

STATE OF RHODE ISLAND AND
PROVIDENCE PLANTATIONS

DEPARTMENT OF HEALTH
HEALTH SERVICES REGULATION

v.

CHARLES HARRIS,
Nursing Home Administrator

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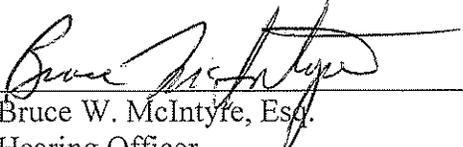
A.H. File No. (HSR) 2005-40

ORDER

By agreement and stipulation of the parties dated December 21, 2012,

1. The Administrative Decision and Order (Amended upon Remand) and dated June 22, 2012, is further amended such that the ORDER reads as follows, "For the reasons stated above, the license of Charles Harris, Nursing Home Administrator is hereby suspended, such suspension to terminate on December 31, 2012, subject to Charles Harris voluntarily relinquishing such license on or before that date and never applying for a Rhode Island nursing home administrator license thereafter."

ENTERED



Bruce W. McIntyre, Esq.
Hearing Officer

December 24, 2012
Date

Gerard R. Goulet
ggoulet@haslaw.com

December 31, 2012

Jennifer Sternick, Esq.
Rhode Island Department of Health
Cannon Building, Room 404
Three Capitol Hill
Providence, RI 02908-5097

Re: **A.H. File No. (HSR) 2005-40**

Dear Ms. Sternick:

In connection with that certain stipulation entered into earlier this month between Charles Harris and the Rhode Island Department of Health, attached is Mr. Harris' license as a nursing home administrator.

Thank you for your assistance with this matter.

Very truly yours,



Gerard R. Goulet

GRG:cjl
Attachment

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

DEPARTMENT OF HEALTH

IN THE MATTER OF
CHARLES HARRIS
Nursing Home Administrator

A.H. FILE NO. (HSR) 2005-40

Administrative Decision and Order
(Amended upon Remand)

This matter came before the Department of Health pursuant to an Administrative Hearing Notice served upon the Respondent, Charles Harris on October 18, 2005 that charged the Respondent with a failure "to provide for the safe and proper operation of Harris Health Center in accordance with the Rules and Regulations for Licensure of Nursing Facilities as evidenced by the Statements of Deficiencies compiled by the departmental staff during surveys of [the] facility." Additionally, Mr. Harris was charged with violating the terms of an August 11, 2005 Consent Order with the Department that placed the Respondent on probation.

The Respondent requested and was granted for good cause a number of continuances both prior to and during the administrative hearing. The hearing was concluded in February of 2006.

The Department was represented by Gregory A. Madoian, Esq., Division of Legal Services and the Respondent was represented by Gerard R. Goulet, Esq., Hinckley, Allen & Snyder, LLP.

The exhibits and testimonial evidence entered into the administrative hearing were considered carefully as follows:

- 1) Hearing notice
- 2) 8/3/05 Survey report and cover letter
- 3) 9/6/05 Survey report and cover letter
- 4) Consent order
- 5) Minutes of Board of Nursing Home Administrators meeting
- 6) Respondent's written response to the Board
- 7) CMS Scope and Severity Grid

Summary of the Testimony

First to testify for the state was Richard E. Fishpaw, a nursing home administrator who has been in that business for the past 25 years. He is currently Executive Director of East Bay Manor. Fishpaw testified that he was familiar with the issues relating to Harris Health Centers through an investigation that was conducted by the Board of Nursing Home Administrators of which he is a member. He testified that a Statement of Deficiencies was forwarded to the Board from the Division of Facilities Regulation. It resulted in a Consent Order entered into between the Respondent Charles Harris and the Board. The Consent Order related to violations of another one of his health centers called Chopmist Hill. The Order put Harris on Probation for one year. When the Division inspected another one of his facilities in August, numerous violations were found. Some of these violations related to pressure sores.

(Pressure Sores are a dangerous degeneration of the skin on a part of the body that touches external forces such as a bed or shoes. Patients who are in bed for long periods of time must be turned regularly and inspected for the beginning stages of "pressure sores". Pressure sores are rated in "stages" by CMS. It is the responsibility of nursing home administrators and resident care staff to insure that proper evaluation and treatment is rendered to nursing home residents.)

