BEFORE THE TENNESSEE BOARD
FOR LICENSING HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Legacy Assisted Living and Memory Care	)	
6551 Knight Arnold Road	)	**Case Number 2017061531**
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 3rd day of October, 2018, 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.

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, **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, 2019.

2. On or about November 1, 2017 through December 4, 2017, surveyors conducted a complaint survey at Respondent facility. The surveys revealed serious deficiencies which affected the health, safety, and welfare of the residents of Legacy Assisted Living.

3. As a result of the 2017 survey, the facility entered into a Consent Order which was approved and ratified by the Board in April 2018. The terms of the Consent Order are as follows:

   a. Respondent shall hire a qualified consultant, at its expense, to enter the facility and work with the facility for a period of six (6) months to cure any remaining deficiencies and to submit an acceptable Plan of Correction (POC). At the outset of this period, the consultant will work with the facility to establish a work plan for curing any remaining deficiencies with specific, measureable goals. A copy of the work plan will be shared with the State within forty-five (45) days of the entry of this Consent Order. The acceptable POC must be submitted within six (6) months of the Board's Order.

   b. For the first two (2) months following the entry of the Consent Order, this consultant will work on site at the facility for a minimum of two (2) days per week and shall be available and involved in the operation of the facility even when not on site including direct contact with the Administrator and Director of Nursing ("DON"). This consultant will report to the owner-operators on a daily basis. The consultant will also submit a weekly report to the owner-operators addressing issues of concern or areas of improvement. The facility will update the State every two (2) weeks with a report that has been approved by the consultant.

   c. After the first two (2) months, the owner-operators and consultant will reassess the

level of achievement in moving through the performance improvement plan and determine what level of continued involvement is appropriate to achieve any remaining objectives on the performance improvement plan. However, the consultant will continue to work on site at the facility for a minimum of one day per week and shall continue to be available and involved in the operation of the facility even when not on site. The consultant will also continue to submit a weekly report to the owner-operators addressing issues of concern or areas of improvement. The facility will continue to update the State every month with a report that has been approved by the consultant.

d. During the six (6) month period, 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.

e. Following the initial six (6) month period, Respondent shall appear before the Board and submit quarterly reports until the end of calendar year 2019, prepared by the Respondent, regarding the adherence of the facility to the regulations cited in the December 2017, February 2018, and March 2018 Statement of Deficiencies.

f. Respondent shall ensure that all staff undergo in-service training regarding recognition of changes in patient condition, updates to the plan of care, and medical record-keeping and documentation. Respondent shall provide written proof of completion of such training to the Board within the six (6) months of the date of the Board's Order.

g. Respondent facility agreed to pay the assessment of nine (9) civil monetary penalties in the amount of five hundred dollars ($500.00) each for a total assessment

of four thousand five hundred ($4,500.00) dollars.

4. 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 were serious deficiencies affecting the health, safety, and welfare of the residents.

5. From March 2018 until the revisit survey in May 2018, Legacy Assisted Living reduced the number of cited deficiencies from thirty (30) to fourteen (14). Nonetheless, pursuant to Tenn. Code Ann. § 68-11-207(6), the Board determined that the conditions in Legacy Assisted Living were or were likely to be, detrimental to the health, safety, or welfare of the residents and suspended the admissions to the facility, effective June 6, 2018 at 5:00 P.M.

6. On July 16, 2018 through July 24, 2018 surveyors were present at the facility for a revisit survey to determine if the plan of corrections had been implemented and to investigate six (6) new complaints.

7. From May 2018 to July 2018, Legacy Assisted Living reduced the number of cited deficiencies from fourteen (14) to three (3).

8. Legacy Assisted Living retained a consultant as outlined in the Consent Order; submitted a POC as outlined in the Consent Order; submitted reports as outlined in the Consent Order; provided in-service training as outlined in the Consent Order. and paid the CMP as outlined in the Consent Order.

9. Surveyors exited the facility on August 7, 2018. In a statement of deficiencies, surveyors re-cited several of the deficiencies from the May 2018 survey and cited additional deficient practice.

a. The facility failed to ensure Resident #11 received medical services from a licensed provider;

b. The facility failed to provide Residents #1, #2, and #11 with protective care; failed to monitor for changes in residents' health status; failed to monitor, assess, and provide appropriate wound care; and ensure that there were physicians' orders for medication administration.

c. The facility also failed to develop and revise Resident #1, Resident #2, and Resident #11's plan of care to ensure all resident needs were met.

10. Despite the marked improvements at the facility, surveyors felt these deficiencies affected the health, safety, and welfare of the residents residing in the facility and recommended that the facility remain under a Suspension of Admissions, which the facility did not contest.

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

12. On or about September 6, 2018, Shelley Morgan, consultant to Legacy Assisted Living, resigned due to health concerns.

13. On or about September 10, 2018 through September 13, 2018, surveyors entered the facility to determine whether the facility had corrected the deficiencies and implemented the plan of corrections. Surveyors also investigated a new complaint.

14. On or about September 13, 2018 surveyors exited the facility. Cited deficiencies at the facility were reduced from three (3) to only one (1) deficiency. Surveyors recited the facility for failure to correct their deficiencies and a deficiency related to the complaint.

15. Resident #1 was admitted to the facility in July 2017 and had diagnoses that included

dementia and hypertension.

