.
> (b) A preliminary nursing evaluation with physician's orders for immediate care, completed on admission.
> (c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment shall be:
> 1. Reviewed no less than once every 3 months;
> 2. Reviewed promptly after a significant change in the resident's physical or mental condition; and,

3. Revised as appropriate to assure the continued accuracy of the assessment.

9. A dispute over whether the treatments recommended by Dr. Soe were implemented before the survey conducted by AHCA or after the facility was cited for not following the treatment protocols following the survey became AHCA's focus during the hearing.

10. Dr. Joshi's records revealed orders and a prescription for Clobetasol cream and Sarna Lotion to help with the irritated skin on April 25, 2014, which was discontinued by his order dated June 23, 2014, and also noted in Nurse Gallant's notes of that date.

11. Another prescription cream, Triamcinolone, was started up again to deal with the Resident's skin irritation on July 23, 2014, during the four-day period when the AHCA survey was taking place. Dr. Soe believed that the Resident's anxiety caused by participation in the AHCA survey of July 2014 could have exacerbated the skin condition which provides an explanation for Dr. Joshi restarting treatment.

12. Numerous notes from the nurses involved in daily care of the Resident discussed matters such as keeping the Resident's nails trimmed and having the Resident wear shoes and socks to avoid hurting his toes and feet.

13. Geri-Sleeves were given to the Resident in August, a full month after the care plan recommended their use for protecting the affected skin areas.

14. Nurse Wells reviewed the care plan dated April 25, 2014, which she testified was not shown to her at the time of the survey. She did review the care plan prior to the hearing, and criticized it in two areas she believes did not comply with Florida law. The plan did not specifically state that the affected area should be washed regularly with Dove soap, and that regular cleansing of skin is a foundation of good nursing practice. Also, she noted that re-education of the Resident in proper care was not included in the plan.

15. Nurse Hill believed the original care plan did not meet the requirements of Florida law, in part because it mentioned nothing about the Resident's scratching the affected skin area or of cutting the Resident's nails. Nurse Hill testified that Respondent's staff updated the plan after she notified them of the deficiencies.

16. The plan was changed on July 23, 2014, in the midst of the survey, to include the language "keep the nails cut short." Additionally, the original plan did not include language about monitoring the Resident for scratching, educating the Resident if problems resurface, encouraging the Resident to use Geri-Sleeves, or to contact the physician immediately if the rash recurs.

17. The MDS coordinator, Nurse Gallant, testified that she changed the care plan during the survey because the issue with the Resident's nails and scratching was a new problem or a recurrence of a problem that had been resolved in June, a month before the survey. The nursing director, Nurse Conde, testified that the Resident had suffered the skin problem the entire time the Resident was in the facility.

18. Ms. Allane, one of AHCA's surveyors, noticed a skin tear on the Resident's arm on July 21, 2014, the first day of the survey. Others among the survey team noticed that the Resident's nails were not cut short at the time of the survey.

19. Nurses Conde and Gallant testified that they cannot force a resident to regularly bathe and to allow nails to be kept cut short. Residents are individuals who have rights, including the right to refuse treatment or even hygienic measures taken by staff to ensure a skin condition, such as the one suffered by the Resident, is alleviated. Respondent's witnesses, the regular caregivers and supervisors for the Resident's care, testified that the Resident often refused bathing and having nails cut short. This testimony is credible and was not rebutted by the surveyors or AHCA's nurses involved in the surveying process. As a result of the Resident's refusal to bathe or have nails cut short on a regular basis, when the Resident's skin affliction recurred, the result would be scratching with long nails that

would tear the skin and irritate the area. This was not the fault of Respondent's staff, which made reasonable efforts to care for the Resident.

20. The testimony and exhibits produced by Respondent evidenced a care plan for the Resident. Respondent's director of nursing testified that she provided the surveyors with the plan of care during the survey. The surveyors testified they were not provided with the care plan at the time of the July 2014 survey.

