STATE OF TENNESSEE
HEALTH FACILITIES COMMISSION
BEFORE THE BOARD FOR LICENSING HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Royal Retreat, LLC	)	**Case No.: 2024033091**
License No. 279,	)	
	)	
Respondent.	)	
	)	
6551 Knight Arnold Road	)	
Memphis, TN 38115	)	

AGREED ORDER

This matter came to be heard before the Tennessee Health Facilities Commission ("Commission"), pursuant to the request of the Commission, by and through the Office of Legal Services, and Royal Retreat, LLC ("Respondent") that the Commission adopt this Agreed Order, the terms of which have been agreed upon by the parties, as signified by their signatures below. This matter was originally heard on July 23, 2025, wherein the State presented evidence at a public hearing before the Commission.

Respondent, by signature to this Consent Order, waives the right to a contested case hearing and any and all rights to judicial review of this matter.

Respondent agrees that presentation to and consideration of this Agreed Order by the Commission for ratification and all matters divulged during that process shall not constitute unfair disclosure such that the Commission or any of its members shall be prejudiced to the extent that requires their disqualification from hearing this matter should the Agreed Order not be ratified. Likewise, all matters, admissions, and statements disclosed or exchanged during the attempted ratification process shall not be used against

Respondent in any subsequent proceeding unless independently entered into evidence or introduced as admissions.

I. JURISDICTION

1. The Commission is empowered to license and regulate hospitals, recuperation centers, nursing homes, homes for the aged, residential HIV supportive living facilities, assisted-care living facilities, home care organizations, residential hospices, birthing centers, prescribed child care centers, renal dialysis clinics, ambulatory surgical treatment centers, outpatient diagnostic centers, adult care homes, and traumatic brain injury residential homes. Tenn. Code Ann. § 68-11-202. Further, Tenn. Code Ann. § 68-11-210 provides that the Commission shall conduct on-site inspections and investigations as may be necessary to safeguard and ensure at all times, the public's health, safety, and welfare.

2. "Assisted-care living facility" ("ACLF") means a facility, building, establishment, complex or distinct part thereof that accepts primarily aged persons for domiciliary care and services. T.C.A.§ 68-11-201(4)(A) and Tenn. Comp. R. & Regs. 0720-26-.02(7).

3. The Commission has the authority to suspend or revoke the license of any facility licensed under Tenn. Code Ann. § 68-11-201 et. seq., Tenn. Code Ann. § 68-11-207(a).

4. In imposing the sanctions authorized in Tenn. Code Ann. § 68-11-207, the Commission may consider all factors that it deems relevant, including, but not limited to, the following:

    1. The degree of sanctions necessary to ensure immediate and continued compliance;
    2. The character and degree of impact of the violation on the health, safety and welfare of the patients in the facility;
    3. The conduct of the facility against whom the notice of violation is issued in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and

4. Any prior violations by the facility of statutes, regulations or orders of the Commission.

5. The Commission may, in its discretion, after the hearing, hold the case under advisement and make a recommendation as to requirements to be met by the facility in order to avoid either suspension or revocation of license or suspension of admissions.

6. Pursuant to Tenn. Code Ann. § 4-5-320(c), the Commission has the authority to take summary action against a license if it finds that the public health, safety, or welfare imperatively requires emergency action.

II. STIPULATION OF FACTS

7. At all times pertinent hereto, Royal Retreat, LLC has been licensed as an Assisted Care Living Facility having been granted license number 279 on June 1, 2006, which currently has an expiration date of May 29, 2026.

8. A complaint and revisit survey were conducted on the premises of the Respondent's facility from March 10, 2025, through March 26, 2025, resulting in deficiencies cited which affect the health, safety, and welfare, of the residents within the ACLF. A copy of the State Statement of Deficiencies was mailed to the Respondent on March 26, 2025.

9. The facility was cited with deficiencies that are a danger to the health, safety, and welfare of residents.

10. Respondent's medical and medication administration records dated February, 2025, through March, 2025, confirmed that Respondent failed to provide proper staffing causing residents to suffer in pain. Residents #5, #9, and #12 complained of pain on multiple night shifts. Respondent did not have a nurse available on multiple night shifts to assess the residents' pain or administer

pain medications. Respondent allowed the residents to suffer without pain medications until the next morning.

