STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES

In the Matter of:	)	
	)	
GRACE CARE HOME, INC.	)	
d/b/a AZALEA TRACE ASSISTED LIVING	)	
ASSISTED CARE LIVING FACILITY	)	
NASHVILLE, TENNESSEE 37216	)	
RESPONDENT	)	**Docket No. 17.17-213986A**
	)	
TENNESSEE LICENSE No. ACLF 0000390	)	

AGREED ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 1st day of June , 2022, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **Grace Care Home, Inc. d/b/a Azalea Trace Assisted Living Care** (hereinafter "Respondent"), that the Board adopt this Agreed Order, the terms of which have been agreed upon by the parties, as signified by their signatures below.

Respondent, by signature to this Agreed 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 Board for ratification and all matters divulged during that process shall not constitute unfair disclosure such that the Board 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. Moreover, by entering into this Agreed Order, such should not be construed and/or considered as constituting any form of admission of any kind by Respondent of the truth of any facts alleged or the correctness of any conclusions set forth within this Agreed Order. Recognizing the risks and uncertainties involved and solely for the purposes of avoiding the uncertainties and expense involved, Respondent has elected to resolve this matter by entering into this Agreed Order. Likewise, this Agreed Order and the contents thereof shall not be used against Respondent in any other proceeding whatsoever.

JURISDICTION

The Board has the power 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. § 68-11-202(b)(1)(A) gives the Department the authority to conduct reviews of assisted-care living facilities to determine compliance with fire and life safety code regulations promulgated by the Board.

Tenn. Code Ann. § 68-11-210 provides that the Department 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. The Board has the authority to suspend or revoke the license of any facility licensed under Tenn. Code Ann. § 68-11-201 *et. seq.* The Board may also place a

facility on probation. Tenn. Code Ann. § 68-11-207(f)(2). If the Board determines during or at the end of the probation that the facility is not taking steps to correct non-compliance or otherwise not responding in good faith pursuant to the plan of correction, the board may take any additional action as authorized by law. Tenn. Code Ann. 68-11-207(f)(8).

The Board is also authorized to establish a system for assessing civil monetary penalties for assisted-care living facilities, adult care homes and traumatic brain injury residential homes that are in serious violation of state laws and regulations, resulting in endangerment to the health, safety and welfare of residents. Tenn. Code Ann. § 68-11-213(i)(2) and Tenn. Comp. R. & Reg. 1200-08-25-.05(4),(5).

Upon a finding by the Board that an assisted-care living facility has violated any provision of the Health Facilities and Resources Act, Part 2 -- Regulation of Health and Related Facilities 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. Tenn. Comp. R. & Reg. 1200-08-25-.05(4). The Board has established by rule a schedule designating the minimum and maximum civil penalties which may be assessed. Tenn. Code Ann. § 68-11-213(i)(2) and Tenn. Comp. R. & Reg. 1200-08-25-.05(4),(5)

Proceedings for disciplinary action against a facility are conducted in accordance with the Tennessee Administrative Procedures Act, Title 4, Chapter 5, of Tenn. Code Ann. Tenn. Comp. R. & Regs. 1200-08-25-.05(7). A Respondent in a disciplinary action is entitled to be represented by legal counsel, to personally appear before the Board, to present witnesses, to have subpoenas issued and to receive thirty (30) days' notice of the charges before being required to appear for a hearing. A Respondent who cannot afford legal counsel may be eligible for free or low-cost counsel. Tenn. Code Ann. § 4-5-101, *et seq.*

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STIPULATIONS OF FACT

1. At all times pertinent hereto, Azalea Trace Assisted Living, 4107 Gallatin Road, Nashville, Tennessee 37216, has been licensed as an assisted care living facility having been issued license number 00000390 on April 4, 2013. Respondent's license has an expiration date of April 4, 2022.

2. On or about January 4, 2021 through January 6, 2021, Department of Health surveyors conducted a complaint survey at the Respondent facility ("Respondent"). As a result of the survey, new admissions to the Respondent facility were suspended on February 1, 2021, and the facility was placed under a monitor.

3. The Respondent facility failed to follow its policy on smoking. A resident was smoking in the facility, and the administrator did not give the resident a written warning as required by the Respondent's policy. Smoking within the facility is a fire hazard.

4. The Respondent failed to ensure that all medications are administered by an appropriately licensed health care professional. The facility hired a medication technician to administer medications. However, the medication technician is certified in North Carolina, not Tennessee. Thus, the medication technician cannot administer medications in Tennessee. The Respondent facility's administrator contends that he was not aware that the medication technician could not administer medications in Tennessee.

5. The Respondent did not provide protective care for a resident. A caregiver employed by the Respondent stomped on the resident's toe causing bleeding and bruising. Further, the same caregiver made disparaging remarks toward the same resident, calling the resident fat and ugly.

