STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Legacy Assisted Living & Memory Care	)	
6551 Knight Arnold Road	)	**Docket #: 201904391**
Memphis, TN 38115	)	
License No. ACLF 00000279	)	

CONSENT ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 2nd day of October, 2019, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **Legacy Assisted Living & Memory Care at Lenox Park** (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 regarding this matter and any and all rights to judicial review of this matter. This matter is limited to the facts and discipline described in this Consent Order.

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.

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

1. At all times pertinent hereto, **Legacy Assisted Living & Memory Care at Lenox Park,** located at 6551 Knight Arnold Road, Memphis, TN 38115 has been licensed as an Assisted-Care Living Facility by the Board, having been issued license number **00000279** on June 13, 2006. Respondent has an active license with an expiration date of May 29, 2020.

2. On or about October 3, 2018, Respondent's license to operate as an assisted care living facility was placed on probation for one (1) calendar year from February 2019 through February 2020. Additional terms of the October 2018 Consent Order were as follows:

    a. The facility will hire a new Executive Director and Director of Nursing prior to the February 5, 2019 Board meeting.

    b. The facility shall install an electronic health records system to ensure that all medical records and plans of care are being correctly implemented.

    c. The facility shall install a new staffing system to ensure the appropriate level of care is in place for each resident.

    d. All employees shall receive training on the electronic health records and staffing system.

    e. The electronic health records and staffing system shall be installed by the end of March 2019 and shall remain in place.

f. A representative shall appear on behalf of the Respondent facility in-person at each regularly scheduled Board meeting for one (1) calendar year and provide reports to the Board regarding the progress of the facility to correct the outstanding deficiencies and to maintain compliance under the terms of this Order.

g. Respondent hereby agrees to remain under the Board's assessed Suspension of Admissions until the facility's Plan of Correction is accepted and all deficiencies have been corrected.

h. Respondent agrees to pay costs for all revisit surveys incurred by the Department since October 2018. The Department will prepare an assessment of cost in this matter. Such costs shall not exceed thirty thousand dollars ($30,000.00).

i. A representative from Respondent facility shall appear in-person before the Board at the February 2020 Board meeting and request that the Board lift its probation. Respondent must show adherence to the Plan of Correction and that any outstanding deficiencies from the November 2018 and January 2019 surveys have been corrected.

j. If after the suspension of admissions have been lifted, any new deficiencies affecting the health, safety, and welfare of the residents have been cited, shall result in a suspension of admissions pending a prompt hearing by the Board.

k. Any violation of this Order shall constitute a violation of this Agreed Order and will be grounds for additional discipline, up to and including, revocation of the facility's licensure.

3. On or about September 11, 2019 and September 16, 2019, surveyors conducted health and life safety surveys at Respondent facility. The surveys revealed serious deficiencies which

affected the health, safety, and welfare of the residents of Legacy Assisted Living.

4. Resident #1 was admitted to the facility in July 2019 with diagnoses that included Alzheimer's with mood and behavior disorders, and diabetes. Resident #1 was a fall risk. The facility contends that Resident #1 was placed on fall prevention protocol, but no documentation to this effect was provided during the survey.

5. Resident #1 was ordered physical and occupational therapy in August 2019. Physical therapists documented that Resident #1 was very unsteady on her feet and required the maximum assistance for transfers.

6. On or about August 16, 2019, Resident #1 was harder to rouse and exhibited difficulty in staying awake.

7. Resident #1 was sent to the emergency room and diagnosed with dehydration, altered mental status, and hypotension.

8. The facility could provide no documentation that Resident #1's plan of care had been revised to prevent dehydration after her emergency room visit.

9. On or about August 31, 2019, Resident #1 was found in the hallway, face down, and complaining of foot and back pain. Resident #1 was sent to the emergency room via ambulance.

10. Resident #1 returned to the facility after her emergency room visit. Although Resident # 1's plan of care indicated she was on fall prevention protocol , there was no documentation that Resident #1's plan of care was revised with new interventions to prevent falls or ensure her safety.

11. On or about September 3, 2019, Resident #1 fell trying to transfer herself to the toilet, but no bruising or injuries were noted.

12. There was documentation that Resident #1's plan of care was updated to prevent falls or ensure her safety.

13. On or about September 11, 2019, the Administrator confirmed that the facility was unable to provide documentation that Resident #1's plan of care had been revised with interventions to prevent falls, ensure safety, and prevent dehydration.

14. Resident #2 was admitted in February 2018 with diagnoses that include dementia and syncope.

15. On or about July 28, 2019, Resident #2 was observed coughing excessively during breakfast and was unable to finish the meal. The facility notified hospice and called Resident #2's physician. Hospice then arrived to visit Resident #2, as Resident #2 was unable to swallow. After the visit, Resident #2 was noted to have dysphagia at times, to cough after swallowing, and that Resident #2's diet should be pureed. There was no documentation provided by the facility that the facility had implemented new interventions to prevent Resident #2 from choking or interventions to assist Resident #2 with swallowing.

16. On or about July 30, 2019, Resident #2 was again observed coughing and to have dysphagia with even think liquids. Hospice documented that Resident #2 should possibly be placed on a diet of thickened liquids. There was no documentation provided by the facility which indicated that the facility implemented new interventions to prevent Resident #2's dysphagia or that Resident #2's physician had been notified.

