BEFORE THE TENNESSEE BOARD
FOR LICENSING HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Caring Estates	)	
4965 Brunswick Road	)	**Case No: 2017032751**
Arlington, TN 38002	)	
	)	
License No. 00000570	)	

CONSENT ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 4th day of October, 2017, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **Caring Estates** (hereinafter "Respondent") that the Board adopt this Consent Order, the terms of which have been agreed upon by the parties, as signified by their signatures below.

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 Consent 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 Consent 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.

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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 of Health ("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. 1200-08-11 *et. seq.*

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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. 1200-08-11-.03. 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. 1200-08-11-.03.

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. 1200-08-11-.03. 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.*

STIPULATIONS OF FACT

1. At all times pertinent hereto, **Caring Estates,** 4965 Brunswick Road, Arlington, TN 38002 has been licensed as a residential home for the aged ("RHA") by the Board, having been issued license number 00000570 on February 16, 2010. Respondent has an active license with an expiration date of July 20, 2018.
2. On or about May 9, 2017, life safety surveyors conducted a revisit to Respondent facility to ensure that the deficiencies cited on November 8, 2016 survey had been corrected.
3. On or about May 9, 2017, life safety surveyors observed that two (2) of three (3) oxygen

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cylinders in Resident #2's room were unsecured.

4. Further observation revealed that the hard ceiling in the hot water heater room had been cut out and had not been replaced. The area was open to the attic.

5. The facility also failed to provide documentation that ground fault circuit interrupters ("GFIC") were in wet areas.

6. The facility also failed to provide all residents rooms with a door leading to a corridor or to the outside.

7. The facility also failed to maintain night lighting.

8. Further investigation in the kitchen revealed that the electrical receptacle behind the fryer was not secured in the wall and the cover was damaged.

9. Surveyors also noted that a three (3) plug electrical adapter without a circuit breaker was in use between the two (2) beds in Room #2.

10. The owner of the facility also could not provide documentation of the annual fire alarm test.

11. To date, Respondent has failed to submit a Plan of Corrections to resolve the life safety deficiencies.

12. An annual licensure survey was performed at the facility on May 15, 2017.

13. In order for a resident to reside in an RHA, residents are required to be ambulatory. An ambulatory resident must be physically and mentally capable of finding a way to safety without physical assistance. The facility retained three (3) residents who did not meet the requirement of an RHA resident to be ambulatory.

14. The facility is licensed for eight (8) beds. At the time of the surveyors visit, ten (10) residents were found to be residing in the facility. Any admission of residents in excess of

licensed bed capacity is prohibited.

15. The facility retained four (4) residents in the home with diagnoses of Alzheimer's disease. The facility failed to have quarterly reviews which documented that care can appropriately or safely be given in the facility for the residents with Alzheimer's disease.

16. The facility was found to be administering medications to two (2) residents who were unable to perform self-administration of medications.

17. The facility failed to provide assistance in opening bottles, observing residents taking their medication, and checking self-administered doses for six (6) of nine (9) residents.

18. The facility failed to document any medication administration on medication administration records ("MARs") for the entire month of May 2017. Further, the MARs were not signed by a physician. As such, there was no documentation that residents had received their medications for the entire month of May 2017.

19. While present in the facility, surveyors observed that there was no menu for resident meals on May 12, 2017. When interviewed, a caregiver stated she did not have a menu for the date in question. The caregiver stated that she would just be making spaghetti with meat sauce for all the residents.

20. Observation revealed that the refrigerator in the kitchen had a temperature of sixty (60) degrees F. Items in the fridge included jello, ground beef, pimento cheese, mashed potato, lima beans, potato salad, yams, and spaghetti. The items in the refrigerator were not labeled or dated. A forty-eight (48) hours supply of food shall be maintained and properly stored at all times.

21. Medical record review for nine (9) of nine (9) residents in the facility revealed that the residents did not have a list of current medications signed by the physician contained in

their charts.

22. Continued medical record review revealed nine (9) residents did not have a MAR or list of current prescriptions continued within their medical records.

