STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Legacy Assisted Living and Memory Care	)	
6551 Knight Arnold Road	)	**Docket #: 17.17-192522A**
Memphis, TN 38115	)	

AGREED ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 6th day of February, 2020, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **LEGACY ASSISTED LIVING AND MEMORY CARE** (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).

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, **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. As a result of surveys in November and December 2017 survey, the facility entered into a Consent Order which was approved and ratified by the Board in April 2018. On or about June 6, 2018, the Board of Licensing for Health Care Facilities heard statements from both the facility and Department of Health surveyors that deficiencies cited on the May 22-23, 2018 survey were serious deficiencies affecting the health, safety, and welfare of the residents.

3. On or about June 6, 2018, the Board suspended the admissions to Respondent facility.

4. On July 16, 2018 through August 2018 surveyors were present at the facility for a revisit survey in which three (3) deficiencies were cited. As such, the facility remained under a Suspension of Admissions.

5. On or about August 16, 2018, the facility submitted a Plan of Corrections. A revisit survey was scheduled for September 2018.

6. On or about September 13, 2018 surveyors exited the facility. Surveyors recited the facility for failure to correct their deficiencies and one new deficiency.

7. On or about October 3, 2018, the facility appeared before the Board and entered into a new Consent Order.

8. On or about October 8, 2018, the facility submitted a Plan of Correction which was deemed to be acceptable to correct the September 2018 deficiencies.

9. From November 26, 2018 through December 6, 2018 surveyors conducted a revisit and complaint survey to ensure the September 2018 deficiencies had been corrected. A deficiency was recited from the revisit survey and new deficiencies were identified during the complaint investigation.

10. On or about December 11, 2018, pursuant to a petition filed under docket number CH-18-

1714 in the Chancery Court of Shelby County, Tennessee for the Thirtieth Judicial District at Memphis, the Chancery Court entered an order appointing KCP Advisory Group, LLC as Receiver (the "Receiver") for Respondent.

11. On or about February 5, 2019 the facility entered into an Agreed Order. Under the terms of the Agreed Order the facility was placed on probation from February 5, 2019 until February 5, 2020 unless earlier lifted by the Board. The facility also submitted a Plan of Correction with certain of the corrective actions being recited in the Agreed Order. The facility also agreed to remain under the Suspension of Admissions until the Plan of Correction was accepted and all deficiencies were corrected. The facility agreed a representative would appear at each Board meeting up to and including the February 2020 Board meeting and make progress reports to the Board at such meetings.

12. On or about May 9, 2019, as a result of a revisit survey conducted on May 22, 2018 – through May 23, 2018, the Department lifted the Suspension of Admissions. On or about October 2, 2019, the facility appeared before the Board and entered into an Agreed Order. In the Agreed Order, the facility agreed that 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.

13. On or about November 15, 2019 surveyors conducted a revisit survey and complaint investigation to determine if the deficiencies had been corrected.

14. Resident #1 was admitted to the facility in January 2018 with diagnoses of dementia, chronic obstructive pulmonary disease, diabetes, and hypertension.

15. In September 2019, Resident #1's care plan was amended to reflect that Resident #1's gait was to be monitored.

16. On or about September 12, 2019, Resident #1 was observed with multiple bruises. Resident #1's was transported to the VA hospital and diagnosed with a hematoma and admitted for treatment.

17. The facility verified that Resident #1's bruises were discovered on September 11, 2019, but were not reported until September 12, 2019.

18. After his hospitalization, Resident #1 returned to the facility. Resident #1's care plan was not revised with new interventions to promote safety or prevent falls.

19. Resident #1 began physical therapy in late September 2019. However, there was no documentation that Resident #1's care plan had been revised.

20. In October 2019, the facility conducted a quarterly review of Resident #1's care plan. The quarterly review did not address Resident #1's falls. No new documentation was found to ensure Resident #1's safety or prevent falls.

21. On or about October 27, 2019, Resident #1's care plan did address any interventions or tasks to prevent falls.

22. On or about October 28, 2019, Resident #1 fell and hit his head.

23. On or about November 3, 2019, Resident #1 fell and was observed with bandages on his arms. However, LPN #5 documented that there was no documentation of Resident #1's fall in his medical record.