11. From around September, 2024, through March, 2025, Respondent failed to provide protective care for Residents #1, #2, #3, and #4, allowing residents to elope from the facility without staff knowledge. Respondent had been previously cited for failing to provide protective care and maintain awareness of the whereabouts of its residents in prior surveys.

12. Respondent failed to implement interventions before or after the elopements to prevent further instances of residents eloping.

13. Resident #1 eloped from Respondent's facility multiple times from December, 2024, through March, 2025, without staff knowledge or supervision of their whereabouts. Respondent put no interventions in place to prevent the Resident from eloping. No documentation was provided to show that Resident #1 was monitored for 4 1/2 hours after the initial elopement.

14. On or around September 21, 2024, Resident #2 was located outside at the corner of the property fence around 4:30 a.m. unaccompanied and without staff knowledge or supervision of their whereabouts.

15. On or around February 21, 2025, Resident #3 eloped without staff knowledge or supervision of their whereabouts. The noted temperature was approximately 34 degrees Fahrenheit outside. Resident #3 was estimated to have been outside for approximately twenty (20) minutes before being found by family.

16. On or around February 28, 2025, Resident #4 eloped without staff knowledge or supervision of their whereabouts. The temperature was noted to be approximately 30 degrees Fahrenheit outside. Resident was found attempting to cross the street by himself.

17. Residents #6, #7, and #8 suffered falls in the Respondent's facility. No interventions were implemented by the Respondent to prevent falls before or after the incidents. Resident #8 was noted in Respondent's records to have fallen more than once, which lead to death from their injuries. Respondent had been previously cited for failing to ensure fall prevention in prior surveys.

18. Respondent failed to conduct care plan meetings with the resident/resident's representative and review and/or revise the plan of care as changes in the residents' needs occurred to prevent elopement and prevent falls. Respondent was unable to produce documentation to show that the Plan of Care for residents noted above had been revised as required. Respondent had been previously cited for failing to update Plans of Care for residents in prior surveys.

19. On or around June 16, 2025, an onsite monitoring visit was conducted by Commission surveyors as part of the Suspension of Admissions procedure.

20. Upon arrival at the facility on June 16, 2025, at approximately 4:00 P.M., the Administrator was not on the premises and had appointed the Maintenance and Safety Director (MSD) to act in his absence. The Maintenance and Safety Director was not a licensed Administrator, or Director. The MSD was unable to pull up emails, access documents related to patient care, or answer health-related questions relating to specific residents.

21. On or around June 16, 2025, at approximately 6:00 P.M. the Administrator admitted during a telephone conversation that he was out of town and would not be back until later that evening and that he had left the MSD in charge, and that the backup Administrator had recently quit.

22. On or around June 16, 2025, Respondent's sole nurse on duty, Licensed Practical Nurse (LPN) #1 was observed to be impaired. LPN #1 had difficulty trying to open the narcotics drawer on the medication cart, had slurred speech at times and was unable to count resident medications correctly

when asked. No records were found for LPN #1 having administered medications to the twenty-eight (28) residents at Respondent's facility for morning or noon administration.

23. Commission surveyors detected an odor of an alcoholic beverage on LPN #1's breath, an almost empty bottle of alcohol was found under the nurse's desk, and the residual liquid in that bottle matched the color of the liquid in the nurse's Styrofoam cup. LPN #1 had surrendered her open cup to the surveyors for inspection but became agitated and struck a Commission surveyor in an attempt to reclaim her open cup of alcoholic beverage. LPN #1 then left Respondent's facility. No other nurse was present at the facility.

24. On or around June 16, 2025, Respondent's Activities Director (AD) confirmed that she had smelled something on LPN's breath earlier in the day, and that she began to notice a real problem with LPN #1's behavior around the time the surveyors arrived at Respondent's facility. AD stated that LPN #1 had confessed to consuming a "cocktail or something" to her.

25. From on or around June 17, 2025, through June 23, 2025, Commission surveyors conducted a revisit survey at Respondent's facility (hereinafter "Revisit").

26. Respondent had failed to submit an acceptable Plan of Correction within the statutory timeframe allowed from the initial survey and revisit dating from March 26, 2025. Respondent was subsequently re-cited again during Revisit, for all deficiencies stemming from the initial survey and revisit dated March 26, 2025.

27. Respondent failed to provide proof that criminal background checks beyond the local county of Shelby had been performed as required by T.C.A. 68-11-256 and Registry checks had been conducted as required pursuant to T.C.A. 63-1-149(a). Respondent failed to review employee files quarterly for compliance and failed to keep employee files up to date.