23. A complaint survey was performed at the facility from June 5, 2017 through June 28, 2017.

24. On or about June 5, 2017, when surveyors entered the facility, a total of eleven (11) residents were found by surveyors to be residing in the facility. Further investigation revealed that two (2) of the residents were permanent residents in the home. The third resident comes and goes at the facility. Respondent is only licensed for eight (8) residents. Respondent facility continues to exceed its licensed capacity by two (2) residents.

25. The Administrator was not in the facility on June 5, 2017, June 6, 2017, or June 27, 2017. Surveyors found that the Administrator was unavailable during the complaint investigation.

26. The Administrator failed to designate a capable and responsible person to act on her behalf during her absences. The Administrator also failed to demonstrate responsibility for all staff caring for residents within the home.

27. Based on observation and interview, the Administrator also failed to ensure that current liability insurance signage was posted at the main public entrance. The owner was unable to provide surveyors with current copies of liability insurance during the survey.

28. The Administrator failed to provide surveyors with a written log of residents residing within the facility for use in potential emergencies.

29. During a visit by the local police department, the owner was observed to flush resident

medication down the toilet. Upon interview with the surveyors, the facility owner admitted to destroying residents' personal property, in the form of medication, for two (2) of eleven (11) residents in the facility.

30. The Administrator also failed to ensure that only a licensed nurse administered medications to Resident #4. Upon observation, an attendant in the facility was observed to open the bottle of medication, remove a tablet, and hand the medication to Resident #4. The attendant is not licensed to administer medications.

31. During interview, the cook/attendant at the facility verified that she gave the medications to all residents when she was on duty. The cook/attendant stated that she did not document on the medication administration record when the medications were given. She further stated that no records were kept of medications self-administered by the residents.

32. Upon further medical record review, surveyors substantiated that the Administrator failed to ensure there were physician orders for medications and failed to ensure staff documented the medications that the residents were given or had taken for Residents #2, #4, #7, and #13.

33. Resident #13 resided in Respondent facility from May 17, 2017 through May 23, 2017. Review of hospital records for May 24, 2017, revealed that Resident #13 presented to the emergency department ("ED") at a local hospital with the complaint that she had "gotten dizzy and passed out twice." The resident's blood pressure in the ED was found to be 87/58. The ED physician's diagnosis was drug induced hypotension. The patient was then admitted to the hospital on May 25, 2017. There was no documentation at the Respondent facility which indicated when Resident #13 took blood pressure medications, how often she had taken the blood pressure

medication she had taken.

34. Review of Resident #13's medical revealed the following documentation, "5/10/17 – admitted to Caring Estates. 5/23/2017 – sister took patient home." Facility staff failed to document health information including changes in health status, medication, or care received for Resident #13.

35. On June 5, 2017, during an interview with the owner of the facility, the owner admitted that there were no physician orders for medication in the home. The owner further stated that the surveyor who was in the facility in May 2017 had told her that she needed physician orders. The owner stated that she did not have physician orders for the residents yet.

36. Respondent facility staff failed to ensure medications were stored so that no resident could obtain another resident's medication, as all medications were stored in a kitchen cabinet above the stove.

37. Since being cited for these deficiencies in both May and June 2017, the facility has failed to submit adequate Plans of Corrections to correct the cited deficiencies.

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 Residential Home for the Aged license exist. Specifically, Respondent has violated the following statutes and/or rules, for which disciplinary action by the Board is authorized.

38. The facts stated in paragraph three (3) and four (4) are sufficient to establish that

Respondent has violated the provisions of Rule 1200-08-11-.07(1)[Building Standards], the relevant portion of which reads as follows:

> (1) An RHA shall construct, arrange, and maintain the condition of the physical plant and the overall RHA environment in such a manner that the safety and well-being of the patients are assured.

