BEFORE THE TENNESSEE BOARD
FOR LICENSING HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Riverdale Assisted Living Facility	)	
6880 E. Raines Road	)	**Case No: 202000067**
Memphis, TN 38115	)	
	)	
License No. 00000370	)	

CONSENT ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 13th day of March, 2020, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **Riverdale Assisted Living Facility** (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

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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 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. § 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. 1200-08-11 *et. seq.*

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. 1200-08-11-.03. 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. 1200-08-11-.03.

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. 1200-08-11-.03. 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, **Riverdale Assisted Living Facility**, 6880 E. Raines Road, Memphis, TN 38115 has been licensed as an assisted care living facility ("ACLF") by the Board, having been issued license number 00000370 on March 14, 2012. Respondent's license has an expiration date of March 14, 2020.

2. From on or about November 12, 2019 through December 2, 2019, health surveyors

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conducted a complaint survey at the Respondent facility for a complaint investigation.

3. Licensed practical nurse number (hereinafter "LPN") #5, was hired by the facility on or about January 7, 2019. LPN #5's nursing licensed expired on July 31, 2019. LPN #5 was currently employed at the facility as a licensed practical nurse performing duties, administering medication, and providing care to residents on November 15, 2019 while surveyors were present at the facility conducting their investigation.

4. LPN #5 verified to the surveyor that his license expired on July 31, 2019.

5. LPN #5 admitted he administered medications to the facility's residents from July 31, 2019 until his termination from the facility on November 15, 2019.

6. The facility failed to ensure appropriately licensed or qualified staff provided medical services in the assisted care living facility.

7. The facility also failed to ensure drugs and biologicals were administered by licensed healthcare professional.

8. Resident #1 was admitted to the facility in August 2017 with diagnoses of arthritis, dementia, stroke, anemia, and failure to thrive.

9. Resident #1 was incontinent of bowel and bladder and dependent on staff for assistance with activities of daily living, including bathing and incontinence care.

10. Review of Resident #1's plan of care dated September 2017 revealed that there was no documentation or intervention to assist Resident #1 with his incontinence care or bathing.

11. Resident #1 was discharged from the facility, but the facility was unable to provide documentation of the date of discharge, reason for discharge, or address for the resident.

12. On or about March 1, 2019, Resident #1 was readmitted to the facility with new diagnoses of atrial fibrillation, anemia, hyperlipidemia, acute pain, dysphasia following a

stroke.

13. On or about May 29, 2019, Resident #1 was sent to a skilled nursing facility with diagnoses of fracture of the right femur. The facility could provide any documentation to surveyors regarding how Resident #1's femur fracture occurred.

14. On or about June 28, 2019, Resident #1 was readmitted back to the facility. The facility could provide no documentation regarding a readmission assessment or a Plan of Care to provide or assist with bathing and incontinence care.

15. On or about August 3, 2019, the resident shower sheets revealed that Resident #1 had refused a shower. The facility could provide no documentation that Resident #1 received another shower until August 22, 2019, nineteen (19) days later.

16. On or about September 9, 2019, Resident #1 received a shower. On or about September 22, 2019, Resident #1 refused a shower. There was no documentation that Resident #1 received a shower until September 27, 2019, eighteen (18) days later.

17. The facility documented that Resident #1 refused showers on October 1, 2019, October 4, 2019, October 7, 2019, October 10, 2019, and October 12, 2019.

18. On or about October 13, 2019, Resident #1's family complained that Resident #1 was dirty, had dried blood and feces on his clothing; and requested that Resident #1 receive a shower. According to the facility's records, Resident #1 had last been showered on September 27, 2019, approximately seventeen (17) days prior.

19. The Director of Nursing verified that the facility did not have a Plan of Care to address Resident #1's incontinence or bathing

20. Review of Resident #1's medication administration record revealed that Resident #1 had missed seven (7) doses of Warfarin, an anticoagulant, in August 2019. The facility could

provide no documentation as to why Resident #1's medication as not administered or if Resident #1's physician had been notified of the missed doses.

21. Review of Resident #1's medication administration record in September 2019 revealed that Resident #1 received two (2) doses of Warfarin, instead of one dose of Warfarin, on four (4) occasions. The facility could provide no documentation as to why Resident #1 received a double dose of Warfarin or that Resident #1's physician was notified of extra doses of Warfarin being administered.

