BEFORE THE TENNESSEE BOARD
FOR LICENSING HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Friendship Haven, Inc.	)	
950 Dodson Ave	)	**CASE # 202003189**
Chattanooga, TN 37406	)	
	)	
RHA License #00000603	)	

CONSENT ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 17th day of December, 2020, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **Friendship Haven, Inc.** (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.

DBM Initial

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. § 68-11202(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. § 6811210 provides that the Department shall conduct onsite 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

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1. At all times pertinent hereto, **FRIENDSHIP HAVEN, INC.,** 950 Dodson Avenue, Chattanooga, TN 37406 has been licensed as Residential Home for the Aged ("RHA") by the Board, having been issued license number 00000603 on April 16, 2014. Respondent has an active license with an expiration date of April 15, 2021.
2. On or about July 21 – July 28, 2020 and August 12-13, 2020, complaint investigations were conducted at Friendship Haven, Inc.
3. Resident #1, aged 88, was admitted to the facility in December 2019. The admission

documents that Resident #1 signed contained a statement that stated, "The resident cannot require nursing home care."

4. The administrator confirmed no history nor physical was entered into the medical record upon Resident #1's admission. The Administrator stated that her diagnoses were insulin dependent diabetes and dementia. Upon her initial admission, the Administrator stated that Resident #1 was ambulatory.

5. In April 2020, Resident #1 was ordered home health. When assessed by home health, Registered Nurse #1 (RN#1) documented that Resident #1 was unable to take injectable medications unless administered by another person. RN #1 also contacted Resident #1's physician as she had concerns regarding Resident #1's bilateral heel unstageable pressure ulcers. Resident #1 also had concern that the facility wasn't appropriately administering Resident#1's insulin.

6. Interview with the Administrator confirmed that the facility did not have any medical records regarding the administration of Resident #1's insulin. Further, the Administrator stated that he did not consider Resident #1's pressure ulcers as a sudden adverse change in condition and he did not have any documentation on file related to her pressure ulcers.

7. Resident #1's physician ordered that the facility's caregiver perform wound care when skilled nursing/home health was unable to perform wound care. However, review of the Resident's file revealed no documentation that wound care was provided by the facility.

8. On June 5, 2020, home health nurses documented that Resident #1 had five pressure ulcers, a sacral wound, and that Resident #1 was chair bound, unable to transfer herself, and unable to ambulate.

9. On or about June 8, 2020, home health ordered that Resident #1 be sent to the hospital, as

Resident #1's wounds had begun to smell. At the time of her transfer, the Administrator noted that she had pressure sores on both hips and her backside, but that she had developed these ulcers "shortly before she went to the hospital."

10. Resident #1 was admitted to the hospital with diagnoses of decubitus ulcers to both heels, decubitus ulcers to her right and left hips, and a sacral wound. Resident #1 also exhibited signs and symptoms of infection and was placed on antibiotics and provided wound care.

11. Despite the statements in Resident #1's admission documents, the facility's administrator stated that he did not have knowledge of facility licensure rules and standards requiring him to transfer a resident to a higher level of care.

12. The Administrator produced a one page document for Resident #1 from the home health agency. No other medical record was located for Resident #1. The facility was cited for failure to have a medical record for Resident #1 which contained a history and physical, a listing of Resident #1's medications in her file, and Resident #1's current health status, results of physician visits, or health care instructions.

13. Resident #3 was admitted to the facility in March 2018 with diagnoses of hypertension and blindness.

14. Resident #4 was admitted to the facility in February 2020 with diagnoses of dementia and Alzheimer's.

15. On or about August 12, 2020, surveyors noted that Residents #3 and #4 sat on the couch in the living room from approximately 2-7 PM. During this time, neither the Administrator nor his wife offered water or checked to see if either resident needed to utilize the restroom.

16. When it was time for supper, the Administrator physically dead-lifted Resident #4 from

the couch and put her in her wheelchair. Resident #4 was then pushed to the table and fed her supper.

17. On or about August 13, 2020, surveyors observed Resident #4 sitting her wheelchair at the table with the same clothes from August 12, 2020. Respondent facility asserts that the facility tried to transfer Resident #4 out of the facility and into a higher level of care, but were unable to do so due to COVID-19.

18. The facility failed to transfer Resident #1 to a higher level of care following the resident's decline in ability to self-administer insulin, ambulate, and the development of serious pressure ulcers. Respondent facility failed to monitor or offer hydration or use of a bathroom to Residents #3 and #4.

19. On the morning of August 13, 2020, surveyors observed the Administrator to administer medications to both Resident #3 and Resident #4. The Administrator was observed removing medications from the bubble pack, placing medications into medication cups, and handing the medications to Resident #3. The Administrator was feeding Resident #4 her breakfast and as he fed her, the Administrator added a tablet or capsule to her food and then gave Resident #4 a bite to eat with her medications. The Administrator acknowledged that he had to administer medications to Resident #3, as she was blind, and to Resident #4, as she was unable to feed herself.

20. Medications in the residential home for the aged setting must be self-administered. If the home chooses to employ a currently licensed nurse, medications may be administered by the nurse. In the present case, neither the Administrator nor his wife are nurses.

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.

21. The facts stated in paragraphs three (3) through seventeen (17) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R. & Regs. 1200-8-11-.05 (6) [Admissions, Discharges and Transfers] the relevant portion of which reads as follows:

> (6) Residents who require professional medical or nursing observation and/or care on a continual or daily basis or who require more technical medical or nursing care than the personnel and the home can lawfully offer on a short term basis as described in paragraph (3), shall be transferred to a licensed hospital, nursing home or assisted care living facility.

22. The facts stated in paragraphs five (5) and eighteen (18) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R. & Regs. 1200-8-11-.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.

23. The facts stated in paragraphs three (3) through seventeen (17) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R. & Regs. 1200811.10 (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.

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 a Residential Home for the Aged shall be placed on probation for **no less than one (1) calendar year.**

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. During the one year 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.

27. The assessment of three (3) civil monetary penalties in the amount of one thousand dollars ($1,000.00) each for a total assessment of three thousand dollars ($3,000.00).

28. Respondent agrees to pay five hundred dollars ($500.00) per month until the entirety of the three thousand dollars ($3,000.00) assessment of civil monetary penalties has been paid. 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

29. Respondent shall appear at the February, June, and October 2021 Board of Licensing for Healthcare Facilities' Board meetings and provide updates to the Board regarding whether or not the cited deficiencies have been corrected.

30. The terms listed in paragraphs twenty-four (24) through twenty-nine (29) must be met and all payment must be received in full 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 prior to a regularly scheduled Board meeting.**

31. 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 17th day of December, 202_.

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

René C. Saunders MD
Chairperson
Board for Licensing Health Care Facilities

AGREED TO:

David Bwana Machoka
Friendship Haven, Inc.
Respondent

12/05/2020
Date

DM Initial

Caroline R. Tippens

12/17/2020
Date

Caroline R. Tippens (BPR #: 030375)
Senior Associate 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 FRIENDSHIP HAVEN, INC., Attn: David Machoka, 950 DODSON AVENUE, Chattanooga, TN 37406 and FRIENDSHIP HAVEN, INC., Attn: David Machoka, 9461 MEMORY LANE, Ooltewah, TN 37363 by delivering same in the United States mail, first class, with sufficient postage thereon to reach its destination and via United States Certified Mail, Return Receipt #s 7020 1810 0000 5315 7347 and 7020 1810 0000 5315 7361.

This 18th day of December, 2020

Caroline R. Tippens
Senior Associate General Counsel