BEFORE THE TENNESSEE BOARD FOR LICENSING HEALTH CARE FACILITIES

In The Matter of:	)	
	)	
Caring Estates, L.L.C.	)	**Docket #: 17.17-156412A**
4965 Brunswick Road	)	
Arlington, TN 38002	)	
	)	
License No. 00000570	)	

AGREED 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 **CARING ESTATES, L.L.C.** (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 unless independently entered into evidence or introduced as admissions.

I. 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.
2. 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.
3. 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).
4. 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).
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).

6. 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.*

II. FINDINGS OF FACT

7. Respondent admits and the State finds and concludes that Caring Estates, located at 4965 Brunswick Road, Arlington, TN 38002 has been licensed as a home for the aged, having been issued license number 00000570 on February 16, 2010. Respondent's license expired on July 20, 2019.

8. Respondent admits and the State finds and concludes that Respondent facility entered into a Consent Order before the Board of Licensing for Health Care Facilities in October 2017 placing the facility's license on probation for a period of one calendar year. The terms of the Consent Order required that during the period of probation, the Respondent shall:

   a) Submit an acceptable plan of correction to correct the deficiencies listed in the Consent Order;

   b) Hire a licensed nurse to maintain records of all prescriptions and medication administration records 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.

   c) Respondent shall provide the Department with a schedule to expedite the removal of inappropriate residents from the facility. Respondent shall remove all inappropriate

resident 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.

d) 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.

e) Respondent shall not increase the bed count of this facility without prior written authorization from the Board.

f) 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.

g) 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 a Suspension of Admissions pending a prompt hearing by the Board.

9. The State represents that, if a hearing were to be held in this matter, it is prepared to present evidence that in September 2018, surveyors and a detective entered Respondent facility and substantiated the following:

a) The facility failed to assume responsibility for the operations of the care home and to ensure residents received the care and services they needed; and

b) Qualified personnel in the home failed to administer medications and percutaneous endoscopic gastrostomy ("PEG") feedings.

c) The facility failed to provide required records to the state surveyor.

d) The facility failed to provide health records that were current and up to date for Employee #1. Employee #1 also did not have a personnel file.

e) The facility could not provide the surveyor with an up-to-date log of the residents in the care home and was not truthful about the number of residents residing in the home.

f) Employee #3 asked Employee #1 to remove a resident from the facility without the knowledge of the surveyor or detective onsite. The employee was stopped from removing the resident from the facility by the detective.

g) The facility failed to maintain medical records for Resident #10, a hospice patient, who required dressing changes

h) The facility failed to ensure the persons in charge provided the medical records of Resident #1 and #11 to the surveyor.

i) The facility failed to ensure health records were current and up-to-date for Employee #1. A health record for Employee #1 could not be located.

j) Resident #11 was bed bound, lower extremity amputee, who required PEG tube feedings, and liquid morphine sulfate administration for chronic pain. The facility failed to ensure a licensed person to administered morphine to Resident #11. Surveyors determined Resident #11 was a medically inappropriate resident, who needed a higher level of care.

k) The facility failed to ensure a written admission agreement and patient rights were obtained for Residents #1 and #11.

l) The facility failed to ensure a written statement regarding fees and services were provided to Residents #1 and #11.

m) The facility failed to ensure Residents #1 and #11 were provided contact information for Adult Protective Services.

n) The facility failed to ensure an interdisciplinary team reviewed admissions and performed quarterly reviews for residents with dementia diagnoses.

o) The facility failed to ensure the plan of correction from the September 2017 was followed regarding medication administration to residents.

p) The facility failed to ensure resident safety by allowing medications to be accessible to residents and by blocking a fire door.

q) The facility violated resident rights by withholding mail.

10. The State represents that, if a hearing were to be held in this matter, it is prepared to present evidence that based on the findings of the September 2018 survey, the Board suspended admissions to Respondent facility effective October 9, 2018. A practice monitor was assigned to the facility as soon as the Suspension of Admissions was issued, pursuant to Tenn. Code Ann. § 68-11-221.

