STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

Case No. 15-4812

RESIDENTIAL PLAZA AT BLUE LAGOON, INC.,

Respondent.
_____/

RECOMMENDED ORDER

On October 27, 2015, Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings (DOAH), conducted the final hearing by videoconference in Miami and Tallahassee, Florida.

APPEARANCES

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

For Respondent: Barbara Galindo, Qualified Representative
Residential Plaza at Blue Lagoon, Inc.
5617 Northwest 7th Street
Miami, Florida 33126

STATEMENT OF THE ISSUES

The issues are whether Respondent, an assisted living facility (ALF), failed to provide adequate supervision of the residents and failed to perform a duty to contact a health care

provider after one resident was struck and injured by another resident. If so, an additional issue is the penalty that should be imposed.

PRELIMINARY STATEMENT

By Administrative Complaint dated April 24, 2015, Petitioner alleged that Respondent operates a 350-bed ALF located in Miami that is licensed as an ALF with license number ALF7551.

The one-count Administrative Complaint alleges a "class II violation" of section 429.26(7), Florida Statutes, and Florida Administrative Code Rule 58A-5.0182(1). The Administrative Complaint mentions a failure to complete a health assessment for two residents, but the operative claims of the Administrative Complaint, as well as the Joint Pretrial Stipulation filed on October 19, 2015, and Respondent's Proposed Recommended Order, are that Respondent allegedly failed to provide adequate supervision for resident activities at the time of the physical confrontation described below and Respondent allegedly failed to perform a duty to contact the physician of the resident who was injured in the physical confrontation. The Administrative Complaint alleges that these failures constitute a Class II violation and seeks a fine of $2500 for this violation.

Respondent timely requested a formal hearing.

At the hearing, each party called two witnesses. Petitioner offered into evidence all or part of five exhibits: Petitioner

Exhibit 1 (checked paragraphs on pages 2, 3, and 6), Exhibit 2 (page 16), Petitioner Exhibit 3 (pages 26 through 30, 35, and 38), Petitioner Exhibit 4 (pages 39 through 42 (not for truth) and 43), and Petitioner Exhibits 6 and 7. Respondent offered into evidence eight exhibits: Respondent Exhibits 4, 6 through 8, 10 through 12, and 14, which is pages 24 and 25 of Petitioner Exhibit 3. All exhibits were admitted.

The court reporter filed the transcript on November 12, 2015. The parties filed proposed recommended orders on December 2, 2015.

FINDINGS OF FACT

1. Respondent operates a ALF in Miami that is licensed for 350 beds. The ALF occupies a 14-story tower. The front desk is on the first floor. The second floor contains common area, including an activities area, a beauty salon, a cafeteria, a physical therapy room, offices for human resources, accounting and administration, a behavioral analyst's office, and offices for health care staff and visiting physicians.

2. Team leaders of the health care staff perform rounds on the second floor. Seven days per week, one team leader is on duty from 5:30 a.m. to 4:00 p.m., one team leader is on duty from 1:00 p.m. to 11:30 p.m., and one team leader is on duty from 11:30 p.m. to 5:30 a.m. At the time of the subject incident, rounds were performed every two hours, 24 hours per day.

3. Resident #1 and Resident #2 were admitted to Respondent's ALF in the summer of 2014. At the time of the subject incident, Resident #1 was 64 years old, and Resident #2 was 88 years old.

4. The health assessment prepared at the time of the admission of Resident #2 states that Resident #2 suffered from moderate progressive dementia and poor cognitive or behavioral status, and he required 24-hour supervision of his activities of daily living. The assessment states that Resident #1 needed assistance eating and needed supervision ambulating, bathing, grooming, toileting, and transferring. The assessment adds that Resident #1 was not a danger to self or others, but needed 24-hour "nursing or psychiatric care." However, the assessment concludes that his needs could be met in an ALF that was not a medical, nursing, or psychiatric facility.

5. Between 2:00 p.m. and 3:00 p.m. on Sunday, November 30, 2014, Resident #1 and Resident #2 were playing dominoes in the activities area on the second floor. Respondent's posted activities list dominoes at this location daily from 9:00 a.m. to 8:00 p.m. The activities area is an open area that does not have doors, so it cannot be locked, but, at 8:00 p.m. daily, staff turn off the lights. The dominoes games in the activities area are initiated by the residents and unsupervised by Respondent's staff, except as the games are observed during routine rounds.

6. A disagreement between Resident #1 and #2 emerged during the game, and the disagreement quickly escalated to a brief physical confrontation between the two men. Resident #1 struck Resident #2 who fell to the ground where he remained for about 30 seconds, but did not lose consciousness. Other residents separated Resident #1 and Resident #2 after Resident #2 stood back up.

