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

In The Matter of:	)	
	)	
South High Senior Living	)	Docket No. 25.05-245689A
Assisted Care Living Facility	)	
License No. 514,	)	
	)	
Respondent.	)	
	)	
Knoxville, Tennessee	)	

AGREED ORDER

This matter came to be heard before the Tennessee Health Facilities Commission ("Commission"), by and through the Office of Legal Services, and South High Senior Living ("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.

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, prescribe childcare centers, renal dialysis clinics, ambulatory surgical treatment centers, outpatient diagnostic centers, adult care homes, and traumatic brain injury residential home. T.C.A. § 68-11-202(a)(1).

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

3. An assisted care living facility ("ACLF") is 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).

4. "Primarily aged" means at least fifty-one percent (51%) of the population of the facility is at least sixty-two (62) years of age. Tenn. Comp. R. & Regs. 0720-26-.02(34).

5. The ACLF shall provide on-site to its residents' room and board and non-medical living assistance services appropriate to each resident's needs, such as assistance with bathing, dressing, grooming, preparation of meals and other activities of daily living. T.C.A.§ 68-11-201(4)(B) and Tenn. Comp. R. & Regs. 0720-26-.02(2).

6. 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. T.C.A. § 68-11-210(c).

7. Upon a finding by the Commission that an ACLF has violated any provision of Tenn. Code Ann. §§ 68-11- 201, 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. T.C.A.§ 68-11-207.

II. STIPULATIONS OF FACT

8. At all times pertinent hereto, Respondent, South High Senior Living, 835 Tipton Avenue, Knoxville, Tennessee 37920, was licensed by the Commission as an ACLF, having been granted license number 514 on July 8, 2020, which currently has an expiration date of July 7, 2025. At all times pertinent to this order, the facility license was held by South High LLC, doing business as South High Senior Living.

A. COMMISSION'S POSITION

9. On or around March 20th, 2023, Respondent failed to ensure that three (3) of fifty-one (51) residents evacuated within the time required of thirteen (13) minutes during a third shift fire drill. Respondent's Executive Director was present with the surveyor when the deficiency was identified, and they acknowledged the deficiency during the exit conference on that same day.

10. On or around April 12th, 2023, Respondent's Administrator reviewed photographs and medication delivery logs with the State which showed that Respondent's staff had failed to properly dispose of unused or expired medications correctly for three (3) residents. The medications were disposed of in a regular trash receptacle in violation of the Respondent's Medication Destruction policy.

11. On or around April 12, 2023, Respondent's staff member #7 confirmed that they had witnessed staff member #6 dispose of the medications in the trash receptacle at the nurse's station.

12. On or around September 14, 2022, Resident #4 exited the back door of Respondent's facility that morning and was assisted back into the building. Resident #4 was noted in

nursing progress notes to be displaying signs of mental disturbance at this time. No interventions were found to have been put in place after this event for increased supervision. Later in the evening, Resident #4 again exited Respondent's facility and began to cross the street before they were stopped. No interventions were found to have been put in place after this event to prevent Resident #4 from eloping. Attempts were made by Respondent's staff to reach Resident #4's POA to discuss transfer to a secure memory unit.

13. Further review of the Respondent's nursing notes for Resident #4 confirmed that on or about the morning of September 19, 2022, staff reported that "this weekend" Resident #4 was seen exiting a residential house nearby.

14. On or around April 12, 2023, Respondent's Administrator acknowledged that the facility staff failed to provide interventions for Resident #4 to prevent elopement off the property and did not sign the resident out.

B. RESPONDENT'S POSITION

15. Respondent's facility was cited during the survey for violating Tenn. Comp. R. and Reg.0720-26-.08(8) because a state surveyor alleges that during a third shift fire drill conducted on March 20, 2023, between 10:30 p.m. and 11:15 p.m., three (3) of fifty-one (51) residents failed to evacuate in the required thirteen (13) minutes.

16. The Respondent has evidence that these three (3) residents could, and in fact, had, properly participated in facility fire drills and were in fact able to evacuate within the required thirteen (13) minutes, or other circumstances that mitigate against the surveyor's findings, as explained below.

    a. One resident cited (DP) had successfully evacuated during past fire drills and subsequent fire drills during the months prior to the survey.

b. Facility staff informed Commission surveyors that the resident (MA) was on hospice, and for the benefit of the resident staff would not evacuate that resident for a drill. This was at time due to recent decline and overall health status for that resident.

c. Resident (JS) was a one-person transfer, but the caregiver on shift did not attempt to get him up. The Facility caregiver stated to the surveyor, "I am not doing that for just a drill, he takes two people at times." He was a one-person transfer and was evaluated as such prior to this drill on March 20, 2023. He was again evaluated as a one-person assist the following day by a physical therapist at the Facility.