24. On or about November 3, 3019, Resident #1's care plan was revised to note that his wounds were to be monitored. There were no new safety interventions for Resident #1's plan of care.

25. On or about November 4, 2019, Resident #1 was observed with numerous bruises.

26. On or about November 5-8, 2019, Resident #1 was observed with additional bruises to

his upper extremities.

27. On or about November 14, 2019, surveyors observed Resident #1 and noted multiple bruises, which included, but were not limited to his shoulders, hips, buttocks, groin, leg, arm and wrist.

28. Surveyors reviewed Resident #1's care plan from November 15, 2019 which revealed that the care plan had been revised to reflect that that Resident #1 would be toileted every two hours. No other interventions were listed to prevent injuries to Resident #1.

29. The facility was cited with failure to revise residents' plan of care with new interventions for Resident #1.

30. On or about December 12, 2019, surveyors conducted a complaint survey at Respondent facility.

31. Surveyors substantiated that the facility failed to investigate multiple allegations against LPNs #1, #2, #3, and #4. Surveyors substantiated that the facility failed to provide documentation of investigation of any of the reported allegations.

32. Resident #1 was admitted to the facility in April 2018 with diagnoses of dementia, hypertension, and diabetes.

33. In October 2019, Resident #1 was examined by a physician who indicated that although the resident was frail, the resident had a pleasant affect and exhibited no behaviors.

34. From October 2019 through November 2019, the facility did not document any changes in Resident #1's behavior.

35. On or about November 24, 2019, LPN #2 found Resident #1 covered in blood. At some point during the night shift, Resident #1 had severely lacerated his finger. Resident #2 was sent to the hospital due to his laceration of unknown origin.

36. Resident #1 received three (3) sutures to his finger and was ordered a Keflex dressing, along with antibiotics.

37. The facility did not obtain the Keflex dressing and antibiotics from the pharmacy until three (3) days after the order was received.

38. On or about November 29, 2019, Resident #1 was found on the floor in his room. The facility failed to notify Resident #1's physician or update Resident #1's plan of care.

39. On or about December 1, 2019, an order was received for antibiotic therapy due to an infection in Resident #1's finger.

40. On or about December 2, 2019, Resident #1 vomited coffee ground emesis. Resident #1's responsible party was notified. There was no documentation that Resident #1's physician was notified of his change in condition.

41. On or about December 2, 2019, a physician's order was received indicating that Resident #1 was to receive x-rays. Surveyors could locate no documentation that the x-rays were performed.

42. On or about December 2, 2019, Resident #1's physician arrived and requested that the resident be given five (5) units of insulin immediately and ordered that Resident #1 be rechecked in two (2) hours and the physician notified. The facility could provide no documentation that Resident #1 received the insulin, as ordered.

43. Nursing staff documented that Resident #1 continued to experience high blood sugar, but the facility could provide no documentation that Resident #1's physician was notified.

44. The physician also ordered a change to Resident #1's antibiotic therapy. There was no documentation that the new antibiotic therapy was administered.

45. Resident #1's physician also noted Resident #1 should be referred to hospice. Resident

#1's physician documented that Resident #1 had a diagnoses of sepsis.

46. On or about December 3, 2019, Resident #1 was found on the floor with coffee grounds emesis coming from his mouth. There was no documentation provided by the facility the Resident #1's physician was notified of this change in condition.

47. On or about December 4, 2019, Resident #1 was in the care of hospice. Resident #1 again vomited. Nursing staff documented that Resident #1 was dying.

48. Resident #1 expired shortly after 12 PM on December 4, 2019.

49. On or about December 4, 2019, Resident #1's medication administrator record was updated to reflect that Resident #1 had been administered antibiotics, several hours after Resident #1 had expired. Resident #1's medication administration record continued to be updated by nursing staff through December 9, 2019.

50. Resident #1's mediations, including Lorazepam, a controlled substance, were observed on the medication cart on or about December 13, 2019. Resident #1's controlled medications had not received proper disposal.