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6. The Respondent failed to provide nutritional meals to the residents of the facility by not following the Registered Dietician's approved menu. Instead, the Respondent fed residents sandwiches at dinner every night without regard to the dietary needs of the residents. The Respondent's cook could not follow the approved menu due to the lack of available food. The Respondent facility's administrator contends that he purchased sufficient food. However, staff removed the food from the facility. He never filed a police report or otherwise reported the missing food.

7. On or about February 23, 2021 to February 25, 2021, the Department conducted another complaint survey at the Respondent facility. The findings are as follows:

8. The Respondent facility failed to ensure medications were self-administered in accordance with a resident's plan of care. The resident did not receive his nebulizer treatments as ordered on or around 10/14/2020. The resident did not receive his nebulizer machine until 1/29/2021.

9. The Respondent facility failed to provide protective care for 15 residents on or around 2/19/2021; 13 residents on or around 3/1/2021; and 12 residents on or around 3/2/2021 by not having a nurse on duty to administer their medications.

10. The Respondent facility left one resident in his room all night after the resident had broken the window inside of his room. It was 30 degrees outside.

11. Respondent facility left another resident in a room all night without any heat and a portable space heater was placed in her room. A portable space heater is a fire hazard.

12. The facility failed to ensure that one resident had transportation to his dialysis appointment's. Consequently, the resident missed several dialysis appointments.

13. The facility failed to provide a nurse to administer medications to one resident, which

resulted in uncontrolled pain and suicidal ideation. The resident was sent to the hospital on or around March 1, 2021 to March 2, 2021.

14. The Respondent facility failed to maintain an environment that was clean, safe, and sanitary. The facility floors were dirty, residents' bathrooms were dirty, and roaches were observed crawling on the floor of the facility.

15. On or around April 6, 2021, the Department conducted another complaint survey and found the following:

16. The Respondent facility failed to ensure that medications were administered in accordance with the residents' plan of care. Due to not having any overnight nursing staff, the day nurses were leaving 1 pain pill for 2 residents at the residents' bedside when the nurses left for the night. The nurses documented on the narcotic sheet that the pain pill was administered at 1 or 2 AM. However, there was no nurse on duty at those times. Further, the two residents did not have a physician order for the self-administration of medication.

17. On or around April 8, 2021, the Department conducted another complaint survey and found the following:

18. The Respondent facility failed to provide protective care for Resident #1 and #2 by leaving them unsupervised while smoking in the designated area. Resident #1 is blind and had burn spots on his shirt and pants.

19. The Respondent also failed to provide safety for Resident #1, who is blind, who eloped from the facility on the night of April 6, 2021 and was found by the police at the main road in front of the facility. Resident #1's plan of care was not updated to reflect his elopement risk or any interventions.

20. The Respondent facility's staff provided residents with the door code so that the residents could exit the building and smoke outdoors.

21. The Department conducted a revisit survey on or around April 26, 2021. The Respondent facility was deemed to not be in substantial compliance due to one resident administering his own nebulizer treatments without a physician's order as well as the facility's lack of a housekeeper.

22. The monitor, who has been assigned to the Respondent facility since the end of March, in her weekly reports for the month of May, documented multiple medications errors including medications documented as being administered when there was no nurse on duty as well as medications documented as signed out on the controlled substance log and not documented as administered on the medication administration report. Additionally, one or about May 24, 2021, the monitor discovered that the Respondent facility had run out of chemical detergent to use in the dish washer. Consequently, dishes were not sanitized in between uses.

23. On or around June 14, 2021, the Respondent facility relocated its residents to another long-term care facility due to the air conditioning unit going out in the facility. The unit had been out for at least six days.

24. After being relocated, some residents chose to permanently leave the Respondent facility. However, some residents did return after the air conditioning unit was repaired.

25. The Respondent facility has a history of deficient practice since on or around May 2020 when the current administrator assumed operation of the Respondent facility.

26. The current administrator is not knowledgeable of the Board's rules related to assisted care living facilities. He became the licensed operator of the facility without having any

previous experience in long term care. Though his intention was to provide quality care to the residents of the facility, his lack of knowledge of long-term care and the regulations led to multiple deficiencies as outlined in this Agreed Order. Those deficiencies placed the residents in danger of harm.

27. The Respondent facility had inadequate staffing and did not have the ability to properly maintain the physical building. The administrator and operator has since left the building, and the business is no longer in operation.

28. The Respondent facility had deficient practice placing its residents in an imminent threat of harm. A summary suspension hearing was conducted on June 23, 2021, and the board voted to summarily suspend the Respondent's license to operate as an assisted living facility in Tennessee.

GROUNDS FOR DISCIPLINE

The facts stated in the Stipulations of Fact section, *supra*, are sufficient to establish that grounds for the discipline of Respondent's Assisted-Care Living Facility license exist. Specifically, Respondent has violated the following statutes and/or rules, for which disciplinary action by the Board is authorized.

29. The facts stated in paragraphs four (4), eight (8), nine (9), twelve (12), thirteen (13), sixteen (16), twenty-one (21) and twenty-two (22) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07 [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;

30. The facts stated in paragraphs three (3), five (5), nine (9) through eleven (11), thirteen (13) through twenty (20), and twenty-three (23) through twenty-eight (28) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07 [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.