11. The State represents that, if a hearing were to be held in this matter, it is prepared to present evidence that as of December 2018, five thousand nine hundred eighty-four dollars and seventy cents ($5,984.70) in monitoring fees remain unpaid. The deficiencies and monitoring fees in this matter remain outstanding.

12. Respondent represents that, if a hearing were held in this matter, that on or about December 14, 2018, the Department received a copy of Respondent's wall license in the mail along with a final closure notice from Respondent facility.

13. Respondent represents that, if a hearing were to be held in this matter, it is prepared to present evidence rebutting the State's claims and evidence. Respondent asserts that the facility is closed.

III. CONCLUSIONS OF LAW

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

14. The facts stated in paragraphs seven (7) through fifteen (15) are sufficient to establish that Respondent has violated Tenn. Code Ann. §68-11-207(a)(1) and (a)(3):

> (1) A violation of this part or of the rules and regulations or minimum standards issued pursuant to this part, or, in the event of a nursing home that has entered into an agreement with the department to furnish services under Title XVIII or XIX of the Social Security Act, compiled in 42 U.S.C. § 1395 et seq. and 42 U.S.C. § 1396 et seq., respectively, any of the requirements for participation in the medical assistance program set out in title 42 of the Code of Federal Regulations, to such an extent that the board considers the licensee a chronic violator; and
>
> (3) Conduct or practice found by the board to be detrimental to the welfare of the patients in such institutions.

15. The facts stated in paragraph seven (7) through fifteen (15), if proven, are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(1) [ADMINISTRATION], the relevant portion of which reads as follows:

> (1) The licensee shall be at least eighteen (18) years of age, of reputable and responsible character, able to comply with these rules, and must maintain financial resources and income sufficient to provide for the needs of the residents, including their room, board, and personal services.

16. The facts stated in paragraphs seven (7) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(6)(c) [ADMINISTRATION], the relevant portion of which reads as follows:

(6) Each home for the aged shall:

(c) Maintain documentation of the checks of the "Registry of Persons Who Have Abused or Intentionally Neglected Elderly or Vulnerable Individuals" prior to hiring any employee.

17. The facts stated in paragraphs seven (7) through fifteen (15) 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 up to date log of all residents and produce the log for the local fire department in the event of an emergency.

18. The facts stated in paragraphs seven (7) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(6)(i) [ADMINISTRATION], the relevant portion of which reads as follows:

(6) Each home for the aged shall:

(i) Cooperate in the Department's inspections including allowing entry at any hour and providing all required records.

19. The facts stated in paragraphs seven (7) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(7) [ADMINISTRATION], the relevant portion of which reads as follows:

(7) No occupant or employee who has a reportable communicable disease, as stipulated by the department is permitted to reside or work in a home unless the home has a written protocol approved by the Department.

20. The facts stated in paragraphs seven (7) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.05(1)(e)[ADMISSIONS, DISCHARGE, AND TRANSFERS], the relevant portion of which reads as follows:

(1) Only residents whose needs can be met by the facility within its licensure category shall be admitted.

21. The facts stated in paragraphs seven (7) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.05(3)(b) [ADMISSIONS, DISCHARGES, AND TRANSFERS], the relevant portion of which reads as follows:

(3) The home shall:

(b) Have a written admission agreement that includes a procedure for handling the transfer or discharge of residents and that does not violate the residents' rights under the law or these rules.

22. The facts stated in paragraphs seven (7) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.05(3)(c) [ADMISSIONS, DISCHARGES, AND TRANSFERS], the relevant portion of which reads as follows:

(3) The home shall:

(c) Have an accurate written statement regarding fees and services which will be provided upon admission.

23. The facts stated in paragraphs seven (7) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.05(5) [ADMISSIONS, DISCHARGES, AND TRANSFERS], the relevant portion of which reads as follows:

> (5) Individuals who are usually, typically, or customarily incapable of self-administering medications or who require medications that are usually, typically, or customarily not self-administered shall not be admitted to or retained in the home unless provided by a home care organization or physician.