7. None of the residents reported this physical confrontation to Respondent's staff, none of whom witnessed the incident. On Sundays, health care staff total 25 persons working various shifts throughout the 24-hour day. Other staff are present onsite, including 20 or 21 persons in housekeeping, memory care staff, maintenance staff, and a manager.

8. On Monday, December 1, a staff person noticed blood on the floor where Resident #2 had fallen. Respondent's staff initiated an investigation, and, by the end of the day, staff learned of Resident #1's participation in the confrontation. Later in the day on Monday or possibly early on the following day, Respondent's staff learned that the other resident in the confrontation was Resident #2. Independently, on December 2, the director of health care, who is a registered nurse, ran into Resident #2 and noticed that he had a bruise on his right ear. She had Resident #2 accompany her to her office where she asked

him what happened. Resident #2 said that he could not recall. He had no other visible wounds, and he seemed fine.

9. Later on the same day, after the director of health care learned from other staff what had happened, she went to Resident #2's room and conducted a general assessment of the resident. She discovered some small bruises on his chest. At this point, the director of health care did not know that Resident #2 had fallen to the floor during the incident. Resident #2 said that he was fine. Due to the size of the bruises on the chest and having seen no other sign of injury besides the bruise on the ear, the director of health care did not document anything except the bruise on the ear and did not contact Resident #2's health care provider.

10. On Wednesday, December 3, a family member visited Resident #2 and, seeing his injured ear, called the police to investigate. A law enforcement officer visited the ALF that day and conducted some interviews. Later that evening, staff took Resident #2 to Baptist Hospital for an evaluation.

11. Resident #2 presented at the hospital with bruising of the right ear and "small skin abrasion[s]" on both elbows. During the three hours that Resident #2 remained at the hospital, he underwent a CT scan of the head due to the fall and a claim of loss of consciousness. After discharge, Resident #2 went to a family member's home and never returned to the ALF.

12. Petitioner failed to prove any act or omission that constitutes an intentional or negligent act seriously affecting the health, safety, or welfare of Resident #2.

CONCLUSIONS OF LAW

13. DOAH has jurisdiction over the subject matter. §§ 120.569 and 120.57(1), Fla. Stat.

14. Section 429.29(1) directs Petitioner to impose an administrative fine for "an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility." Section 408.813(2)(b), Florida Statutes, defines class II violations as "those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients" that are not class I violations, which pose an imminent danger or substantial probability of death or serious physical or emotional harm. Section 429.29(2)(b) authorizes an administrative fine of between $1000 and $5000 for each class II violation.

15. Section 429.26(7) states in relevant part: "The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment."

16. Florida Administrative Code Rule 58A-5.0182(1) provides:

> An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.
>
> (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:
>
> (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C.
>
> (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.
>
> (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.
>
> (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
>
> (e) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

17. Petitioner bears the burden of proving the material allegations by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996).

18. As noted above, Petitioner failed to prove any act or omission seriously affecting the health, safety, or welfare of Resident #2, even given his vulnerability. In particular, Petitioner failed to prove that Respondent's staff was not conducting rounds every two hours; that rounds at such a frequency were inadequate; that Respondent was on notice that Resident #1 or Resident #2 had tendencies to engage in or provoke confrontations; or any other facts establishing a lack of adequate supervision. The physical confrontation could not reasonably have been anticipated, arose suddenly, and ended quickly. Even if staff were conducting rounds every 15 minutes, they probably would not have witnessed the confrontation.

19. Petitioner failed to prove a failure to perform a duty to inform Resident #2's health care provider of his injuries. The existence of such a duty does not arise from the cited authority, but, for the sake of discussion, may be inferred from the general duty not to commit "an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility." The injuries at issue were scratches and bruises of no consequence. Petitioner faults Respondent for failing to rule out a closed head injury, but the director detected no signs of such an injury during two assessments of Resident #2, and it is unlikely that the hospital would have discharged Resident #2 in

three hours if the CT scan that it conducted had revealed such an injury.

RECOMMENDATION

It is

RECOMMENDED that the Agency for Health Care Administration enter a final order dismissing the Administrative Complaint.

DONE AND ENTERED this 1st day of February, 2016, in Tallahassee, Leon County, Florida.

ROBERT E. MEALE
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 1st day of February, 2016.

COPIES FURNISHED:

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

Barbara Galindo, Qualified Representative
Residential Plaza at Blue Lagoon, Inc.
5617 Northwest 7th Street
Miami, Florida 33126

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

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

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

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.