22. Review of Resident #1's medication administration record in October 2019 revealed that Resident #1 missed his dose of Warfarin on three (3) occasions in October 2019. There was no documentation as to why Resident #1's Warfarin was not administered or that the physician was notified of the missed doses.

23. The facility also confirmed that the facility did not have a Care Plan on Resident #1 and indicated that the Care Plan used was from an outside agency. When asked to provide records from the outside agency on Resident #1, the facility was unable to do so.

24. On or about October 14, 2019, Resident #1 passed away.

25. The facility could not provide any documentation that Resident #1's medications were destroyed or returned to the family or pharmacy after Resident #1 expired.

26. The Assistant Director confirmed the facility was unable to provide documentation of Resident #1's medication disposal.

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.

27. The facts stated in paragraphs three (3) through six (6) are sufficient to establish that Respondent has violated provisions of Rule 1200-08-25-.07(2)[Services Provided], the relevant portion of which reads as follows:

(2) Medical Services in an ACLF shall be provided by:
(a) Appropriately licensed or qualified staff of an ACLF;
(b) Appropriately licensed or qualified contractors of an ACLF;
(c) A licensed home care organization;
(d) Another appropriately licensed entity; or
(e) Appropriately licensed staff of a nursing home.

28. The facts stated in paragraphs three (3) through seven (7) are sufficient to establish that Respondent has violated provisions of Rule 1200-08-25-.07(5)(b)[Services Provided] the relevant portion of which reads as follows:

(5) Resident medication. An ACLF shall:

(b) Ensure that all drugs and biologicals shall be administered by a licensed or certified healthcare professional operating within the scope of the professional license or certification and according to the resident's plan of care.

29. The facts stated in paragraphs eight (8) through nineteen (19) are sufficient to establish that Respondent has violated provisions of Rule 1200-08-25-.07(7)(a)(6)[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:
6. Non-medical living assistance with activities of daily living.

30. The facts stated in paragraphs twenty (20) through twenty-two (22) are sufficient to establish that Respondent has violated provisions of Rule 1200-08-25-.12(3)(e)[Resident Records] the relevant portion of which reads as follows:

(3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside

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source, which shall include at a minimum:

(e) Medications administered and procedures followed if an error is made.

31. The facts stated in paragraphs eight (8) through twenty-three (23) are sufficient to establish that Respondent has violated provisions of Rule 1200-08-25-.12(5)(b)(1)[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.

32. The facts stated in paragraphs twenty-four (24) through twenty-six (26) are sufficient to establish that Respondent has violated provisions of Rule 1200-08-25-.07(6)(b)[Services Provided] the relevant portion of which reads as follows:

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

(b) Upon the death of a resident, unused prescription medication must be destroyed in the manner outlined, and by the individuals designated, in the facility's medication disposal policy, unless otherwise requested by the resident's family member or the resident's legal representative and accompanied by a written order by a physician. The ACLF's medication disposal policy shall be written in accordance with current FDA or current DEA medication disposal guidelines.

ORDER

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

33. Respondent's license to operate as an assisted living shall be placed on probation for one

calendar year.

34. Respondent is also hereby assessed five (5) civil monetary penalties in the amount of three thousand dollars ($3,000) each and one civil monetary penalty in the amount of one thousand dollars ($1,000.00) for a total assessment of sixteen thousand dollars ($16,000.00) in civil monetary penalties.

35. 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

36. The citation of any further serious violations affecting the health, safety, and welfare of the facility's residents shall result in Suspension of Admissions pending a prompt hearing by the Board.

37. A representative shall appear on behalf of the Respondent facility in-person at each regularly scheduled Board meeting in June 2020 and October 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.

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

39. Upon ratification by the Board, the listing of the public discipline, including deficiencies, 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 13th day of March, 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:

Administrator
Tommy L. Baker, Administrator
Riverdale Assisted Living Facility
Respondent

2/13/20
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

3/13/2020
Date

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CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon Respondent, Riverdale Assisted Living Facility, ATTN: Administrator, Tommy L. Baker, 6880 E. Raines Road, Memphis, TN 38115, and AMERICARE-TENNESSEE PROPERTY GROUP, LLC, 9114 Technology Lane, Fishers, IN 46038 via United States Mail Certified Numbers 7019 2970 0002 1304 5226 and 7019 2970 0002 1304 5233 delivering same in the United States mail, first class, with sufficient postage thereon to reach its destination.

This 16th day of March, 2020.

Caroline R. Tippens

Caroline Tippens
Senior Associate General Counsel