28. On or around March 12, 2025, Respondent's Administrator confirmed that background checks are performed for the local county only, and a national search is not conducted.

29. Respondent failed to have a licensed nurse available to assess the needs, manage pain, and administer medications for Residents #5, #9, and #12. This is a repeat violation from a prior health complaint survey completed in August of 2024.

30. On or around March 17, 2025, Resident #5 confirmed that they had needed pain medication for their back and could not get any at night.

31. On or around March 17, 2025, Resident #9 confirmed that they had needed pain medication at night and were told that no one at the facility can give them anything and that they would have to wait until morning.

32. On or around March 21, 2025, Resident #12 confirmed that they have back pain that prevents them from sleeping without pain medication, that they had asked for medication at night but was told that they could not get it, and that only caregivers are present at night and that nurses are not present.

33. On or around March 16, 2025, LPN #2 confirmed that the residents who requested pain medications at night do not receive it because after 7:00 P.M. there is no nurse present to administer medication until 7:00 A.M.

34. On or around March 17, 2025, Respondent's Administrator admitted that if the nurse was not on site, then the residents could not get pain medication, that the caregivers could call the nurse, but that it would depend upon the nurse responding.

35. Respondent was unable to provide documentation of licensed nursing staff during night-time hours during Revisit.

36. Respondent failed to provide documentation that the facility reviews and maintains hospice logs, medical records for patients on hospice, and documents related to the quality measure for hospice for Residents #5, #8, and #9. This is a repeat violation from a prior health complaint survey completed in August of 2024.

37. On or around March 12, 2025, Respondent's Administrator confirmed that there was no documentation of monitoring the hospice services each month.

38. Respondent failed to ensure that medications were administered properly and timely for Residents #1, #2, #3, #4, #5, #6, #7, #8, and #9.

39. On or around June 17, 2025, no nurse was found to be available at Respondent's facility from 8:30 A.M. until 11:15 A.M. to assess residents' needs and administer medication for Residents #1, #2, #3, #4, #5, #6, #7, #8, and #9. Residents did not receive their doses on time in accordance with their Plan of Care. There was no documentation that the Residents' physician had been notified of the late or missed medication doses, or that blood sugars had been checked.

40. On or around June 17, 2025, Respondent failed to secure resident medications that were stored in the unlocked Nursing Office in an unlocked medication cabinet. Controlled substances were found to be stored under a single lock, instead of the required double lock. A bottle of liquid lorazepam was observed on the counter, and an unsecured bottle of wine was observed underneath.

41. On or around June 17, 2025, Respondent's MSD admitted that he had received the bottle of medicine from a co-worker but did not have the keys to the medication cart to secure and was unsure of his authority to dispose of the medication. He further admitted that the Nursing Office is to remain locked at all times.

42. Respondent failed to submit an acceptable Plan of Correction to address the elopement risks of Residents #1, #2, #3, and #4 and failed to follow their previously submitted Plan of Correction

from November of 2024 in relation to resident elopement. All Residents above were noted in Respondent's Incident Reports and Nursing notes as having exited the building without staff knowledge or proper sign out. Each resident was noted to have significant cognitive deficiency issues which would pose a danger to themselves when unsupervised outside. No documentation was found or provided noting the specific safety and protective interventions developed and implemented for each resident to prevent them from exiting the facility without staff knowledge. This is a repeat and uncorrected violation from a prior health complaint survey completed in August of 2024.

43. On or around December 29, 2024, Resident #1 exited the rear of the Respondent's facility and walked around to the front unaccompanied and without the staff knowledge or supervision of their whereabouts.

44. On or around September 21, 2024, Resident #2, who was noted with wandering and confusion issues, was reported by staff as missing from their room at approximately 4:30 A.M. Resident #2 was located outside at the corner of the property fence unaccompanied and without staff knowledge or supervision of their whereabouts.

45. On or around February 21, 2025, Resident #3 was observed by staff walking unaccompanied on the outside of the building near the kitchen door and without the staff knowledge or supervision of their whereabouts.

46. On or around May 5, 2025, Resident #3 was noted in Respondent's Observation notes as having suffered a fall in the Respondent's Activity room. No documentation was found or provided of new interventions developed and implemented after May 5, 2025, to prevent future falls for resident #3.