24. The facts stated in paragraphs seven (7) through 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 the 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 the placement in the facility. The interdisciplinary team shall consist of, at a 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).

25. The facts stated in paragraphs seven (7) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.05(12) [ADMISSIONS, DISCHARGES, AND TRANSFERS], the relevant portion of which reads as follows:

(12) Any residential facility licensed by the Board of Licensing for Health Care Facilities shall upon admission provide to each resident the division of adult protective services' statewide toll-free number: 888-277-8366.

26. The facts stated in paragraphs seven (7) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06(3) [PERSONAL SERVICES], the relevant portion of which reads as follows:

(3) Assistance in reading labels, opening bottles, reminding residents of their medication, observing the resident while taking medication and checking the self-administered dose against the dosage shown on the prescription are permissible in the self-administration of medications.

27. The facts stated in paragraphs seven (7) through fifteen (15) 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 medication.

28. The facts stated in paragraphs seven (7) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.08(8) [LIFE SAFETY], the relevant portion of which reads as follows:

(8) Corridors and exit doors shall be kept clear of all equipment, furniture and other obstacles at all times. There shall be a clear passage at all times from the exit doors to the safe area.

29. The facts stated in paragraphs seven (7) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.11(14) [RESIDENT RIGHTS], the relevant portion of which reads as follows:

(14) To send and receive unopened mail.

V. ORDER

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

30. **CARING ESTATES, L.L.C.,** agrees to **VOLUNTARILY SURRENDER** its license to operate as a home for the aged.

31. A voluntary surrender has the same legal effect as a **REVOCATION.**

32. Respondent facility shall cease operations as a home for the aged **IMMEDIATELY.**

33. Respondent's voluntary surrender (revocation) constitutes disciplinary action, and upon ratification by the Board, this disciplinary action will be reported on the Disciplinary Action Report pursuant to T.C.A. § 68-1-114.

34. Eshonishonetta Knight and Mary Louise Knight both agree never to operate a facility or apply for licensure to operate any residential facility providing residential or skilled nursing care to any aged, disabled, or incapacitated persons.

35. Failure to comply with the terms set forth in paragraphs thirty-three (33) through thirty-seven (37) will result in the Department immediately initiating a petition for injunctive relief or any other relief available in law or equity, pursuant to Tenn. Code Ann. § 68-11-213.

Upon the agreement of the parties, this **AGREED ORDER** was 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 5 day of February, 2019.

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

René Saunderson
Chairperson
Board for Licensing Health Care Facilities

AGREED TO:

Eshonishonetta Knight
Eshonishonetta Knight
Administrator & Co-owner
Caring Estates, L.L.C.

2/4/19
Date

Mary Louise Knight
Mary Louise Knight
Licensee and Co-Owner
Caring Estate

I signed this because I don't have the money to fight those allegations which are some not true.

2/4/2019
Date

2/4/2019
Date

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2/5/19
Date

Ricky E. Wilkins
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2/5/19
Date

Caroline R. Tippens, BPR # 030375
Assistant General Counsel
Tennessee Department of Health
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(615) 741-1611

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 7 day of February, 2019.

J. Richard Collier
Administrative Law Judge
Administrative Procedures Division

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this document has been served upon the Respondent, Eshonishonetta Knight, by and through her attorney, Garrett Asher, Surber, Asher, Surber & Mouson, PLLC, Plaza 1, Suite 480, 220 Athens Way, Nashville, TN 37228 and to Ricky E. Wilson, attorney for Mary Louise Knight, Law Offices of Ricky E. Wilkins, 66 Monroe Avenue, Suite 103, Memphis, TN 38103, by delivering same in the United States mail, first class, with sufficient postage thereon to reach its destination.

This 8th day of February 2019.

Caroline R. Tippens
Assistant General Counsel