BEFORE THE TENNESSEE BOARD
FOR LICENSING HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
PRESTIGE ASSISTED LIVING OF LOUDON CO.	)	Docket No. 17.17-153696A
110 RIVER ROAD WEST	)	
LOUDON, TN 37774	)	
	)	
License No. #53	)	

AGREED ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 3rd day of April, 2018, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **Prestige Assisted Living of Loudon** (hereinafter "Respondent") that the Board adopt this Agreed Order, the terms of which have been agreed upon by the parties, as signified by their signatures below.

Respondent, by signature to this Agreed 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 Agreed Order.

Respondent agrees that presentation to and consideration of this Agreed 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 Agreed 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, Prestige Assisted Living of Loudon, located at 110 River Road West, Loudon, TN 37774, has been licensed as an Assisted Care Living Facility by the Board, having been issued license number 00000053 on August 24, 1998. Respondent has an active license with an expiration date of June 23, 2019.
2. On or about June 12-20, 2018, surveyors conducted an annual survey and investigation of seven (7) complaints at Prestige Assisted Living of Loudon.

3. The facility's admission agreement provides that smoking was allowed on the premises, but restricted to an area outside of the building. Residents were not allowed to smoke in the building or around entrance areas. Residents were also responsible for keeping all smoking materials in their possession. Further, the facility is not responsible for keeping any smoking materials. Failure to comply with these policies resulted in a thirty (30) day notice to the resident.

4. Resident #1 was admitted to the facility in September 2017 with diagnoses of chronic obstructive lung disease ("COPD"), bipolar disorder, oxygen use, and tobacco use.

5. Resident #1 was on hospice. The facility failed to obtain physician certification that the facility was appropriate for hospice care for Resident #1.

6. Plans of care for Resident #1 revealed oxygen use and smoking of cigarettes were not addressed and no plan or education related to the risk of fire was documented.

7. Interview with the Administrator and Director of Nursing confirmed residents' care plans did not address safety needs related to smoking and oxygen use.

8. The facility also failed to formulate and provide plans of care consistent with resident needs for Resident #1.

9. Surveyors observed crawling insects in Resident #1's bathroom, on the floor of the office of the Director of Nursing's office, cobwebs and a dead insect in the kitchen, and flying insects in the hallways.

10. Resident #3 was on hospice. At the time of the survey, the facility failed to provide physician certification that the facility was appropriate for hospice care for Resident #3.

11. Resident #3's medical record with the facility indicated that he was full code. However, his hospice file indicated that Resident #3 was do-not-resuscitate ("DNR").

12. The facility failed to ensure that Resident #3's documented status for resuscitation was consistent with Resident #3's advance directive.

13. Resident #4 was admitted to the facility in April 2017 with diagnoses including hemiplegia following a stroke, heart failure, and tobacco use. Resident #4 required assistance with activities of daily living and utilized a wheelchair.

14. Resident #4 was also on hospice. The facility failed to provide physician certification that the facility was appropriate for hospice care for Resident #4.

15. From September 2017 until April 2018, Resident #4 engaged in multiple verbal and physical altercations with staff and other residents alike; bit a staff member on her breast; was frequently intoxicated; was found passed out on the bathroom floor due to intoxication; had multiple falls; threatened suicide; and threatened to slit another resident's throat.

16. Despite Resident #4's increasingly escalating behaviors, the facility failed to update Resident #4's plan of care.

17. After police were called on April 12, 2018, Resident #4 was finally discharged.

18. The facility failed to immediately discharge Resident #4 who posed an imminent threat to self or others.

19. After Resident #4 was discharged, the facility disposed of Resident #4's lorazepam and failed to account for the disposal of the MS Contin tablets and morphine syrup.

20. The facility failed to document medications for discharged Resident #4. The facility also failed to follow the procedure to count narcotics twice a day and failed to investigate when the narcotic count was incorrect.

21. Resident #5 was admitted to the facility in April 2017 with diagnoses of history of alcohol abuse, frequent falls, and hypertension.

22. Resident #5 was also a hospice patient. The facility failed to provide physician certification that the facility was appropriate for hospice care for Resident #5.

23. From July 2017 to June 2018, Resident #5 was found to have fallen due to intoxication; engaged in a physical and verbal altercation with residents and staff; threatened suicide; and threatened staff with a pocket knife which resulted in a psychological evaluation.

24. Despite Resident #5's escalating behaviors, the facility failed to update the plan of care for Resident #5.

25. Resident #5 still resides within the facility.

26. The facility failed to discharge Resident #5 who posed an imminent threat to self or others.

27. Resident #6 was admitted to the facility in April 2011 with diagnoses including severe peripheral vascular disease with bilateral above the knee amputation and chronic obstructive pulmonary disease ("COPD"). Resident #6 utilized a wheelchair and was a smoker.