47. On or around March 27, 2025, Resident #4 was noted to in the Respondent's Incident Report to have fallen on the floor in their bedroom. No documentation was found of new interventions developed or implemented after this event to prevent future falls.

48. On or about June 8, 2025, Resident #4 again fell onto the floor and no documentation was found of new interventions developed or implemented after this event to prevent future falls.

49. The Commission became aware of videos which appear to show resident abuse and exploitation on or around June 16, 2025. The videos were made by facility employees between May of 2023 and around April of 2024, approximately, and were furnished to the Commission by a former employee.

50. Respondent failed to report and investigate the emotional abuse or exploitation of Residents #13 and #15, failed to follow their Elder Abuse and Cell Phone policy when inappropriate videos were made of the residents by staff members.

51. Video #1 showed Resident #13 sitting on the side of his bed, and Caregiver #1 pushed Resident #15 to sit down on the side of the bed beside Resident #13. Resident #13 grabbed Resident #15 by the left arm with both of his hands and pushed Resident #15 off of his bed. Resident #15 stumbled a few steps and fell into the lap of Caregiver #1 who was sitting on the couch. Caregiver #1 was sitting beside Caregiver #2, and both were laughing at this time. Resident #13 and Resident #15 did not smile or laugh at any time during the video. Resident #15 scooted herself off of Caregiver #1's lap and sat on the couch beside her. The person videotaping this incident (unidentified) approached Resident #13 while they were sitting on the side of the bed and spoke to them in Spanish and patted their hand. Resident #13's demeanor did not change, and he did not smile.

52. Video #2 showed Resident #16 lying on the couch and covered with a blanket with eyes closed. Caregiver #2 was seated on the couch next to them looking at her cell phone. Caregiver #1 was

lying on Resident #16's bed with her left arm draped over her head and her eyes closed. Caregiver #1 had on tennis shoes which were on Resident #16's bed. The person who was recording the video was unseen in the video and could not be identified. The resident and caregivers seen in the video were identified by the Administrator while reviewing the video. There was no evidence the resident in the video gave permission to be videotaped.

53. Video #3 showed Resident #13 lying in their bed and covered with a blanket. Caregivers #1 and #2 were lying on the floor at the foot of the bed and began to make cat noises, dog noises, and random unintelligible growling noises. After Caregiver #1 and #2 began to make noises, Resident #13 asked, "What are you doing?" Caregivers #1 and #2 continued to make noises while they were lying on the ground. Caregiver #1 reached up and grabbed Resident #13's foot and then ducked back down behind the bed several times. Resident #13 would raise his head up and then lie back down. Caregiver #2 crawled around to the side of the bed and then reached up to either push or grab Resident #13's leg and then ducked back down to the floor. Caregiver #1 and #2 continued this behavior for the entire video and were seen giggling and laughing each time they grabbed or shook Resident #13. Resident #13 did not laugh during the video and appeared annoyed since they kept trying to lie back down. The person who was recording the video was unseen in the video and could not be identified. The resident and caregivers were identified by the Administrator while reviewing the video. There was no evidence the resident in the video gave permission to be videotaped.

54. On or around June 18, 2025, Respondent's Administrator denied seeing the videos previously and admitted that the behavior observed on the video by the caregivers was inappropriate in all three (3) videos. No documentation was found to show that the Administrator initiated an investigation

into the staffs' behaviors in the video or reported the incidents to the State as required by law, Tenn. Comp R & Regs. 0720-26-13 (1).

55. On or around June 18, 2025, Respondent's former Marketing Director stated that Respondent's Administrator had seen the videos and stated that he would take care of it, but no action was taken by the Administrator.

56. Respondent's POC from November of 2024 required the business office manager to be appointed to review employees files to ensure the Form I-9 is completed and the employee's identity and eligibility to work in the United States is completed.

57. Respondent failed to follow its undated policy "Employee Eligibility Verification (I-9)". No I-9 documentation could be found for the Administrator, Housekeeper #2, Caregiver (CG) #8, CG #10, and CG #11. This is a repeat violation from the survey completed in August of 2024.

58. Respondent was found to be out of compliance with its POC from November of 2024, and its undated "Mantoux [Tuberculosis] Testing Policy". This is a repeat violation from a prior health complaint survey completed in August of 2024

59. Respondent failed to provide annual and new hire certification for the MSD, LPN #3, and Caregiver #2 documenting that they were communicable disease free upon hire and had completed their annual recertification.