16. In August, 2018, Resident #1 was observed to have a slow, shuffling gait. The facility obtained orders for physical therapy and occupational therapy, and updated Resident #1's plan of care to document Resident #1's risk for falls.

17. Documentation from August 2, 2018 revealed that Resident #1's insurance was unable to pay for the physical therapy and occupational therapy evaluation. After August 2, 2018, there was no documentation found that the Resident #1's plan of care had been revised with interventions for Resident #1's worsening gait or measures to prevent Resident #1 from falling.

18. On or about August 21, 2018, Resident #1 was found on her buttocks in front of her toilet. The facility documented that Resident #1 was to be screened by physical therapy.

19. An August 22, 2018 note revealed that Resident #1's co-insurance was unable to pay for a physical therapy, occupational therapy or speech therapy. As such, there was no documentation that Resident #1 had been evaluated.

20. As a result Resident #1's plan of care was not updated.

21. On or about August 26, 2018, Resident #1 was observed to have her left eye swollen shut, a drooping mouth, and elevated blood pressure. Resident #1 was taken via EMS to the hospital.

22. Resident #1 was treated for altered mental status due to dehydration, sepsis, and accelerated hypertension. Resident #1 was then transferred to a different hospital for additional care.

23. Upon admission to Hospital #2, Resident #1 was diagnosed with acute metabolic encephalopathy due to dehydration, hypernatremia due to dehydration, and acute kidney injury.

24. Resident #1 was discharged to a skilled nursing facility for a higher level of care on or about August 31, 2018.

25. Resident #2 was admitted to the facility in July 28, 2016 with diagnoses of atrial fibrillation, Alzheimer's, breast cancer, and osteoarthritis.

26. Resident #2 was prescribed a variety of anti-depressants, Seroquel, an anticonvulsant, and an anti-psychotic. All of these medications can cause drowsiness.

27. Resident #2 experienced falls on May 4, 2018, May 11, 2018, May 25, 2018, May 28, 2018, and June 5, 2018. A physician ordered a physical therapy evaluation for assistance with mobility and ambulation.

28. On or about August 30, 2018, an assessment revealed that Resident #2 was capable of ambulation prior to her medications taking effect. Once her medications take effect, Resident #2 was observed to be extremely drowsy and unable to function.

29. However, the facility could provide no documentation that Resident #2's plan of care had been review or revised to reflect Resident #2's drowsiness due to medication or to continue progressing with physical therapy.

30. Surveyors personally observed Resident #2 from September 10-September 11, 2018. During their observation of Resident #2, she was always observed to be asleep in her wheelchair or her bed.

31. A review of Resident #2's medications during this period revealed that she continued to receive anti-depressants, Seroquel, anticonvulsants, and anti-psychotics all during this period. The facility could provide no documentation that her medications had been reviewed or that her plan of care had been updated to address her continued drowsiness.

32. The facility confirmed that Resident #2's drowsiness had not been addressed.

33. The facility called the surveyor on September 12, 2018 and informed her that the facility inquired of Resident #2's physician about her drowsiness after being notified of the issue by the surveyor.

34. Surveyors determined that the facility failed to review the 24-hour report, new orders, medication administration records, and nurse's notes for Residents #1 and #2.

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.

35. The facts stated in paragraphs eleven (11) through thirty-four (34) are sufficient to establish that Respondent has violated the provisions 1200-08-25-.05(3)[REGULATORY STANDARDS], the relevant portion of which reads as follows:

> (3) Either failure to submit a plan of correction in a timely manner or a finding by the Department of Health that the plan of correction is unacceptable may subject the ACLF's license to disciplinary action.

36. The facts stated in paragraphs eleven (11) through thirty-four (34) 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 healthcare 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 occurs, but not less than semi-annually by the above appropriate individuals.

ORDER

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

37. Respondent's license to operate as an assisted care living facility shall be placed on probation for an additional four (4) months. As such, the total timeframe that Respondent shall be on probation is ten (10) months. During the period of probation, the Respondent shall submit an acceptable Plan of Correction ("POC").

38. 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.

39. Respondent agrees to pay costs for subsequent revisit surveys incurred by the Department, if the same or different deficiencies are cited after the third (3rd) revisit survey.

40. Respondent shall appear before the Board at the February 2019 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 September 2018 survey have been corrected.

41. During the additional four (4) 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.

42. 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 3rd day of October, 2018.

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

Terri Saunders MD
Chairperson
Board for Licensing Health Care Facilities

AGREED TO:

Cedric Davis, Administrator
Legacy Assisted Living & Memory Care
at Lenox Park
Respondent

10-3-18
Date

Rebecca Adelman BPR # 014736
Michael Goodin, BPR # 27256
Attorney for the Respondent
Adelman Law Firm, PLLC
647 S Main St
Memphis, TN 38103-4813

10-3-18
Date

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

10-3-18
Date

CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon Respondent, by and through their attorney, Rebecca Adelman, Attorney for the Respondent, Adelman Law Firm, PLLC 647 S Main St, Memphis, TN 38103 by delivering same in the United States mail certified mailing # 7017 3380 0000 9972 5016, and via USPS first class, with sufficient postage thereon to reach its destination.

This 4th day of October, 2018.

Caroline R. Tippens

Caroline R. Tippens
Assistant General Counsel