51. Surveyors also observed multiple items such as razors and bleach within reach of residents in the memory care unit.

52. Resident #2 was admitted to the facility in November 2016 with diagnoses of dementia.

53. On or about August 30, 2019, nursing staff documented that Resident #2 was struck in the back with a sign by Resident #4. Thereafter, Residents #2 and #4 engaged in an altercation. Resident #2 was observed angrily pacing the hall.

54. On or about August 30, 2019, Resident #2's physician ordered that Resident #2 be transferred to the hospital. The facility called Resident #2's responsible party who requested that the facility adjust Resident #2's medications and sedate the resident.

Resident #2 was transported to the hospital.

55. On or about August 31, 2019, Resident #2 was transported back to the facility with no new orders.

56. On or about September 2, 2019, Resident #2's medication as increased due to new behaviors. From September 4-5, 2019, Resident #2 continued to exhibit increased behaviors. The facility could provide no documentation that Resident #2's plan of care had been revised.

57. From on or about October 16, 2019 through November 16, 2019, Resident #2 exhibited aggressive behaviors. There was no documentation Resident #2's care plan had been revised to address aggressive behaviors or protect other residents.

58. On or about November 29, 2019, Resident #2 engaged in an altercation with two other residents. The residents were separated, but the facility could provide no documentation Resident #2's care plan was revised.

59. From on or about November 30, 2019 through December 3, 2019, Resident #2 exhibited aggressive behavior.

60. On or about December 3, 2019, Resident #2 kicked another resident. Resident #2 became verbally abusive and physically threatened staff. The facility called 9-1-1 and Resident #2 was transported by police to a psychiatric hospital. Resident #2 was returned to the facility later that evening. The facility could not provide any documentation that Resident #2's plan of care was revised in light of this incident.

61. At the time of the survey, Resident #2 was still present in the facility.

62. Resident #3 was admitted to the facility in June 2019 with diagnoses of stroke. Resident #3 was at risk for falls.

63. On or about October 29, 2019, Resident #3 had a fall. Resident #3 was ordered to use a call pendant for assistance.

64. On or about December 2, 2019, Resident #3 was wheeled into the dining room table by a caregiver resulting in a skin tear to Resident #3's forearm. The facility was unable to provide documentation that Resident #3's care plan had been updated to prevent further injury.

65. The facility could not provide documentation of any new safety education to staff after this incident.

66. Surveyors were in the facility from December 10-12, 22019 and did not observe any call pendants in resident rooms.

67. Interviews with multiple residents confirmed that call pendants were not in use.

68. Resident #4 was admitted to the facility in July 2019 with diagnoses of Alzheimer's. Resident #4 was placed on hospice in September 2019.

69. From December 9-11, 2019, nursing staff documented a golf ball sized pressure sore on the resident's bottom.

70. On or about December 12, 2019, the surveyor observed a tennis ball sized pressure sore on Resident #4's bottom.

71. The facility was unable to provide any documentation that Resident #4's plan of care had been revised to address pressure sores or preventative interventions.

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.

72. The facts stated in paragraphs one (1) through sixteen (16) are sufficient to establish that Respondent has violated the provisions of Tenn. Code Ann. § 68-11-207(a)(3), which indicates that the Board may suspend or revoke the license issued under this part based on any of the following grounds:

(3) Conduct or practice found by the board to be detrimental to the welfare of the patients in such institutions.

(c) In imposing the sanctions authorized in this section, the Board may consider all factors that it deems relevant, including, but not limited to, the following:

(1) The degree of sanctions necessary to ensure immediate and continued compliance;

(2) The character and degree of impact of the violation on the health, safety and welfare of the patients in the facility;

(3) The conduct of the facility against whom the notice of violation is issued in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and

(4) Any prior violations by the facility of statutes, regulations or orders of the Board.

73. The facts stated in paragraph fourteen (14) through twenty-nine (29), thirty-two (32) though forty-eight (48), fifty-two (52) through sixty-one (61), sixty-two (62) through sixty-five (65), and sixty-eight (68) through seventy-one (71) 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 reach 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.

(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.