d. The Respondent's Administrator refutes that they "agreed" with the deficiencies cited.

e. Respondent would argue that each resident cited was able to evacuate during previous and subsequent fire drills, of which the Facility has documentation. The Facility conducted fire drills both before and after March 20, 2023, that evacuated all residents successfully within the required thirteen (13) minutes on the dates noted in the Facility's fire drill records.

f. The regulation at Tenn. Comp. R. and Reg.0720-26-.08(8) Admissions, Discharges, and Transfers directs that an ACLF may not retain a resident who cannot evacuate within thirteen (13) minutes. While the surveyor did note these four (4) residents did not successfully evacuate on March 20,

2023, the Facility can present evidence rebutting the allegation that these residents were inappropriate for residence in the facility.

g. An ACLF resident qualifying for hospice care shall be able to receive hospice care services and continue as a resident if the resident's treating physician certifies that such care can be appropriately provided in the ACLF. Tenn. Comp. R. and Reg.0720-26-.08(5). On March 20, 2023, one of the identified residents noted above was receiving hospice services in the Facility. The Facility had documentation from the residents' physicians that care could appropriately be provided in the Facility. Additionally, since the residents did successfully evacuate both prior to the March 20, 2023 -- the Facility argues that their residence in the Facility was otherwise appropriate.

h. Respondent did not reasonably believe that these residents were incapable of evacuation as required, since they had done so previously, and that it would have been a significantly difficult decision morally and against the spirit of the law regarding aging-in-place for the facility to discharge an individual who, by the fact they were on hospice, were nearing the end of their life.

17. Respondent does not materially dispute that the staff member in question did improperly dispose of certain resident medications. However, the Statement of Deficiencies is misleading in how it describes the series of events involving that staff member, as well as the Facility's response to the improper procedure. Respondent also disputes that the "Facility" had any practice or repeated instances of failing to properly dispose of medications.

18. Respondent acknowledges that Staff member #6 improperly failed to give the medications that were disposed of, and instead placed them in a trash bag, and placed the trash bag in regular trash can. Respondent believes this was done by Staff Member #6 to conceal his actions and conduct. Staff member #6 was a nurse and a care director at the facility. Respondent's facility leadership had trained this person on the proper procedure for medication administration and proper disposal on multiple occasions as part of its normal initial and ongoing education and training of its staff. The medication in question was not unused or expired.

19. Respondent made no attempt whatsoever to conceal this event, and in fact filed an incident report regarding the event as soon as leadership was made aware of it. As noted in the statement of another staff member (#7) who discovered the improper disposal, this event occurred in January of 2023 – but the Facility administrator was not made aware of it until April 4, 2023, upon which, it was then promptly reported as per state requirements.

20. Respondent would present numerous factors to mitigate the culpability of the Facility for the above cited violation.

    a. The Facility had properly trained the staff member involved in the proper policies and procedures on multiple occasions.

    b. The Facility leadership promptly self-reported the event once it was made aware of it, whether or not it actually met the conditions for being reportable.

    c. The event was the result of the misconduct and actions of a single employee, who was terminated.

    d. The event also was isolated and not repeated.

Each of these are factors under T.C.A.§ 68-11-207 that the Health Facilities Commission (HFC) should consider before or in conjunction with imposing any sanctions.

21. Respondent would rebut the allegations of elopement and present proof at a hearing, and thus eliminate or reduce any penalty that could be assessed from them, as follows:

a. The medical records and nurses progress notes for Resident #4 reflect that the Facility was aware of and did respond to the resident's change in condition.

b. The examples of behaviors of Resident #4 that the Commission alleges to be "elopements" are not, in fact, elopements or issues of significant concern when the totality of the events is reviewed.

c. The Respondent's facility staff were aware of Resident #4's whereabouts.

d. The Resident retained the right to come and go within and out of the facility as unequivocally stated in the resident's rights section of the regulations for the Facility.

e. Respondent would show that Resident #4 walked out the back door on April 12, 2023, and began walking down to the parking lot, multiple attempts were made by staff to redirect the resident. Resident refused to cooperate and stated that her husband is coming to get her. Staff informed resident that her husband would have to come through the main entrance, resident stated that she would go in after that. Staff attempted to call Resident's daughter (POA) three (3) times, which went straight to voicemail each time. Resident #4 walked out front and started to walk across the street. Nurse and caregivers redirected resident to come back to the chairs out front. Resident #4 did not leave Respondent's property.

f. Respondent's staff will testify that the elopement event dated September 19, 2022, was not an "elopement", and that the staff were generally aware of this resident's whereabouts.

g. Respondent's staff will testify that Resident #4 regularly visited the occupant of the house across the street in her time at South High. Resident #4 had befriended this gentleman, visited regularly, and had always returned without incident. The gentleman (from the house across the street) frequently came over and sat out front with Resident #4 and other residents.