39. The facts stated in paragraph five (5) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.07(13)[Life Safety], the relevant portion of which reads as follows:

> (13) Electrical drawings shall include where applicable:
>
> (a) A seal, certifying that all electrical work and equipment is in compliance with all applicable codes and that all materials are currently listed by recognized testing laboratories;
>
> (b) All electrical wiring, outlets, riser diagrams, switches, special electrical connections, electrical service entrance with service switches, service feeders and characteristics of the light and power current, and transformers when located within the building;
>
> (c) An electrical system that complies with applicable codes;
>
> (d) Color coding to show all items on emergency power;
>
> (e) Circuit breakers that are properly labeled; and
>
> (f) Ground Fault Circuit Interrupters (GFCI) that are required in all wet areas, such as kitchens, laundries, janitor closets, bath and toilet rooms, and within six (6) feet of any lavatory.

40. The facts stated in paragraph six (6) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.08(4)[Life Safety], the relevant portion of which reads as follows:

> (4) Each resident's room shall have a door that opens directly to the outside or a corridor which leads directly to an exit door and must always be capable of being unlocked by the resident.

41. The facts stated in paragraph seven (7) are sufficient to establish that Respondent has

violated the provisions of Rule 1200-08-11-.08(7)[Life Safety], the relevant portion of which reads as follows:

> (7) General lighting and night lighting shall be provided for each resident. Night lighting shall be equipped with emergency power.

42. The facts stated in paragraph eight (8) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.08(13)[Life Safety], the relevant portion of which reads as follows:

> (13) All electrical equipment shall be maintained in good repair and in safe operating condition.

43. The facts stated in paragraph nine (9) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.08(15)[Life Safety], the relevant portion of which reads as follows:

> (15) The electrical systems shall not be overloaded. Power strips must be equipped with circuit breakers. Extension courts shall not be used.

44. The facts stated in paragraph ten (10) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.08(21)[Life Safety], the relevant portion of which reads as follows:

> (21) All safety equipment shall be maintained in good repair and in safe operating condition.

45. The facts stated in paragraph thirteen (13) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.01(28)[Definitions], the relevant portion of which reads as follows:

> (28) Home for the Aged Resident. "A person who is ambulatory and who requires permanent, domiciliary care, but who will be transferred to a licensed hospital, licensed nursing home or licensed assisted care living facility when health care services are needed which must be provided in such other facilities."

46. The facts stated in paragraph fourteen (14) and twenty-four (24) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.02(6)[Licensing Procedures], the relevant portion of which reads as follows:

> (6) Any admission in excess of the licensed bed capacity is prohibited.

47. The facts stated in paragraph fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.05(7)[Admissions, Discharges, and Transfers], the relevant portion of which reads as follows:

> (7) A home for the aged shall not admit or retain residents who pose a clearly documented danger to themselves or to other residents in the home. Persons in the early stages of Alzheimer's disease and related disorders may be admitted only after it has been determined by an interdisciplinary team that care can appropriately and safely be given in the facility. The interdisciplinary team must review such persons at least quarterly as to the appropriateness of placement in the facility. The interdisciplinary team shall consist of, at minimum, a physician experienced in the treatment of Alzheimer's disease and related disorders, a social worker, a registered nurse, and a family member (or patient care advocate).

48. The facts stated in paragraph sixteen (16) and thirty (30) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06(2)[Personal Services], the relevant portion of which reads as follows:

> (2) Medications shall be self-administered. If the home chooses to employ a currently licensed nurse, medications may be administered by the nurse.

49. The facts stated in paragraph nineteen (19) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06(10)[Personal Services], the relevant portion of which reads as follows:

> (10) Residents shall be provided at least three (3) meals per day. The meals shall constitute an acceptable diet. 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 a safe temperature. Prepared foods shall be kept hot (140F or above) or (41F or less). The food must be adapted to the habits,

preferences, needs, and physical abilities of the residents.

50. The facts stated in paragraph twenty (20) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06(12)[Personal Services], the relevant portion of which reads as follows:

> (12) A forty-eight (48) hour supply of food shall be maintained and properly stored at all times.