60. Respondent was found to be out of compliance with its POC from November of 2024, and its undated policy on infection control. Respondent's LPN #1 failed to follow hand-washing procedure during medication administration for Resident #12, #15, #16. This is a repeat violation from a prior health complaint survey completed in August of 2024.

61. On or around March 11, 2025, LPN #1 used Resident #16's sink, hand soap, and paper towels, and used an alcohol rub when complete. LPN #1 used Resident #12's sink, hand soap, and having no

paper towels she used her bare hands to turn off the faucet and let her hands drip dry. LPN #1 used Resident #15's sink, soap, and towels, performed a blood sugar check, and used Resident #15's sink again when complete.

62. Respondent's Director of Nursing (DON) is not a licensed nurse in Tennessee. Respondent's DON had nursing license in Tennessee (40953) which was revoked in June of 1995 based on convictions in state and federal courts for Medicare and Medicaid Fraud. Her license was subsequently voluntarily surrendered in Mississippi on or around June 17, 1994 for failure to meet the generally accepted standards of such nursing practice. Respondent's DON was reinstated by Mississippi in 2022.

63. Respondent employed the DON without verifying her license status, criminal conviction, or registry status as required under T.C.A. 68-11-256 and T.C.A. 63-1-149.

III. GROUNDS FOR DISCIPLINE

The facts stated in Section II, *supra*, are sufficient to establish that grounds for the discipline of Respondent's license exist. Specifically, Respondent has violated the following statutes and/or rules, for which disciplinary action by the Commission is authorized:

64. The facts in paragraphs eight (8) through sixty-three (63) are sufficient to constitute a violation of Tenn. Comp. R. & Regs. 0720-26-.05 (4) [Regulatory Standards] - the relevant part of which reads as follows:

> (4) Upon a finding by the Commission that an ACLF has violated any provision of the Health Facilities and Resources Act, Part 2—Regulation of Health and Related Facilities (T.C.A. §§ 68-11201, et seq.) or the rules promulgated pursuant thereto, action may be taken, upon proper notice to the licensee, to impose a civil penalty, deny, suspend, or revoke its license.

65. The facts stated in paragraph twenty-six (26) are sufficient to establish that Respondent has violated T.C.A. § 68-11-213(k)(1-2) [Injunctions and penalties - Promulgation of regulations]. The relevant portion on which reads as follows:

> (1) After notification of deficiencies following a licensure or complaint survey, any facility licensed under this part has ten (10) days from the date of notification to submit an acceptable plan of correction. Should the facility submit a plan of correction that is deemed unacceptable by the commission, then the facility has an additional ten (10) days from the date of notification that the plan of correction is unacceptable to submit an acceptable plan of correction. The commission shall provide a facility with no less than three (3) opportunities to submit an acceptable plan of correction and provide clear guidelines so that the facility understands what a plan of correction must include to be deemed acceptable.
>
> (2) If a facility is not able to submit an acceptable plan of correction after three (3) attempts, then a representative from the facility shall appear before the commission and submit a plan of correction for the commission's approval.

66. The facts stated in paragraph twenty-six (26) are sufficient to establish that Respondent has violated Tenn. Comp. R & Regs. 0720-26-.05(2-3) et seq. [Regulatory Standards] . The relevant portion on which reads as follows:

> (2) Plan of Correction. When Commission inspectors find that an ACLF has committed a violation of this chapter, the [Commission], will issue a statement of deficiencies to the ACLF. Within ten (10) days of receipt of the statement of deficiencies, the ACLF must return a plan of correction including the following:
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> (a) How the deficiency will be corrected;
> (b) The date upon which each deficiency will be corrected;
> (c) What measures or systemic changes will be put in place to ensure that the deficient practice does not recur; and
> (d) How the corrective action will be monitored to ensure that the deficient practice does not recur.

(3) Either failure to submit a plan of correction in a timely manner or a finding by the Department of Health that the plan of correction is unacceptable may subject the ACLF's license to disciplinary action.

67. The facts stated in paragraphs twenty (20) through twenty-four (24) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.06(1)(a)(1) [Administration]. The relevant portion on which reads as follows:

(1) Each ACLF shall meet the following staffing and procedural standards:

(a) Staffing Requirements:

1. The licensee must designate in writing a capable and responsible person to act on administrative matters and to exercise all the powers and responsibilities of the licensee as set forth in this chapter in the absence of the licensee.