28. Resident #6's care plan did not document that Resident #6 was a smoker.

29. Resident #6 was also a hospice patient. At the time of the survey, the facility failed to provide physician certification that the facility was appropriate for hospice care for Resident #6.

30. On or about March 24, 2018, Resident #6 was thrown from his wheelchair and down a hill, after another resident who had pushed Resident #6 outside to smoke, lost control of his wheelchair.

31. Resident #6's was sent to the Emergency Room and was discharged. However, his broken hip was not treated until two (2) days later.

32. Medications were ordered for administration on May 11, 2018 by Resident #6's physician, which included Ceftriaxone (antibiotic) and Lidocaine. Medical records revealed these medications were not actually administered until May 13, 2018. A non-licensed medical technician initialed the medications as administered, but failed to actually administer the medications until two (2) days later. The facility terminated the unlicensed medical technician, but indicated that the technician's failure to administer the medications caused a decline in Resident #6's condition.

33. The facility also failed to revise the plan of care as Resident #6's needs changed which resulted in harm to Resident #6.

34. Resident #7 was admitted to the facility in November 2017 with diagnoses of chronic obstructive lung disease ("COPD"). Resident #7 required oxygen and needed assistance with activities of daily living. He also utilized a cane or wheelchair while ambulating. Resident #7 was on hospice from November 2017 – December 2017.

35. The facility failed to provide physician certification that the facility was appropriate for hospice care for Resident #7.

36. Review of Resident #7's care plan revealed that the resident had diagnoses including COPD. The resident required oxygen and needed assistance with activities of daily living. The resident was on oxygen at all times except when smoking. Resident #7 was also caught by his hospice nurse actively smoking on multiple occasions, which was reported to the facility administration. However, there was no plan for Resident #7 to safely smoke and no resident education documented on the danger of smoking while on oxygen.

37. On or about December 21, 2017, Resident #7, lit a cigarette while using his oxygen concentrator which caused his oxygen tubing to ignite and catch on fire. Staff ran into the resident's room and observed Resident #7 on fire.

38. Emergency medical services were called. Resident #7 was admitted to the hospital with second and third degree burns on twelve (12%) of his total body area. Resident #7 expired at the hospital from his injuries.

39. The facility also failed to formulate and provide plans of care consistent with resident needs for Resident #7. As a result, Resident #7 expired in a fatality fire while smoking on oxygen.

40. The facility failed to follow the resident admission agreement regarding safe smoking for Residents #7, #6, #13A, #1, #5, #2A, #10A, #4A, and #7A.

41. The facility was cited for failure to provide safety in the facility for nine (9) residents, #7, #6, #13A, #1, #5, #2A, #10A, #4A, and #7A.

42. The facility's failure to prevent unsafe smoking resulted in Resident #7's fatality fire and provides an unsafe environment for all forty (40) residents currently in the facility.

43. Review of the facility's policies revealed that only employees who are registered nurses or licensed practical nurses were to administer medications.

44. While surveyors were present in the facility, surveyors observed certified clinical medical assistants ("CCMAs") administering medication to residents.

45. The facility also failed to administer Resident #8 a Fentanyl patch until six (6) days after it was ordered.

46. The facility failed to ensure all medications were administered by a licensed nurse for all forty (40) residents residing in the facility.

47. On or about July 14, 2018, the Commissioner of the Department of Health suspended admissions to Prestige Assisted Living of Loudon on the basis of the aforementioned findings.

48. On or about July 20, 2018, the facility timely appealed the Commissioner of Health's Suspension of Admissions.

49. To date, the facility has submitted three (3) unacceptable Plans of Corrections. The facility has been unable to correct the cited deficiencies. At present, the facility remains under a Suspension of Admissions.

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.

50. The facts stated in paragraphs three (3) through forty-six (46) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.06(1)(b)(2)[Administration], the relevant portions of which read 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.

51. The facts stated in paragraphs three (3) through forty-six (46) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.06(1)(b)(3)[Administration], the relevant portions of which read as follows:

> (1) Each ACLF shall meet the following staffing and procedural standards;
>
> (b) Policies and Procedures:
>
> (3) An ACLF shall develop a written policy, plan or procedure concerning a subject and adhere to its provisions whenever required to do so by these rules. A licensee that violates its own policy established as required by these rules and regulations also violates the rules and regulations establishing the requirement.

52. The facts stated in paragraphs forty-three (43) through forty-six (46) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-2507(5)(b) [SERVICES PROVIDED], the relevant portions of which read as follows:

> (5) Resident medication. An ACLF shall:
>
> (b) Ensure that all drugs and biologicals shall be administered by a licensed professional operating within the scope of the professional license and according to the resident's plan of care.