21. The Resident's mother, Ms. W[redacted], testified she observed scratches, open sores, and scabs on the Resident on July 22, 2014, during the course of the survey. However, she also acknowledged signing a letter which was admitted into evidence at hearing in which she praised Respondent for providing the "highest care" for her son, "a willing-ness [sic] to address any concern I or [the Resident] have had." Further, she stated in the letter, "While [the Resident] has always had issues with [the Resident's] skin, you have always addressed them quickly to try to resolve them and kept me in the loop with [the Resident's] condition." The clear contradictions in her testimony, as well as the fact she seemed confused, at times, while testifying, lend little credence to her testimony.

22. Ms. W[redacted] and Nurse Hill both observed scabs and scratches on the Resident's arm that were healing on July 22 and 23, 2014, respectively.

23. Nurse Hill further observed that the Resident had scratched the Resident's arms severely and noted that scabs indicated scratching that occurred at least two days previously, based upon her more than 20 years of experience in nursing.

24. Nurse Wells testified she deemed the finding of scabs and scratches and, in her view, the lack of a care plan for the skin condition, to be Class II deficiencies.

25. Petitioner's finding of Class II deficiencies is based upon the personal observation of the surveyors, some of whom are long-serving nurses, and their view that an adequate care plan did not exist for the Resident. While both Nurse Hill and Nurse Freed were offered and accepted as experts in the field of nursing, the testimony they provided was factual, and their opinions, while not based on scientific study or treatise, were allowable as based upon their relevant personal expertise in surveying nursing facilities and having practiced in the field for many years. The opinions offered were based upon sufficient facts or data, are the product of reliable principles and methods, and the witnesses applied the principles and methods reliably to the facts of the case pursuant to section 90.702, Florida Statutes. Their professional opinions were based on their personal observations of the Resident, the care documents provided by Respondent, and their experience in conducting

surveys and applying what they and their team observe to the applicable Florida law and rules.

26. Nurse Hill concluded that the itching and scratching must have been present for at least a week, based upon her experience. This testimony was based upon her years of experience as a nurse, not upon any studies conducted by national organizations or health care providers. She personally observed the Resident scratching "feverishly" when she first came into the room to meet with the Resident. She also testified the Resident told her, in person, the itching and scratching had gone on for a week and "kept [the Resident] up at night." She testified the Resident told her that the nails had not been cut.

27. Dr. Joshi confirmed that evidence of a tear or scabs would indicate the itching and scratching had occurred over a period of time.

28. Nurse Hill believed that Dr. Soe, the dermatologist, should have been contacted again about the recurrence of the intense itching and scratching. Dr. Joshi believed that the care plan was sufficient to address any recurrence of the skin irritation. More weight is given to Nurse Hill's cautionary approach to the skin care in light of the Resident's other significant health issues.

29. The physician's note dated April 25, 2014, stated that the Resident's nails should be kept short.

30. Respondent's staff members who were called to testify stated that sometimes the Resident allowed staff to cut the Resident's nails, but at other times refused. The Resident refused to allow staff to cut the nails at the time of the survey.

31. Nurse Hill testified that a doctor was contacted on the day of the survey, that the care plan was produced, and that the Resident's nails were cut short.

32. The Administrative Complaint in this matter cited Respondent for failure to provide an appropriate "resident care plan" for the Resident pursuant to rule 59A-4.109(1). It also alleged that a basis for violation of statute or rule was based upon failure to provide a "comprehensive care plan" specifically addressing the skin condition pursuant to rule 59A-4.109(2). The comprehensive care plan dated November 7, 2013, noted, among other conditions affecting the Resident, that the potential for skin breakdown was a concern that should be monitored. Further, paragraph 19 of the Administrative Complaint alleges that the MDS coordinator returned the comprehensive care plan to the survey team on the afternoon of July 23, 2014, with updates to that plan. The Resident's care plan also was revised on that date (or the next day) by Respondent's staff.

33. Respondent produced as evidence Comprehensive Nursing Care Plans dated November 7, 2013, April 25, 2014, and revised on

July 24, 2014. The documentary evidence also includes updates for several months following the July 2014 survey.

CONCLUSIONS OF LAW

34. The Division of Administration Hearings has jurisdiction over the subject matter of and the parties to this proceeding. §§ 120.569 and 120.57(1), Fla. Stat.

35. Petitioner, as the party asserting the affirmative of the issue in this proceeding, has the burden of proof. Balino v. Dep't of Health & Rehabilitative Servs., 348 So. 2d 349 (Fla. 1st DCA 1977); Dep't of Agric. & Consumer Servs. v. Strickland, 262 So. 2d 893 (Fla. 1st DCA 1972).