68. The facts stated in paragraph ten (10) and paragraphs twenty-nine (29) through thirty-five (35) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.06(1)(a)(4) [Administration]. The relevant portion on which reads as follows:

(1) Each ACLF shall meet the following staffing and procedural standards:

(a) Staffing Requirements:

4. An ACLF shall have a licensed nurse available as needed.

69. The facts stated in paragraphs thirty-six (36) and thirty-seven (37) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.07 (1)(b) [Services Provided], the relevant portion of which reads as follows:

(1) An ACLF may provide medical services as follows:

(b) All other medical services prescribed by the physician that could be provided to a private citizen in the citizen ' s home, including, but not limited to:

1. Part-time or intermittent nursing care;
2. Various therapies;
3. Podiatry care;
4. Medical social services;
5. Medical supplies;
6. Durable medical equipment; and
7. Hospice services.

70. The facts stated in paragraphs thirty-eight (38) and thirty-nine (39) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.07 (5)(a) [Services Provided], the relevant portion of which reads as follows:

(5) Resident medication. An ACLF shall:

(a) Ensure that medication shall be self-administered in accordance with the resident's plan of care.

71. The facts stated in paragraphs forty (40) and forty-one (41) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.07 (5)(d) [Services Provided], the relevant portion of which reads as follows:

(5) Resident medication. An ACLF shall:

(d) Store all medications via a locked or closed container and/or room which includes, but is not limited to, some type of box, piece of furniture, an individual resident room, and/or a designated room within the facility which maintains resident medication out of the sight of other residents.

72. The facts stated in paragraphs eleven (11) through sixteen (16) and forty-two (42) through forty-five (45) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.07(7)(a)(1) [Services Provided], the relevant portion of which reads as follows:

(7) An ACLF shall provide personal services as follows:

(a) Each ACLF shall provide each resident with at least the following personal services:

1. Protective care.

73. The facts stated in paragraphs seventeen (17) and forty-six through forty-eight (48) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.07(7)(a)(2) [Services Provided], the relevant portion of which reads as follows:

(7) An ACLF shall provide personal services as follows:

(a) Each ACLF shall provide each resident with at least the following personal services:

2. Safety when in the ACLF.

74. The facts stated in paragraphs thirty-six (36) and thirty-seven (37) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.12 (3)(g) [Resident Records], the relevant portion of which reads as follows:

(3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum:

(g) Notes, including, but not limited to, observation notes, progress notes, and nursing notes.

75. The facts stated in paragraphs eighteen (18) and forty-six (46) through forty-eight (48) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.12 (5)(a) [Resident Records], the relevant portion of which reads as follows:

(5) Plan of care.

(a) An ACLF shall develop a plan of care for each resident admitted to the ACLF with input and participation from the resident or the resident' s legal representative, treating physician, or other licensed health care professionals or entity delivering patient services within five (5) days of admission. The plan of care shall be reviewed and/or revised as changes in resident needs occur, but not less than semi-annually by the above-appropriate individuals.

76. The facts stated in paragraphs forty-nine (49) through fifty-five (55) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.13 (1) [Reports], the relevant portion of which reads as follows:

(1) The ACLF shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.

77. The facts stated in paragraphs forty-nine (49) through fifty-five (55) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.14 (1)(b) [Resident Rights], the relevant portion of which reads as follows:

(1) An ACLF shall ensure at least the following rights for each resident:

(b) To be free from mental and physical abuse. Should this right be violated, the ACLF shall notify the department and the Tennessee Department of Human Services, Adult Protective Services at 1-888-277-8366.

78. The facts stated in paragraphs forty-nine (49) through fifty-five (55) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.14 (1)(j) [Resident Rights], the relevant portion of which reads as follows:

(1) An ACLF shall ensure at least the following rights for each resident:

(j) To be treated with consideration, respect and full recognition of his or her dignity and individuality.

79. The facts stated in paragraphs fifty-six (56) and fifty-seven (57) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.06 (1)(b)(3) [Administration], the relevant portion of which reads as follows:

> (1) Each ACLF shall meet the following staffing and procedural standards:
>
> (b) Policies and Procedures:
>
> 3. An ACLF shall develop a written policy, plan or procedure concerning a subject and adhere to its provisions whenever required to do so by these rules. A licensee that violates its own policy established as required by these rules and regulations also violates the rules and regulations establishing the requirement.