When regulators returned in September, violations were found again and even more patients had pressure sores, according to the testimony of Fishpaw. "These

deficiencies lead to a finding of "immediate jeopardy." Fishpaw described this finding as follows: "Immediate jeopardy basically identifies a deficiency within a resident that if it's not corrected immediately it could result in further care issues including, you know, up to leading to possibly death of a resident." He testified that the administrator would know that the deficiencies found in one survey would be followed-up by regulators with another survey. He testified that there did not appear to be a system in place for prevention of the pressure sores. He testified that, in his opinion, the minimum standards of care were not being met at the Harris facility. "The basis [for this determination] after several hours of review and deliberations by the Board[a] consensus was made that based upon the survey of 9/6/05 that the minimum care was not being adhered to at Harris Manor and that there was concern for the safety of the residents in that facility."

Fishpaw testified that as the owner and administrator of the facility Harris should be held to a higher standard. He testified that there didn't seem to be adequate systems in place for prevention. "I think there has to be systems in place that address these issues to prevent furtherskin issues. Part of the Board's contention is that with the last two residents that were identified there didn't seem to be systems in place to make sure that the preventative measures were being maintained." Fishpaw felt that the facility was going in the wrong direction despite the hiring of a "wound consultant."

"And when you put all this together, it seemed like the facility was going in the wrong direction....Instead of seeing the corrections of 8/3, we're seeing additional findings relating to the care of the residents as well as the safety of the residents, and the Board felt that Mr. Harris was responsible, administrator on record at the time, felt that the

systems that were in place there were either not in place or failed to prevent further jeopardy to the residents.”

Upon cross-examination, Fishpaw said the Board was justified in putting Harris on probation and violating his probation due to the deficiencies found at other Harris facilities of which he was owner/administrator. He testified that the Board establishes standards of practice for nursing home administrators through the Board of Examiners for Nursing Home Administrators. Additionally, the Board considers state and federal regulations. Fishpaw was questioned about how standards are circulated so that administrators know about them. He replied that administrators are licensed by the State of Rhode Island and both state and federal part of the licensure exam encompasses minimal standards of care. “Being a licensed administrator and passing the exam would make me believe that most administrators should know the prevailing practice,” he added.

The defendant’s first witness was Linda Mastrobuono, R.N. who was an employee of Harris Health Center for the past two years including the time of her testimony. She testified that she was the Regional Director for the three Harris Health Centers located in East Providence, Central Falls and North Scituate, Rhode Island. She was formerly a Director of Operations for Quality Assurance Consultants, a long term care consulting company.

Mastrobuono’s testimony primarily dealt with the statement of deficiencies that were the result of a Department of Health Survey of August 3, 2005 and a subsequent survey a month later in September. Charles Harris’s sons Chad and Jason were administrators of two of the three facilities (Chad in Central Falls and Jason in East

Providence). She proffered the theory that she would have been unable to “prevent the deficiency from occurring” on patient Number 1. The issue was the care and treatment of a pressure sore. Mastrobuono testified that a Certified Nursing Assistant was responsible for alerting a nurse that the dressing on the wound ordered by the doctor was not in place. She testified that facilities have a system in place upon admission to assess the risk of pressure sores utilizing a nationally recognized scale. Depending upon the determined risk, a monitoring and/or treatment plan would be put into place. This plan would be noted in the patient’s care plan for the “interdisciplinary team”. She testified that many things could break down in this system. As an example, Mastrobuono testified that a patient could be on a “turning schedule” every two hours so that pressure sores do not form. She indicated that patients could be a bedpan that prevented them from being positioned on their sides. Others with breathing difficulties need to be positioned to “accommodate their breathing which would supercede pressure turning side to side.” She said that once the care plan is communicated to all caregivers it is expected that it be followed. If “somebody doesn’t follow it...and doesn’t inform you that it’s not being followed...that’s why you have the system in place where somebody else is looking in a timely fashion.” Regarding Patient Number 1, Mastrobuono said she personally took the referral for admission. She said he had a “gaping stage 4” pressure wound from another nursing home. He arrived with a “wound vac” which is a “fairly sophisticated new technology” in healing large wounds.

She testified that they had healed the wound but it reopened follow the removal of the Foley catheter and the return of the patient’s incontinence. She stated that the nurse has incorrectly staged the wound as a Stage 2 rather than a Stage 4. She testified that the

nurse has to be re-educated on proper wound staging. "Once a 4 always a 4," she testified. She said that the deficiency didn't rise to that as cited by the Department of Health, in her opinion. The Department noted that the proper dressing was not on the patient wound. "It was just a minute in time and that CNA should have brought it to the Nurse's attention." She felt that the nurse in charge would have dealt with the situation immediately. "...the system broke down that day" she added.