53. The facts stated in paragraph nineteen (19) through twenty (20) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(6)(g) [SERVICES PROVIDED], the relevant portion of which reads as follows:¶

> (6) An ACLF shall dispose of medications as follows:
>
> (g) The ACLF's medication disposal policy shall also address the disposal of scheduled drugs, non-scheduled drugs, and devices that are misbranded, expired, deteriorated, not kept under proper conditions, and kept in containers with illegible or missing labels.

54. The facts stated in paragraphs three (3) through forty-six (46) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(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.

55. The facts stated in paragraphs thirteen (13) through twenty-six (26) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.08(1)(d) [SERVICES PROVIDED], the relevant portion of which reads as follows:

> (8) An ACLF shall not admit or permit the continued stay of any ACLF resident who has any of the following conditions:
>
> (d) Exhibits verbal or physical aggressive behavior which poses an imminent physical threat to self or others, based on behavior, not diagnosis.

56. The facts stated in paragraph five (5), ten (10), fourteen (14), twenty-two (22), twenty-nine (29), thirty-four (34), and thirty-five (35) are sufficient to establish that Respondent

has violated the provisions of Rule 1200-08-25-.08(5)(a)[ADMISSIONS, DISCHARGES, AND TRANFSFERS], the relevant portion of which reads as follows:

(5) An ACLF resident qualifying for hospice care shall be able to receive hospice care services and continue as a resident if the resident's treating physician certifies that such care can be appropriately provided in the ACLF.

(a) In the event that the resident is able to receive hospice services in an ACLF, the resident's hospice provider and the ACLF shall be jointly responsible for a plan of care that is prepared pursuant to current hospice guidelines promulgated by the Centers for Medicaid and Medicare and ensures both the safety and well-being of the resident's living environment and provision of the resident's health care needs.

57. The facts stated in paragraph nine (9) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.10(10)(a)[LIFE SAFETY] the relevant portion of which reads as follows:

(10) An ACLF shall maintain its physical environment in a safe, clean, and sanitary manner by doing at least the following:

(a) Prohibit any condition on the ACLF site conducive to the harboring or breeding of insects, rodents, or other vermin.

58. The facts stated in paragraphs eleven (11) and twelve (12) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.12(3)(k)[RESIDENT RECORDS], the relevant portion of which reads as follows:

(3) Medical record. An ACLF shall ensue that its employees develop and maintain a medical record for each resident who requires healthcare services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement from an outside source, which shall include at a minimum:

(k) Special information, e.g., do not resuscitate orders, allergies, etc.

59. The facts stated in paragraphs sixteen (16), twenty-four (24), and thirty-three (33) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.12(5)(a) [PLAN OF CARE], the relevant portion of which reads as follows:

> (5)(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 delivery 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.

ORDER

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

60. Respondent's license to operate as an assisted care living facility shall be placed on probation for one (1) year. During the period of probation, the Respondent shall submit an acceptable Plan of Correction.

61. **Respondent hereby agrees to remain under the Commissioner's assessed Suspension of Admissions until deficiencies have been corrected.**

62. Respondent agrees to the pay the ten thousand dollars ($10,000.00) in civil monetary penalties assessed by the Commissioner of the Department of Health.

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

63. During the one (1) year 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.

64. 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.

65. Respondent may appear before the Board until the end of calendar year 2019 and submit quarterly reports prepared by the Respondent regarding the adherence of the facility to the regulations cited in the June 2018 Statement of Deficiencies.

66. After the expiration of one (1) calendar year, the Respondent must submit a Petition for Order of Compliance and personally appear before the Board to request the probationary period to be lifted.

67. 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 3 day of October, 2018.

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

Irene C Saunders MD
Chairperson
Board for Licensing Health Care Facilities

AGREED TO:

Nikki Zaveri, Administrator — Date 9/27/18
Prestige Assisted Living of Loudon County
Respondent

Alicia J. McMurray BPR #035258 — 9/27/2018
Alicia J. McMurray
General Knox Law, P.C.
PO Box 26072
Knoxville, TN 37912

Caroline R. Tippens, BPR # 030375 — 10/3/2018 Date
Assistant General Counsel
Tennessee Department of Health
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243
(615) 741-1611

CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon Respondent, by and through their attorney, Alicia J. McMurray, General Knox Law, P.C., P.O. Box 26072, Knoxville, TN 37912 by delivering same in the United States mail certified mailing #70173390000 9972 5078, and via USPS first class, with sufficient postage thereon to reach its destination.

This 4th day of October, 2018.

Caroline R. Tippens
Assistant General Counsel

:s

CERTIFICATE OF FILING

This Order was received for filing the Office of the Tennessee Secretary of State, Administrative Procedures Division, and became effective on the 4th day of October _____, 2018.

J. Richard Collier

Richard Collier
Administrative Procedures Division