BEFORE THE TENNESSEE BOARD FOR LICENSING HEALTH CARE FACILITIES

In The Matter of:	)
	)
Azalea Trace Assisted Living	)
License No. 00000390	)
Assisted Care Living Facility	)
	)
	)
Respondent	)

ORDER OF SUMMARY SUSPENSION

This matter came to be heard before the Board for Licensing Health Care Facilities pursuant to Tennessee Code Annotated section ("T.C.A. §") 4-5-320(c) on June 23, 2021. The State presented evidence that the public health, safety, and welfare imperatively require this emergency action in light of the fact that the Respondent, **Azalea Trace Assisted Living, 4107 Gallatin Road, Nashville, Tennessee 37216**, has a history of significant deficiencies including, but not limited to, staffing shortages, inadequate food supply, unsanitary kitchen, and failure to provide safety for residents.

The Board, having heard and considered the positions of both the Tennessee Department of Health, Office of General Counsel ("State") and the Respondent, finds and concludes the following:

JURISDICTION

1. The Board for Licensing Health Care Facilities (hereinafter "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. § 68-11-210 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.

2. The Board 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).

3. In imposing the sanctions authorized in [§ 68-11-207], the board 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 continuous 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 board.

4. The board 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.

5. Under T.C.A. § 4-5-320(c), the Board has the authority to summarily suspend a license if it finds that the public health, safety, or welfare imperatively requires emergency action.

FINDINGS OF FACT

6. 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 has an active license with an expiration date of April 4, 2022.

7. 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 is currently under a monitor. The grounds for the suspension of admissions were as follows:

8. 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.

9. 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.

10. 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.

11. 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.

12. 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:

13. 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.

14. 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.

15. 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.

16. 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.

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

18. 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.

19. 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.

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

21. 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.

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

23. 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.

24. 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.

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

26. 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.

27. 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.

28. 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.

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

30. 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.

31. The current administrator is not knowledgeable of the Board's rules related to assisted care living facilities.

32. The Respondent facility continues to have inadequate staffing and continues to have the inability to properly maintain the physical building.

33. The Respondent facility's continued deficient practice places its residents in an imminent threat of harm and emergency action is necessary.

CONCLUSIONS OF LAW

The facts stated in the Findings of Fact section, *supra*, are sufficient to establish that grounds for the summary suspension of Respondent's license exist. Specifically, Respondent has violated the following statutes and/or rules, for which disciplinary action by the Board is authorized:

34. The facts stated in paragraphs nine (9), thirteen (13), fourteen (14), eighteen (18), twenty-one (21), 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:

(5) Resident medication. An ACLF shall:

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

35. The facts stated in paragraphs nine (9) through eleven (11), thirteen (13) through nineteen (19), twenty-one (21), and twenty-three (23) through twenty-nine (29) 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

36. The facts stated in paragraphs nine (9) through eleven (11), thirteen (13) through nineteen (19), twenty-one (21), and twenty-three (23) through twenty-nine (29) 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

37. The facts stated in paragraph seventeen (17) 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.

38. The facts stated in paragraphs twenty-four (24) and twenty-five (25) 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;

39. The facts stated in paragraph eleven (11) 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

40. 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.

POLICY STATEMENT

The summary suspension statute requires a showing that protection of "public health, safety, or welfare imperatively requires emergency action." T.C.A. § 4-5-320(c). The failures of the Respondent and Respondent's staff resulted in a serious threat to the health and safety of the residents residing in the Respondent's facility. The Board's position is that the severity of the Respondent's conduct constitutes a serious threat to the public health, safety, and welfare.

SUSPENSION

In consideration of the evidence presented, and pursuant to the authority granted under T.C.A. § 4-5-320(c), T.C.A. §§ 68-11-207(a), the Board hereby preliminarily finds that the misconduct of Respondent, **Azalea Trace Assisted Living**, is so severe that it imperatively requires emergency action in order to protect the public health, safety and welfare prior to the initiation of formal disciplinary charges.

It is therefore **ORDERED** that:

1. Respondent's license as an assisted care living facility, license #**00000390**, is hereby **SUMMARILY SUSPENDED, effective within 7 days of the effective day of this Order.**
2. Upon receipt of this Order, Respondent shall not accept any new residents.
3. Respondent shall safely relocate each resident that is currently residing in its facility.
4. Respondent shall submit a report to the Board's administrative staff detailing the safe placement of each resident currently residing in the facility.
5. The monitor shall remain in the Respondent facility until each resident is safely relocated.

SO ORDERED, this the 23rd day of June, 2021

Chairperson
Tennessee Board for Licensing Health Care Facilities

PREPARED FOR ENTRY:

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this Order of Summary Suspension has been served upon the Respondent, Azalea Trace Assisted Living, 4107 Gallatin Road, Nashville, Tennessee 37216, c/o Mr. Uche Felix Ekwuazi, Administrator, Azalea Trace Assisted Living, 4107 Gallatin Road, Nashville, Tennessee 37216 and Grace Home Care, Inc., 4107 Gallatin Road, Nashville, Tennessee 37216; by hand delivery on June 23, 2021, via email correspondence at felix@azaleatraceliving.com, and via certified mail, certified number _____ on this the 23rd day of June, 2021.

Kyonzté Hughes Toombs,
Deputy General Counsel

Mr. Ekwuazi: 7020 3160 0001 1682 0627

Azalea Trace: 7020 3160 0001 1682 0634