80. The facts stated in paragraphs fifty-eight (58) and fifty-nine (59) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.06 (1)(b)(3) [Administration], the relevant portion of which reads as follows:

> (5) Infection Control
>
> (a) An ACLF shall ensure that neither a resident nor an employee of the ACLF with a reportable communicable disease shall reside or work in the ACLF unless the ACLF has a written protocol approved by the Commission's administrative office.

81. The facts stated in paragraphs sixty (60) and sixty-one (61) are sufficient to establish that Respondent has violated Tenn. Comp. R. & Regs. 0720-26-.06 (5)(c) [Administration], the relevant portion of which reads as follows:

> (5) Infection Control
>
> (c) An ACLF and its employees shall adopt and utilize standard precautions in accordance with guidelines established by the Centers for Disease Control and Prevention (CDC) for preventing

transmission of infections, HIV, and communicable diseases, including adherence to a hand hygiene program which shall include:

1. Use of alcohol-based hand rubs or use of non-antimicrobial or antimicrobial soap and water before and after each resident contact if hands are not visibly soiled.

82. The facts stated in paragraphs twenty-seven (27), twenty-eight (28), sixty-two (62), and sixty-three (63) are sufficient to establish that Respondent has violated T.C.A. § 68-11-256 (a) [Criminal Background Checks], the relevant portion of which reads as follows:

(a) All nursing homes, as defined in § 68-11-201, and assisted-care living facilities, as defined in § 68-11-201, shall have a criminal background check completed prior to employing any person who will be in a position that involves providing direct care to a resident or patient.

83. The facts stated in paragraphs twenty-seven (27), twenty-eight (28), sixty-two (62), and sixty-three (63) are sufficient to establish that Respondent has violated T.C.A. § 63-1-149 (a-b) [Registry Check], the relevant portion of which reads as follows:

(a) On and after October 1, 2010, before employing or contracting with any person who would be providing direct patient care, for whom a background check has not been completed, a health care professional licensed under any chapter of this title or title 68, chapters 24 and 140, shall initiate and perform a "registry check" which for the purposes of this section is defined as:
   (1) A state-by-state look in any state in which the person has lived in the previous seven (7) years of the national sex offender public registry website coordinated by the United States department of justice, including, but not limited to, the sexual offender registry maintained by the Tennessee bureau of investigation pursuant to title 40, chapter 39, part 2; and
   (2) Any adult abuse registry maintained for any state in which the person has lived in the previous seven (7) years; and
   (3) The department of health's elder abuse registry established pursuant to title 68, chapter 11, part 10.

(b) Should an applicant be listed on any of the registries listed in subdivisions (a)(1)-(3), the health care professional shall not employ or contract with the person if the person would be providing direct patient care.

IV. STIPULATED DISPOSITION

For the purpose of avoiding further administrative action with respect to this cause, the Commission and Respondent agree to the following settlement terms:

84. Respondent understands the allegations, charges, and stipulations in this Order. Entry into this Consent Order by the Respondent does not constitute an accord on its part as to the accuracy of the Commission's findings and conclusions drawn therefrom.

85. Respondent understands the rights found in the Code, Rules, and the Uniform Administrative Procedures Act, TENN. CODE ANN. §§ 4-5-101 thru 4-5-404, including the right to a hearing, the right to appear personally and by legal counsel, the right to confront and to cross-examine witnesses who would testify against Respondent, the right to testify and to present evidence on Respondent's own behalf, as well as to the issuance of subpoenas to compel the attendance of witnesses and the production of documents, as well as the right to appeal for judicial review. Respondent voluntarily waives these rights in order to avoid further administrative action.

86. Respondent agrees that presentation of this Order to the Commission and the Commission's consideration of it and all matters divulged during that process shall not constitute unfair disclosure such that the Commission or any of its members become prejudiced requiring their disqualification from hearing this matter should this Order not be ratified. All matters, admissions, and statements disclosed during the attempted ratification process shall not be used against the Respondent in any subsequent proceeding unless independently entered into evidence or introduced as admissions.

87. Respondent agrees that facsimile/PDF copies of this Order, including facsimile/PDF signatures thereto, shall have the same force and effect as originals.

88. Respondent also agrees that the Commission may issue this Order without further process. If the Commission rejects this Order for any reason, it will be of no force or effect for either party.