74. The facts stated in paragraph thirty-one (31) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.06(1)(b)(2)[Administration] the relevant portion of which reads as follows:

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

(b) Policies and Procedures:

(2) An ACLF shall develop and implement an effective facility wide performance improvement plan that addresses plans for improvement for self-identified deficiencies and documents the outcome of remedial action.

75. The facts stated in paragraphs thirty-two (32) through fifty (50) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(3)[Services

Provided] the relevant portion of which reads as follows:

(3) Oversight of medical services in an ACLF shall be consistent with oversight provided in private residential settings as defined through rules and regulations promulgated by the applicable licensing boards and shall ensure quality of care to residents.

76. The facts stated in paragraphs forty-nine (49) and fifty (50) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(6)(c)[Services Provided] the relevant portion of which reads as follows:

(6) An ACLF shall dispose of medications as follows:

(c) The ACLF shall properly dispose of prescription medication administered by the facility in accordance with the facility's medication disposal policy, which shall be written in accordance with current FDA or current DEA medication disposal guidelines.

77. The facts stated in paragraph fifty-one (51) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(7)(a)(1)[Services Provided] the relevant portion of which reads as follows:

(7) An ACLF shall provide personal services as follows:

(a) Each ACLF shall provide each resident with at least the following personal services:

1. Protective care.

78. The facts stated in paragraphs fifty-two (52) through sixty-four (64) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(7)(a)(2)[Services Provided] the relevant portion of which reads as follows:

(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.

ORDER

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

79. The Respondent hereby agrees that the Respondent facility shall be **SUSPENDED**, effective June 3, 2020, if prior to that date, all deficiencies are not cleared and all of the following conditions are not met by the facility:

a. The Respondent facility must hire a new management company from a State approved provider list.

b. The management company must be in the facility five (5) days a week, one day of which must be a Saturday or Sunday. This 5-day-per-week requirement can be met if either the facility Administrator or Director of Nursing is a direct employee of the management company, and if another employee of the management company, to whom the Administrator or DON reports, is also on-site at the facility on a reasonably frequent basis, and as needed.

c. The receiver or its authorized representative must be in the facility one day a week. The authorized representative must be an individual who is contractually obligated to report direct to Mr. Paul Valentine. This authorized representative of the receiver will provide oversight of the management company, and coordinate with the consultant and the management company, and keep the receiver reasonably apprised as to the facility's compliance.

d. Within fourteen (14) days of the date of this Order, the Respondent facility shall hire a consultant from a State approved list who must submit every other month an acceptable report to Board staff which must contain the following:

1. the facility's staffing ratio;
2. the amount of payment that the facility is paying to a management company;
3. the number of residents in the facility;
4. a clinical assessment of each resident's condition;
5. each resident's payor source; and
6. a transfer plan for each resident which must be updated bi-monthly.

e. Each resident shall be issued a notice of discharge thirty (30) days prior to June 3, 2020, in case the facility is unable to comply with these terms.

f. If the Respondent facility is unable to comply with these terms, the facility hereby agrees that all residents will be transferred out of the facility by June 3, 2020.

g. If Respondent facility is able to comply with the terms set forth in paragraph 79(d)(1-6) and successfully clear all its deficiencies, the suspension set to take effect June 3, 2020 shall be null and void, and Respondent facility shall be able to apply to have their probationary status lifted at the June 3, 2020 Board meeting.

80. In order to facilitate the Respondent Facility's compliance with this Agreed Order, the appropriate representatives of the Department will participate with the receiver and/or its counsel and representatives in a conference call upon the submission of each report by the consultant.

81. 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 **AGREED 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, 2020.

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:

By Paul Valentine on behalf of KCP Advisory Group, LLC as Receiver For Legacy Assisted Living & Memory Care at Lenox Park with permission

2-5-20
Date

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2-5-20
Date

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Senior Associate General Counsel
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665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243
(615) 741-1611

2/05/2020
Date

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 6th day of February, 2020.

Stephanie Shackleford, Director
Administrative Procedures Division

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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 #s 7019 0700 0001 2470 9360 7019 0700 0001 2470 9377 via USPS first class, with sufficient postage thereon to reach its destination.

This 7th day of February, 2020.

Caroline R. Tippens

Caroline R. Tippens
Senior Associate General Counsel