36. Pursuant to Florida law, "[f]indings of fact shall be based upon a preponderance of the evidence, except in penal or licensure disciplinary proceedings or except as otherwise provided by statute, and shall be based exclusively on the evidence of record and on matters officially recognized." § 120.57(1)(j), Fla. Stat.

37. Petitioner has the burden to establish by clear and convincing evidence that the allegations contained in the Administrative Complaint support the findings by the agency of Class II violations and imposition of a fine. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996). The clear and convincing standard of evidence has been described by the Florida Supreme Court as follows:

> [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

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

38. Petitioner must also establish, by a preponderance of the evidence, that the allegations of Class II deficiencies warrant the imposition of a conditional license. Beverly Enterprises-Florida v. Ag. for Health Care Admin., 745 So. 2d 1133 (Fla. 1st DCA 1999). See also Fla. Dep't of Transp. v. J.W.C. Co., Inc., 396 So. 2d 778 (Fla. 1st DCA 1981); Balino v. Dep't of Health & Rehabilitative Servs., 348 So. 2d 349 (Fla. 1st DCA 1977).

39. "Preponderance of the evidence" has been defined as follows:

> [The] greater weight of the evidence, not necessarily established by the greater number of witnesses testifying to a fact but by evidence that has the most convincing force; superior evidentiary weight that, though not sufficient to free the mind wholly from all reasonable doubt, is still sufficient to incline a fair and impartial mind to one side of the issue rather than the other.

S. Fla. Water Mgmt. Dist. v. RLI Live Oak, LLC, 139 So. 3d 869, 872 (Fla. 2014)(citing Black's Law Dictionary).

40. The clear and convincing standard of proof requires more than a preponderance of the evidence, but less proof than beyond and to the exclusion of a reasonable doubt. See generally In re Ford-Kaus, 730 So. 2d 269 (Fla. 1999).

41. Patricia Freed and Kathryn Hill, both registered nurses with many years of experience, were accepted as experts in nursing which allowed them to offer opinion testimony in this matter. Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993), was adopted in 2013 as the standard for qualifying an expert in Florida. Under the Daubert standard, the requirements for scientific testimony by a witness necessitate a greater showing of expertise than previously by the counsel proffering the witness. In this matter, the testimony relied upon from these two experienced nurses was factual, based upon their personal observations of the Resident, and reliable based upon principles and methods used by nurses and surveyors from AHCA in examining skilled nursing facilities in Florida. Their testimony satisfies the requirements of section 90.702 and Daubert.

42. Section 400.23(8) defines the various classes of deficiencies that may be imposed. For purposes of this analysis, Classes II and III are relevant. They are defined as follows:

(b) A class II deficiency is a deficiency that the agency determines has compromised the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. A class II deficiency is subject to a civil penalty of $2,500 for an isolated deficiency, $5,000 for a patterned deficiency, and $7,500 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection. A fine shall be levied notwithstanding the correction of the deficiency.
(c) A class III deficiency is a deficiency that the agency determines will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or reach his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. A class III deficiency is subject to a civil penalty of $1,000 for an isolated deficiency, $2,000 for a patterned deficiency, and $3,000 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 citation for a class III deficiency must specify the time within which the deficiency is required to be corrected. If a class III deficiency is corrected within the time specified, a civil penalty may not be imposed.

43. 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.

44. The Resident clearly suffered from an ongoing skin condition that is psychosomatic in origin, and brought on, at times, by anxiety. The condition has been treated by Respondent's staff when it has manifested itself, and the evidence supports that the treatment has worked to alleviate the symptoms of itching that led to excessive and forceful scratching that broke the skin, resulting in tears and, ultimately, scabs as the wounds healed. These conditions were observed by the surveyors and nurses conducting the survey in July 2014 on behalf of AHCA.

45. Respondent produced substantial documents to prove the diagnosis and plan of treatment for the Resident's skin affliction. This was clearly a resident who suffered from multiple significant medical issues, neurodermatitis pruritus being just one of a long list of ailments. Respondent also produced significant credible evidence that the Resident was a difficult resident/patient at times. The Resident was known to

refuse bathing and the cutting of nails on more than one occasion, including just before the survey conducted in July 2014. After coaxing from the staff nurses and from at least one of the AHCA nurses during the survey, the staff was able to cut the Resident's nails before the surveyors completed their work onsite.