89. Respondent agrees that the facility has not received any threats or promises of any kind by the State or any agent or representative thereof, except such as is detailed herein.

V. ORDER

NOW THEREFORE, Respondent, for the purpose of avoiding further administrative action with respect to this cause, agrees to the following:

90. Respondent's license to operate as an ACLF shall be and is hereby **VOLUNTARILY SURRENDERED**, beginning the effective date of this Order. A voluntary surrender has the same effect as revocation.

91. Respondent's admissions shall remain SUSPENDED and no new residents shall be admitted to the facility.

92. A temporary manager, to be determined at the selection of the Commission and its staff, is hereby appointed to administer an orderly transfer of all residents within Royal Retreat within thirty (30) calendar days from the date of this Order.

93. Respondent shall provide the temporary manager with full and complete access to the facility, and all records and computer systems to provide care for the Residents and shall surrender operational control of the facility to the temporary manager.

94. Respondent shall notify all residents and family members regarding the imminent closure of the facility in a formal letter, the contents of which must be approved by the Commission's staff in advance of distribution.

95. In this letter, respondent must provide residents with a minimum of three choices of licensed assisted living facilities or nursing facilities, if applicable, for their chosen placement.

96. All residents must be removed from Royal Retreat **within 30 calendar days** from the date of this Order.

97. Respondent shall participate on daily calls with the Health Facilities Commission staff and external stakeholders until each and every resident is transferred.

98. Respondent shall work with TennCare and Area Agency on Aging and Disability to complete Pre-Admission Evaluation (PAE) and Preadmission Screening and Resident Review (PASRR) on any resident who may require a transfer to a higher level of nursing care.

99. Respondent shall grant immediate access to the facility to the Tennessee Health Facilities Commission, its surveyors who will be monitoring the transfer process, and to the representatives of the temporary manager to administer the building.

100. Respondent shall provide resident records, accounting, **including** any funds held in trust for each resident, transfer location, notification of each resident's responsible party, etc. as directed by Commission licensure staff and external stakeholders, as part of the transfer process for all residents residing in Royal Retreat as of August 1, 2025.

101. Pursuant to T.C.A. § 68-11-221, Respondent shall be responsible for the costs of any transfers and the costs of any monitoring.

102. Respondent shall be responsible for reimbursing the State the costs of the temporary manager.

103. The temporary manager will continue in that role at Royal Retreat until every remaining resident is transferred to an appropriate facility.

104. Respondent **SHALL** submit a final report to the Commission's administrative staff in the West Tennessee Regional Office (**WTRO**) in Jackson detailing the safe placement and location of each

resident residing in the facility as of August 1, 2025, and confirming that no more residents remain to be placed and that all resident funds have been accounted for and properly disbursed to the individual residents or their responsible party.

105. In consideration for the Voluntary Surrender of Respondent's license, the Executive Director for the Commission **does hereby waive** the Civil Monetary Penalties (CMPs) assessed on the Suspension of Admissions Order issued April 2, 2025.

106. In consideration for the waiver of the CMPs by the Executive Director, the Respondent will execute and file a dismissal ending their appeal of the Suspension of Admissions (SOA), docket number **25.05-252064A** filed with the Administrative Procedures Division of the Tennessee Secretary of State's Office.

107. All parties will be responsible for their own attorney's fees.

APPROVED FOR ENTRY:

Manivannan Sivalingam 8/6/25
Manivannan Sivalingam 8/6/25 (Aug 6, 2025 09:18:11 CDT)

Signature of Authorized Representative
Royal Retreat, LLC
License No. 279
Respondent

Manivannan Sivalingam
Printed Name of Authorized Representative

Administrator
Title of Authorized Representative for LLC

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Approval by the Commission

Upon the agreement of the parties, and the record as a whole, this **AGREED ORDER** was approved as a **FINAL ORDER** by a majority of a quorum of the Health Facilities Commission at a public meeting of the Commission and signed this 6th day of August, 2025.

ACCORDINGLY, IT IS ORDERED that the agreement of the parties does hereby become the Final Order of the Commission.

Chairperson
Health Facilities Commission

Logan Grant
Executive Director

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this document has been served upon the Respondent facility, Royal Retreat, by and through their counsel, Matt Sitton, Esq., Butler Snow, LLP via electronic service by email at matt.sitton@butlersnow.com

Jeremy J. Gourley, Esq., LLM
Senior Associate General Counsel