31. The facts stated in paragraphs three (3), five (5), nine (9) through eleven (11), thirteen (13) through twenty (20), and twenty-three (23) through twenty-four (24) are sufficient to establish that Respondent has violated the provisions of Rule 1200- 08-25-.07 [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.

32. The facts stated in paragraph twenty-one (22) through (24) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07 [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 (6) Non-medical living assistance with activities of daily living.

33. The facts stated in paragraphs nineteen (19) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07 [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 (3) Daily awareness of the individual's whereabouts;

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34. The facts stated in paragraph six (6) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07 [SERVICES PROVIDED], the relevant portion of which reads as follows: (7) An ACLF shall provide personal services as follows: (c) Dietary services. 1. An ACLF shall have organized dietary services that are directed and staffed by adequate qualified personnel. An ACLF may contract with an outside food management company if the company has a dietitian who serves the ACLF on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section while providing for constant liaison with the ACLF for recommendations on dietetic policies affecting resident treatment. 2. An ACLF shall have an employee who: (i) Serves as director of the food and dietetic service; (ii) Is responsible for the daily management of the dietary services and staff training; and (iii) Is qualified by experience or training. 3. An ACLF shall ensure that menus meet the needs of the residents as follows: (i) The practitioner or practitioners, as qualified within the scope of practice, responsible for the care of the residents shall prescribe therapeutic diets as necessary. (ii) An ACLF shall meet nutritional needs, in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the residents. (iii) An ACLF shall have a current therapeutic diet manual approved by the dietitian readily available to all ACLF personnel (iv) Menus shall be planned one week in advance. 4. An ACLF shall: (i) Provide at least three (3) meals constituting an acceptable and/or prescribed diet per day. There shall be no more than fourteen (14) hours between the evening and morning meals. All food served to the residents shall be of good quality and variety, sufficient quantity, attractive and at safe temperatures. Prepared foods shall be kept hot (140°F. or above) or cold (41°F. or less) as

appropriate. The food must be adapted to the habits, preferences and physical abilities of the residents. Additional nourishment and/or snacks shall be provided to residents with special dietary needs or upon request. (ii) Provide sufficient food provision capabilities and dining space. (iii) Maintain and properly store a forty-eight (48) hour food supply at all times. (iv) Provide appropriate, properly repaired equipment and utensils for cooking and serving food in sufficient quantity to serve all residents

35. The facts stated in paragraph nineteen (19) and twenty-seven (27) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07 [SERVICES PROVIDED], the relevant portion of which reads as follows: (7) An ACLF shall provide personal services as follows: (c) Dietary services (5) An ACLF shall maintain a clean and sanitary kitchen 41. The facts stated in paragraph twenty-seven (27) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07 [SERVICES PROVIDED], the relevant portion of which reads as follows: (7) An ACLF shall provide personal services as follows: (c) Dietary services (6) Employees shall wash and sanitize equipment, utensils and dishes after each use

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ORDER

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

36. The license for Grace Care Home, d/b/a/ Azalea Trace Assisted Living is **VOLUNTARILY SURRENDERED.** Respondent understands that a voluntary surrender has the same effect as a revocation.

37. Prior to application for new licensure of any facility type licensed by this Board, the

current operator, Felix Ekwauzi, must pay any outstanding civil monetary penalties stemming from any Commissioner or Board order involving Respondent facility.

Payment shall be submitted to the following address within thirty (30) days of the effective date of this Order:

Tennessee Department of Health
Division of Health Care Facilities
Attn: Niraj Soni
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243

38. Upon ratification by the Board, the listing of the public discipline, including deficiencies and civil penalties on the Disciplinary Action Report pursuant to T.C.A. § 68-1-114.

Upon the agreement of the parties, this **AGREED ORDER** is approved as a **FINAL ORDER** by a majority of a quorum of the Tennessee Board for Licensing Health Care Facilities at a public meeting of the Board and signed this 1st day of June, 2022.

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

Chairperson
Board for Licensing Health Care Facilities

AGREED TO:

Felix Ekwauzi, Administrator
Grace Care Home,
d/b/a Azalea Trace Assisted Living
Respondent

6/1/'22
Date

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Mark Cole

6/2/22

Mark Cole, BPR # 020020
Senior Associate General Counsel
Tennessee Department of Health
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243
(615) 741-1611

Date

CERTIFICATE OF FILING

This Order was received for filing in the Office of the Tennessee Secretary of State, Administrative Procedures Division, and became effective on the 2 day of June, 2022.

Director
Administrative Procedures Division

CERTIFICATE OF SERVICE

A true and exact copy of this Agreed Order is being served upon Respondent, Grace Care Home, Inc. d/b/a Azalea Trace Assisted Living, Nashville, Tennessee 37216 by delivering same in the United States mail, via United States Postal Service first class, with sufficient postage thereon to reach its destination and via electronic correspondence at felix@azaleatraceliving.com

This _____ day of June, 2022.

Mark Cole
Senior Associate General Counsel

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