BEFORE THE TENNESSEE BOARD
FOR LICENSING HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Cades Center, INC.	)	
82 Will McKnight Drive	)	**Case Number #: 201804380**
Jackson, TN 38301	)	
	)	
License No. ACLF 00000350	)	

CONSENT ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 5th day of February, 2019, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **Cades Center** (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.

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).

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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. 1200-08-25-.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.*

STIPULATIONS OF FACT

1. At all times pertinent hereto, Cades Center, INC. has been licensed as an Assisted-Care Living Facility by the Board, having been issued license number **00000350** on November 18, 2010. Respondent has an active license with an expiration date of April 21, 2019.
2. On or about August 29, 2018, surveyors conducted a complaint survey at Respondent facility.
3. During their time in the facility, surveyors observed unlicensed medication techs administering resident medications. The facility failed to ensure medications were

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administered by licensed personnel within their scope of practice.

4. Resident #1 was admitted to the facility in October 2017. Resident #1 was ordered Hydrocodone three hundred twenty-five (325) milligrams one table by mouth three (3) times a day for severe pain. Medication records revealed that no hydrocodone medication was available to administer to the resident as prescribed on June 23, 2018 and June 24, 2018. Resident #1 missed five (5) doses of medication. However, the medication administration record reflected that hydrocodone had been administered to Resident #1.

5. Resident #3 was admitted to the facility in March 2018. Resident #3 was diabetic. Beginning in March 2018, Resident #3 was to receive Levemir Flextouch 100 unit/ml 25 units twice (2) a day.

6. From June to July 2018, Resident #30 received Levemir 60 units daily, which was administered twice (2) daily, in derogation of the physician's orders.

7. On August 17, 2018, Resident #3's physician changed Levemir Flextouch to 70 units twice (2) a day. However, review of medical Records revealed that Resident #4 was administered 60 units daily by unlicensed personnel.

8. Resident #3 did not begin receiving Levimir Flextouch 70 units twice (2) a day until August 21, 2018.

9. Review of the medication administration records revealed that in June, July, and August, Resident #3 did not receive any noon blood sugar tests, due to Resident #3's refusal. There was no documentation that the physician was notified of Resident #3's refusal of noon blood sugar checks or that Resident #3's plan of care had been revised.

10. Resident #4 was admitted to the facility in June 2017 and was also diabetic.

11. Resident #4 was ordered Levimir Flextouch 100 unit/ml 24 units at bedtime and Novolog

[fast acting insulin] 100 units per milliliter with 10 units to be injected before breakfast and supper. Resident #4 was also ordered Novolin sliding scale insulin. Resident #4's physician ordered that Novolin insulin be administered based on the sliding scale of Resident #4's blood sugar.

12. Resident #4's medication administration record for June 2018 revealed the incorrect name of the insulin and incorrect dosages of the sliding scale insulin.

13. The facility could not provide documentation of Resident #4's blood sugar from June 1-2, 2018, despite documenting that Resident #4 had received multiple doses of insulin. Further, the facility could not provide documentation that Resident #4 had been administered bedtime doses of insulin as ordered on June 1-3, 2018.

14. On June 3, 2018, Resident #4's blood sugar was four hundred eighty (480). Sliding scale insulin was not administered in accordance with physician's orders.

15. On June 4, 2018, Resident #4's blood sugar was four hundred eleven (411). The facility failed to administer sliding scale insulin in accordance with Resident #4's physician orders.

16. On or about June 5, 2018, Resident #4 had a blood sugar of five hundred nineteen (519). Resident #4 was transferred to the hospital with high blood sugar and swelling of the right foot.

17. On June 11, 2018, Resident #4's third right toe was amputated. Resident #4 was discharged to a skilled nursing facility for rehabilitation.

18. On or about June 23, 2018, Resident #4 returned to the facility. Upon return to the facility, the incorrect Novolog sliding scale insulin continued to be administered by unlicensed personnel on June 23-30, 2018.

19. On June 25, 2018, Resident #4's physician decreased the Levemir from 35 units at bedtime to 22 units at bedtime. However, the medication administration record revealed the incorrect insulin and sliding scale had been transcribed onto the medication record. As a result, Resident #4 received the incorrect insulin amounts for all of July 2018. Resident #4's blood sugar was over four hundred (400) on seven (7) out of thirty-one (31) days in July. There was no documentation of the physician being notified in accordance with the physician's order.

20. The medication record for August 2018 also revealed that the incorrect sliding scale insulin had again been transcribed. Review of Resident #4's medical record revealed that Resident #4's blood sugar was over four hundred (400) on August 7 and August 10, 2018.

21. Resident #4 was admitted to the hospital with blood sugar of four hundred eighty-nine (489) on August 10, 2018. Resident #4 was treated in the emergency room for hyperglycemia with insulin and discharged back to the facility.

22. The facility failed to ensure blood sugar checks were performed, reported appropriately, and sliding scale insulin was administered as ordered by the physicians' care plan for Residents #1, #3, and #4. As a result, Resident #4 was hospitalized two (2) times for hyperglycemia between June and August 2018.

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.

23. The facts stated in paragraphs three (3) through twenty-two (22) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.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.

ORDER

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

24. Respondent's license to operate as an Assisted Care Living Facility shall be placed on probation for **no less than six (6) months.**

25. Within thirty (30) days of the ratification of the Board's Order, the Respondent shall submit a completed plan of correction for approval.

26. Respondent shall hire a licensed nurse to administer medications to residents. Such licensed nurse shall maintain the records of all prescriptions and medication administration records within each resident's file.

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

28. During the six (6) month period of probation, any serious violation affecting the health, safety, and welfare of residents within the facility shall result in a suspension of admissions pending a prompt hearing by the Board.

29. The assessment of three (3) civil monetary penalties in the amount of five hundred dollars ($500.00) each for a total assessment of one thousand five hundred ($1,500.00) dollars. 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: Eddie J. Stewart
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243

30. Respondent shall appear at the June 2019 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.

31. The terms listed in paragraphs twenty-four (24) through thirty-one (31) must be met before the facility may petition the Board to have its probationary status lifted. **The facility shall submit its petition in written form to be considered at a regularly scheduled Board meeting.**

32. 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 5th day of February, 2019.

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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:

Linda K. Burton, Administrator
Cades Center, INC.
Respondent

1/21/19
Date

Caroline R. Tippens, BPR # 030375
Assistant General Counsel
Tennessee Department of Health
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243
(615) 741-1611

2/5/19
Date

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CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon Respondent, Cades Center, Inc., by and through its Administrator, Linda K. Burton, 82 Will McKnight Drive, Jackson, TN 38301 and at Cades Center, INC, 300 Hopper Road, Lexington, TN 38351 by delivering same in the United States mail certified mailing # 7018 2290 0001 1403 0262 and via USPS first cmd 7018 2290 0001 1403 0286 class, with sufficient postage thereon to reach its destination.

This 6th day of February, 2019.

Caroline R Tippens

Caroline R. Tippens
Assistant General Counsel

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