III. GROUNDS FOR DISCIPLINE

Respondent does not admit or concede the facts set forth by the Commission in Section 2(A) above. However, Respondent, for the sole purpose of avoiding an administrative hearing adjudicating this cause, does acknowledge that the Commission has evidence which, at a hearing, could be sufficient to establish that grounds exist for the discipline of Respondent's ACLF license. Specifically, Respondent agrees the stipulated disposition of this matter based on the Commission's position that it has violated the following regulations, for which disciplinary action by the Commission is authorized.

22. The facts in paragraph nine (9) are sufficient to constitute a violation of Tenn. Comp. R. and Reg.0720-26-.08(8), the relevant portion of which reads as follows:

> (8) An ACLF may not retain a resident who cannot evacuate within thirteen (13) minutes unless the ACLF complies with Chapter 19 of the 2006 edition of the NFPA Life Safety Code, and the Institutional Unrestrained Occupancy of the 2006 edition of the International Building Code.

23. The facts in paragraph ten (10) and eleven (11) affecting three residents are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 0720-26-.07(6)(c), the relevant portion of which reads as follows:

> (6) An ACLF shall dispose of medications as follows:
>
> (c) The ACLF shall properly dispose of prescription medication administered by the facility in accordance with the facility's medication disposal policy, which shall be written in accordance with current FDA or current DEA medication disposal guidelines.

24. The facts in paragraph twelve (12) through fourteen (14) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 0720-26-.12(5), 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.
>
> (b) The plan of care shall describe:
>
> 1. The needs of the resident, including the activities of daily living and medical services for which the resident requires assistance, i.e.,

what assistance/care, how much, who will provide the assistance/care, how often, and when;

"

IV. STIPULATED DISPOSITION

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

26. Respondent understands the allegations, charges, and stipulations in this Order. Entry into this Agreed 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.

27. 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.

28. 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.

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

30. 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.

31. 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:

32. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount of **one thousand dollars ($1,000.00)**. This CMP is issued for the deficiency cited on or about March 20th, 2023, for retaining residents who cannot evacuate within the required thirteen (13) minutes.

33. Respondent is hereby assessed **one (1)** Civil Monetary Penalty in the amount of **one thousand five hundred dollars ($1,500.00)**. This CMP is issued for the deficiency cited on April 12th, 2023, for failure to properly dispose of residents' medication.

34. Respondent is hereby assessed **one (1)** Civil Monetary Penalty in the amount of **one thousand dollars ($1,000.00)**. This CMP is issued for deficiency cited on April 12th, 2023, for failure to develop and maintain a plan of care for each resident.

35. The total of all Civil Monetary Penalties in this Order equal to **three thousand five hundred dollars ($3,500.00).**

36. Payment shall be submitted to the following address within **thirty (30) calendar days** of the effective date of this Order.

Tennessee Health Facilities Commission
Attention: Licensure and Regulation- Discipline
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243

PLEASE DO NOT REMIT PAYMENT UNTIL THE AGREED ORDER HAS BEEN RATIFIED AND APPROVED BY THE COMMISSION

37. Each condition of discipline herein is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

APPROVED FOR ENTRY:

Marshall McCauley
South High Senior Living
License No. 514
Signature of Authorized Representative
Respondent

Marshall McCauley
Printed Name of Authorized Representative

Executive Director
Title of Authorized Representative

Jeremy Gourley w/ permission by CCP

Jeremy Gourley (BPR # 022812)
Senior Associate General Counsel
Health Facilities Commission
665 Mainstream Dr. 2nd Floor
Nashville, Tennessee 37243
Office: (615) 741-7221
Fax: (615) 741-7051
Jeremy.J.Gourley@tn.gov

Christopher C. Puri

Chris Puri, Esq. (BPR # 019552)
Counsel
Bradley, Arrant, Boult, Cummings, LLP
1221 Broadway, Suite #2400
Nashville, Tennessee, 37203
Office: (615) 252-4643
Fax: (615) 252-4706
cpuri@bradley.com

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 27th day of August, 2025.

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

Chairperson
Tennessee Health Facilities Commission

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this document has been served upon the Respondent, South High Senior Living, c/o Chris Puri, Esq., Bradley Arant Boult Cummings LLP. A copy was sent via electronic mail to: cpuri@bradley.com and ED@southhighknoxville.com.

This 27th day of August, 2025.

w/ permission
BPR 034233

Jeremy Gourley
Senior Associate General Counsel