17. On or about July 31, 2019, Resident #2 was discovered to be very lethargic and sleepy. Resident #2 could not feed due to risk of aspiration. Hospice and the physician were notified and a new order was put in place for thicker liquid nectar consistency. The facility

could not provide documentation that Resident #2's plan of care had been revised with new interventions for safety and preventive measures for dysphagia until three days after the resident's first incident of choking.

18. Resident #3 was admitted to the facility in June 2019 with diagnoses that included hypertension, stroke, and history of falls.

19. On or about August 4, 2 019, Resident #3 fell from her bed while trying to put on her pants.

20. The facility contends that Resident #3 was on fall prevention protocol, however, no documentation to this effect was provided during the survey. After her call, the facility could not provide any additional documentation that Resident #3's fall had been reviewed or that her plan of care had been revised with new interventions to prevent falls and ensure resident safety.

21. The facility failed to promote safety, prevent falls, and treat dysphagia for Residents #1, #2, and #3.

22. On or about September 16, 2019, surveyors substantiated that the facility failed to prohibit portable space heaters, as surveyors observed a portable space heater in the activities director's storage room.

23. On or about September 16, 2019, surveyors substantiated that the facility failed to conduct the following fire drills:

    a. Third shift, 4th quarter of 2018.

    b. Third shift, 1st quarter of 2019.

    c. Second and third shifts, 2nd quarter of 2019.

24. On or about September 16, 2019, the facility could not provide surveyors with documentation of the following disaster drills:

a. Severe hot weather;

b. Earthquake;

c. Flood;

d. Severe cold weather; and

e. Bomb threat.

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 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.

25. The facts stated in paragraphs three (3) through twenty-one (21) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.12(5)(a) [RESIDENT RECORDS], the relevant portion of which reads as follows:

> (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.

26. The facts stated in paragraphs twenty-two (22) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.10(2)(h) [LIFE SAFETY], the relevant

portion of which reads as follows:

(2) An ACLF shall ensure fire protection for residents by doing at least the following:

(h) Prohibit open flame and portable space heaters.

27. The facts stated in paragraphs twenty-three (23) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.10(3) [LIFE SAFETY], the relevant portion of which reads as follows:

(3) An ACLF shall conduct fire drills in accordance with the following:

(a) Fire drills shall be held for each ACLF work shift in each separate ACLF building at least quarterly.

28. The facts stated in paragraphs twenty-four (24) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.16(2) [DISASTER PREPAREDNESS], the relevant portion of which reads as follows:

(2) An ACLF shall comply with the following:

(a) Maintain a detailed log with staff signatures designating training that each employee receives regarding disaster preparedness.

(b) Train all employees annually as required in the plans listed above and keep each employee informed with respect to the employee's duties under the plans.

(c) Exercise each of the plans listed above annually.

V. ORDER

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

29. Respondent's license is already on probation. Respondent's probationary period shall be extended until June 2020 Board meeting.

30. Respondent will be suspended from admitting any new patients effective October 2, 2019. Respondent shall remain under the Suspension of Admissions until surveyors have deemed all deficiencies to be corrected.

31. If after the suspension of admissions have been lifted, any new deficiencies affecting the health, safety, and welfare of the residents have been cited, shall result in a suspension of admissions pending a prompt hearing by the Board.

32. The facility shall assess all residents and transfer any residents that require a higher level of care that the facility is unable to provide within thirty (30) days of the date of this Order.

33. For those residents that remain in the building, the facility must assess these residents and coordinate with their physicians to ensure that all plans of care are appropriately up to date and reflect the necessary interventions.

34. A representative shall appear on behalf of the Respondent facility in-person at each regularly scheduled Board meeting in February 2020 and June 2020 and provide reports to the Board regarding the progress of the facility to correct the outstanding deficiencies and to maintain compliance under the terms of this Order.

35. Respondent agrees to pay three (3) civil monetary penalties in the amount of five thousand dollars ($5,000.00) each, for a total assessment of fifteen thousand dollars ($15,000.00).

The facility may pay this amount in installment payments. A payment plan may be set up by contacting:

Eddie J. Stewart/Health Facilities Program Manager
Division of Health Licensure and Regulation
Office of Health Care Facilities, Licensure Supervisor
665 Mainstream Drive, Second Floor
Nashville, TN 37243

36. If there are any further deficiencies after October 2019 revisit survey, the facility agrees that the Department will file a Notice of Charges, and set this case for a hearing before the Board in February 2020.

37. Each condition of discipline herein is a separate and distinct condition. If any condition of this Agreed Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

38. Upon the agreement of the parties, this CONSENT 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 2nd day of October, 2019.

39. 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:

Paul Valentine
Legacy Assisted Living & Memory Care
at Lenox Park
Receiver

10/2/19
Date

Emily C. Taube
Jerry Taylor
Attorneys for the Receiver
Burr & Forman
222 2nd Ave S., Suite 2000
Nashville, TN 37201

10/2/19
Date

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

10.2.2019
Date

CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon the Receiver, Paul Valentine, by and through his counsel, Emily Taube & Jerry Taylor w Burr & Forman, 222 2nd Ave S., Suite 2000, Nashville, TN 37201 by delivering same in the United States mail certified mailing # 7017 0190 0001 0037 3074 and via USPS first class, with sufficient postage thereon to reach its destination.

This 31st day of October, 2019.

Caroline R. Tippens
Senior Associate General Counsel