BEFORE THE TENNESSEE BOARD
FOR LICENSING HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Carriage Court of Memphis	)	
1645 West Massey	)	**Case Number: 2018051971**
Memphis, TN 38120	)	
	)	
License No. ACLF 00000061	)	

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 June, 2019, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **Carriage Court of Memphis** (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 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).

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, Carriage Court of Memphis, located at 1645 West Massey, Memphis, TN 38120, has been licensed as an Assisted-Care Living Facility by the Board, having been issued license number 00000061 on September 11, 1998. Respondent has an active license with an expiration date of May 12, 2019.
2. In April 2018, the facility was cited by life safety surveyors for failure to evacuate Residents #23, #34, and #35 within the thirteen (13) minute evacuation period.
3. On or about June 12, 2018, the Department conducted a follow-up complaint survey at

the Respondent facility.

4. On or about June 29, 2018, the facility was cited again for a second offense for failure to evacuate residents within the thirteen (13) minute evacuation period

5. On or about October 3, 2018, Respondent entered into a Consent Order for failure to conduct fire drills. The facility agreed to the assessment of one thousand dollars ($1,000.00) in civil monetary penalties. A copy of the Consent Order is attached hereto as Exhibit 1.

6. On or about October 18, 2018, the Department conducted a life safety survey. On or about October 23, 2018, the Department conducted a complaint investigation at Respondent facility. The following deficiencies were cited which jeopardized the health, safety, and welfare of the residents therein.

7. Resident #1 was admitted to Respondent facility with diagnoses of dementia and osteoporosis.

8. Resident #1 was found on the floor in her room on August 20, 2018.

9. On or about August 31, 2018, Resident #1 began receiving physical therapy due to lower extremity weakness and unsteady gait.

10. Resident #1's care plan was not updated to reflect Resident #1's issues with weakness and unsteady gait, nor were any new interventions put in place by staff to ensure the safety of Resident #1.

11. On or about October 18, 2018, Resident #1 fell during an emergency fire drill and sustained a fractured hip and clavicle. Resident #1 was left on the floor until fire drill was completed.

12. Resident #1's plan of care indicated that she was to be provided assistance when

evacuating in an emergency. However, Resident #1's care plan failed to state how staff would assist her during an emergency evacuation.

13. Interview the facility's Administrator revealed that there were no specific steps or directions for staff to assist residents out of the facility during an emergency evacuation.

14. Resident #2 was admitted to Respondent facility with diagnoses of altered mental status.

15. Resident #2's care plan indicated that Resident #2 had a potential for falls and required observation for safety needs. However, Resident #2's care plan failed to specify how frequently Resident #2 should be observed by staff.

16. On or about August 15, 2019, Resident #2 was found by staff on her bathroom floor.

17. The facility failed to provide documentation that a Fall Risk Took had been completed or that Resident #2's care plan had been revised following this incident.

18. On or about October 8, 2018, Resident #2 lost her balance in her room and was assisted to the floor by staff.

19. The facility failed to provide documentation that Resident #2's care plan had been revised with interventions to assist with the safety needs of Resident #2.

20. On or about October 18, 2018, Resident #2 lost her balance as she was walking down the hall as part of a fire drill.

21. The facility failed to provide documentation that the resident's care plan had been revised to assist with safety interventions for Resident #2 to assist with preventing falls.

22. Respondent facility also failed to ensure it provided safety interventions for Resident #1 and Resident #2 during daily functioning and during emergency fire evacuations. The facility also failed to provide assistance for all residents requiring assistance during emergency evacuations.

23. The facility administration failed to ensure the fire safety procedures specified the manner in which staff would assist residents residing in the assisted care living facility and residents residing in the secured unit in the event of a fire emergency, which resulted in the fall and injury of Resident #1.

24. On or about February 26, 2019, surveyors conducted a follow up complaint and fire safety survey at Respondent facility. On or about February 28, 2019, surveyors also conducted a health related survey. As a result of these surveys, the following deficiencies were observed;

25. The facility was not able to provide fire safety surveyors with a copy of the updated roster of the correct number of residents in the facility.