51. The facts stated in paragraphs seventeen (17), eighteen (18), twenty-one (21), twenty-two (22), thirty-one (31), thirty-four (34), and thirty-five (35) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.10(1)(g)[Records and Reports], the relevant portion of which reads as follows:

> (1) An individual resident file shall be maintained for each resident in the home. Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the resident. These files shall be retained for one (1) year after the resident is transferred or discharged. The resident file shall include:
>
> (g) Health information including all current prescriptions, major changes in resident's habits, or health status, results of physician's visits, and any health care instructions.

52. The facts stated in paragraph twenty-five (25) and twenty-six (26) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(2)[Administration], the relevant portion of which reads as follows:

> (2) 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.

53. The facts stated in paragraph twenty-seven (27) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(6)[Administration], the relevant portion of which reads as follows:

(6) Each home for the aged shall:

(e) Post whether they have liability insurance, the identity of their primary insurance carrier, and if self-insured, the corporate entity responsible for payment of any claims. It shall be posted on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height and displayed at the main public entrance.

54. The facts stated in paragraph twenty-eight (28) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(6)(f)[Administration], the relevant portion of which reads as follows:

(6) Each home for the aged shall:

(f) Keep a written and up-to-date log of all residents and produce the log for the local fire department in the event of an emergency.

55. The facts stated in paragraph twenty-nine (29) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(6)(h)[Administration], the relevant portion of which reads as follows:

(6) Each home for the aged shall:

(h) Not allow an owner, responsible attendant, employee or representative thereof to act as a court appointed guardian, trustee, or conservator for any resident of the facility or any of such resident's property or funds, except as provided by rule 1200-08-11-.10.

56. The facts stated in paragraph thirty-six (36) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06(4)[Personal Services], the relevant portion of which reads as follows:

(4) All medications shall be stored so that no resident can obtain another resident's medications.

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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:

57. Respondent's license to operate as a Residential Home for the Aged shall be **placed on probation for no less than one (1) year.** During the period of probation, the Respondent shall submit an **acceptable** Plan of Correction.

58. If Respondent is administering medication to residents, Respondent facility shall hire a licensed nurse and will maintain the records of all prescriptions and MARs within each resident's file. If Respondent is unable to hire a licensed nurse, Respondent shall transfer all residents who cannot self-administer their own medications.

59. Respondent shall provide the Department with a schedule to expedite the removal of inappropriate residents from the facility. Respondent shall remove all inappropriate residents from the facility within seven (7) days of the date of this Order. Respondent shall provide written proof of the removal of such residents from the facility to the Board.

60. Respondent shall ensure that all staff undergo training on proper medication administration and disposal. Respondent shall provide written proof of such training to the Board.

61. Respondent shall NOT increase the bed count in this facility without prior written authorization from the Board.

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62. The Respondent facility shall appear at the June 2018 Board of Licensing for Healthcare Facilities' Board meeting and provide an update to the Board regarding whether or not the cited deficiencies have been corrected before probation of the facility's licensure will be lifted.

63. Failure to complete the requirements cited in paragraphs fifty-seven (57) through sixty-three (63) or any further serious violations affecting the health, safety, and welfare of the facility's residents shall result in Suspension of Admissions pending a prompt hearing by the Board.

64. 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 **CONSENT 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 4 day of October, 2017.

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:

Eshonishunetta Knight, Administrator
Caring Estates, LLC.
Respondent

9-8-17
Date

EK Initial

Caroline R. Tippens

10/4/2017
Date

Caroline R. Tippens (BPR#: 030375)
Assistant General Counsel
Department of Health
665 Main Stream Dr., 2nd Floor
Nashville, Tennessee 37243
(615) 741-1611

CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon Respondent, Administrator: ESHONISHUNETTA KNIGHT, c/o CARING ESTATES, LLC, 4965 BRUNSWICK ROAD, Arlington, TN 38002, by delivering same in the United States mail, first class, with sufficient postage thereon to reach its destination.

This 5th day of October, 2017.

Caroline R. Tippens

Caroline Tippens
Assistant General Counsel