Mastrobuono later offered her opinions on other issues cited in the statement of deficiencies such as edema and fluid build up in patient's lower extremities and the relationship to those conditions and the formation of pressure sores. Notably, when asked by counsel about the high level of deficiency for insufficiency of staff, Mastrobuono replied, "I do not understand that at all." She testified that she didn't feel that the deficiencies didn't have a "relationship to the administration of the facility." On cross-examination she admitted that she had no "expertise" as a nursing home administrator. She also conceded that Charles Harris was the "administrator of record" of the East Providence facility. She also conceded that the pressure sore deficiencies were cited in August and again in September. She acknowledged that she worked for Harris up to the time of her testimony.

FINDINGS OF FACTS

1. Charles Harris is the owner of three health centers located in Central Falls, East Providence and Scituate, Rhode Island. He is a Licensed Nursing Home Administrator.

2. He was the Administrator of Record when the Department of Health cited his two of his facilities for failure to adhere to the minimal standards of practice. One case resulted in a public "Consent Order" put the Respondent on Probation for one year.
3. While on Probation, another facility was cited by the Department of Health for very serious patient care issues. One month later, the Department of Health found the same type of violations in the facility with even more patients with serious pressure sores.
4. Respondent Charles Harris had the responsibility to ensure proper staffing levels and to train resident care staff appropriately. The Respondent failed to do so in a manner that constitutes a pattern of neglect.
5. The Respondent's explanation for these problems came largely through an expert witness who was employed by the Respondent. While this witness was certainly knowledgeable about wound evaluation and care, a fair reading of her testimony indicates a pattern of inappropriate care on the part of the staff.
6. Respondent failed to testify at the hearing due to an injury allegedly received from a fall following the first day of the administrative hearing. No inferences were drawn from his failure to testify. Respondent's viewpoints were admirably represented by counsel and through an expert witness.

7. Respondent's claim that the citations levied in September were inappropriate or erroneously levied are without merit. As the owner/administrator of these facilities he had an obligation and a legal responsibility to the residents and to the state that regulates the facility. He entered a Consent Order with the Department of Health for violations at one facility. Part of that Consent Order called for Probation and a promise to adhere to laws and regulations "governing the practice of Nursing Home Administrators." He agreed to be subject to suspension or other appropriate disciplinary action. Three months later serious violations were found at another facility. He filed a "plan of correction" that was accepted by the Department of Health. The following month surveyors returned to the facility and found more serious violations.
8. Respondent failed to take the necessary steps to provide for the health and safety of residents of his nursing home facilities as required by law for his continued licensure. In doing so, he forfeits the privilege to administer to the care of Rhode Island's neediest population.

Conclusions of Law

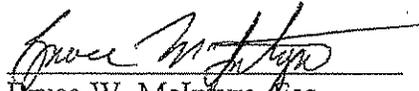
The Respondent was placed on probation by virtue of a Consent Order dated August 11, 2005. The Respondent violated the Rules and Regulations for Licensing Nursing Home Administrators (R5-45-NHA) § 8.1(e) "Neglect or misconduct in professional practice". Further, the Respondent violated the terms

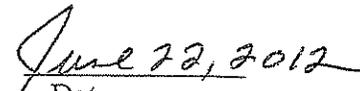
of his probation that began August 11, 2005 by neglecting to provide the care required to residents at the nursing home.

Order

For the reasons stated above, the license of Charles Harris, Nursing Home Administrator is hereby Revoked.

Entered:


Bruce W. McIntyre, Esq.
Hearing Officer


Date

Appeals

If you are aggrieved by this final agency order, you may appeal this final order to the Rhode Island Superior Court within thirty (30) days from the date of mailing of this notice of final decision pursuant to the provisions for judicial review established by the Rhode Island Administrative Procedures Act, specifically, R.I. Gen. Laws § 42-35-15.

Certification

I certify that a copy of this order was sent via regular mail on June 22, 2012 to:

Jennifer Sternick, Esq.
Department of Health
3 Capitol Hill
Providence, RI 02908

Michael R. Edwards, Esq.
Gerard R. Goulet, Esq.
Hinckley, Allen and Snyder, LLP
1500 Fleet Center
Providence, RI 02903