26. Surveyors on the premises observed that the facility was not able to evacuate four (4) of the ninety-three (93) residents within the required thirteen (13) minutes during a fire drill, as the facility failed to evacuate Residents #43, #69, #70, and #71.

27. The facility failed to have an adequate number of keys to evacuate Resident #70 from a locked resident room. As such, Resident #70 was unable to evacuate.

28. Surveyors also observed that only seventeen (17) staff members had not been trained on fire and evacuation procedures.

29. Resident #1 was admitted to the facility in January 2019 with diagnoses of dementia, depression, lupus, and hypertension.

30. Resident #1 experienced multiple falls in January and February 2019. Resident #1 was found on the floor in her room on February 24, 2019. The facility revised her care plan noting that Resident #1 required additional monitoring and assistance with toileting. However, the revision to the care plan failed to indicate how often Resident #1 should be

monitored.

31. The facility failed to follow its Plan of Correction to ensure it provided safety interventions for all residents in the facility.

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.

32. The facts stated in paragraphs two (2) through twenty (20), twenty-eight (28) through thirty-one (31) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(7)(a)(2)[Services Provided]:

> (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.

33. The facts stated in paragraphs two (2) through twenty (20) and twenty-eight (28) through thirty-one (31) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.12(5)(a)[Resident Records]:

> (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.

34. The facts stated in paragraphs two (2) through twenty (20) and twenty-eight (28) through

thirty-one (31) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.12(5)(b)[Resident Records]:

(5) Plan of Care.
(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.

35. The facts stated in paragraphs two (2) through twenty-seven (27) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.16(1)[Admissions, Discharges, and Transfers]:

(1) An ACLF shall have in effect and available for all supervisory personnel and staff written copies of the following disaster, refuse and/or evacuation plans readily available at all times:
(a) Fire Safety Procedures Plan shall include:
(1) Minor fires;
(2) Major fires;
(3) Fighting the fire;
(4) Evacuation procedures; and
(5) Staff functions.

36. The facts stated in paragraphs twenty-three (23) through twenty-seven (27) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.06(1)(c)[Admissions, Discharges, and Transfers]:

(1) Each ACLF shall meet the following staffing and procedural standards:

(b) An ACLF shall keep a written up-to-date log of all residents that can be produced in the event of an emergency.
(c)

37. The facts stated in paragraphs twenty-three (23) through twenty-seven (27) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.08(8)(a)[Admissions, Discharges, and Transfers]:

(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

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NFPA Life Safety Code, and the Institutional Unrestrained Occupancy of the 2006 edition of the International Building Code.

ORDER

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

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

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

40. During the six (6) month period of probation, any new 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.

41. The assessment of six (6) civil monetary penalties in the amount of one thousand dollars ($1,000.00) each for a total assessment of six thousand dollars ($6,000.00).

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

42. 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.

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43. Respondent agrees to pay costs for all revisit surveys incurred by the Department after February 26, 2019. The Department will prepare an assessment of cost in this matter. Such costs shall not exceed ten thousand dollars ($10,000.00). The facility may pay this amount in installment payments. A payment plan may be set up by contacting Eddie J. Stewart, at the address listed above.

44. The terms listed in paragraphs thirty-seven (37) through forty-three (43) 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.**

45. 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 June, 2018. **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:

Lisa Taylor Bobal, Administrator
Carriage Court of Memphis

4-18-19
Date

Caroline Tippens

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

6/5/2019
Date

CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon Respondent, Carriage Court of Memphis, ATTN: Lisa Taylor Bobal, 1645 West Massey, Memphis, TN 38120, and by sending a copy to the parent corporation, WC-Memphis, OPS, LLC, 303 East Wacker Drive, Suite 2400, Chicago, IL 60601 by delivering same in the United States mail, certified return receipt numbers # 7018 2290 0001 1403 1948 and 7018 2290 0001 1403 1955 a United States Postal Service first class, with sufficient postage thereon to reach its destinations.

This 6th day of June, 2019.

Caroline Tippens

Caroline R. Tippens
Assistant General Counsel