46. The Resident Care Plan and Comprehensive Plan of Care were both adequate at the time they were originally prepared. However, over time, the entries were less frequent, resulting in inadequate documentation of flare-ups of the Resident's skin condition. The fact that the surveyors personally witnessed the Resident at a time when the skin condition had again manifested itself may have been an unfortunate coincidence, but is more likely the result of the ongoing treatment for the skin being discontinued on June 23, 2014, one month prior to the survey. There is clear and convincing evidence to support the fact that the Resident's skin affliction had manifested itself at least a week prior to the survey, as evidenced by scabs and healing skin tears observed by the nurses and Dr. Joshi. Further, clear and convincing evidence supports that the Resident was suffering from itching when the surveyors personally observed scratching to the point where the skin was freshly torn.

47. The undersigned believes, from the evidence produced and the professionalism of Respondent's witnesses, that

Respondent operates a high-quality skilled nursing facility and that efforts were made to encourage the Resident to agree to better hygiene, which included more frequent bathing and nail trimming. When the Resident refused the treatment, the documentation does not support that additional efforts were made to strongly encourage and insist that the Resident agree to better hygienic measures. Little, if any, documentation was produced to support Respondent's staff efforts to persuade the Resident to allow them to help prevent the itching and scratching. The most substantial documentation of nursing and medical involvement was provided to the AHCA surveyors during the survey in the form of a revised and updated Resident Care Plan. While this remedial measure was appropriate action by Respondent, this type of documentation should have already been evident from the Resident's records at the initiation of the survey.

48. Clear and convincing evidence exists in the record to support a finding of deficiencies at Respondent's skilled nursing facility. The undersigned believes, however, that the deficiencies will result in no more than minimal physical, mental, or psychosocial discomfort to the Resident in this case and that this is an isolated case involving one resident of the facility. Both the Resident Care Plan and the Comprehensive Plan of Care must include better documentation and have more regular entries for the Resident. This may have already been done

sufficiently when the updated plans were provided to the AHCA surveyors during the July 2014 survey. If not, this is action that should be taken immediately since documentation, especially of the difficulties regarding the Resident's compliance with recommended care and treatment of the skin affliction, will better support Respondent's defense of its actions, if required, on subsequent surveys. It also appears that the Resident can be cajoled into submitting to bathing and nail cutting on a more frequent basis. This, of course, will require even more attention on the part of staff, but it might avoid prolonged flare-ups of the skin affliction in the future. The Resident's condition, at the time of the July 2014 survey, demonstrated that best efforts were not made to ensure the condition was under control. The active itching accompanied by skin tears and scabbing could have been alleviated, at least to some extent, with more persuasive tactics employed by Respondent's professional staff.

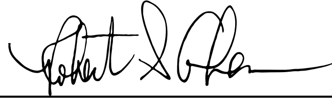
49. Since the conclusion reached in this Recommended Order is that no Class I or II deficiencies exist, there is no need to further discuss the change in status of the license from standard to conditional. It is expected the deficiencies will be quickly corrected, if they have not already been corrected, by Respondent.

50. For the foregoing reasons, Respondent has violated the applicable statutes and rules by committing two Class III deficiencies.

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 finding that Respondent, 1351 Golden, LLC, d/b/a Cross Terrace Rehabilitation Center, violated section 400.022(1)(l), Florida Statutes, for failure to fully and adequately provide the care required by a resident care plan and adequate and appropriate health care and protective and support services; and violated Florida Administrative Code Rule 59A-4.109 concerning having an adequate plan properly updated to treat the medical needs and adverse physical conditions of the Resident. These two violations constitute Class III deficiencies; should result in a fine to Respondent of $1,000 per deficiency pursuant to section 400.23(8)(c); require Respondent to correct the deficiencies within 30 days of the date of the Final Order, unless they have already been corrected; and maintain Respondent's status as a standard license holder.

DONE AND ENTERED this 4th day of December, 2015, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 4th day of December, 2015.

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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.