

IN THE MATTER OF:

Case #: 201903051

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. 1200-08-25-.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, **Schilling Gardens Assisted Living by Americare**, located at 15 Schilling Bend Commons, has been licensed as an Assisted-Care Living Facility by the Board, having been issued license number 00000290 on June 25, 2009. Respondent has an active license with an expiration date of March 17, 2020.
2. On or about April 1, 2019, surveyors conducted a revisit survey at the facility to ensure

- that the previously cited deficiencies from a January 29, 2019 survey were corrected.
3. Resident #4 had a prescribed physician diet for low concentrated sweets and no added salt. When the cook was interviewed, the cook indicated that she did not have any residents on therapeutic diets. The cook confirmed she did not have a list of any resident diets or directions on how to serve them.
 4. Interview with a personal care attendant in the facility's dining room revealed that she did not know which of the residents were unable to have sweetened beverages. The personal care attendant stated that she just gave residents whatever beverages they wanted.
 5. Resident #4 was interviewed. She indicated that she had received sweetened tea with her meal over the weekend, but did not drink it because it was so sweet. She also confirmed that she received regularly sweetened desserts, but did not eat them. Resident #4 confirmed that she wanted to follow her diabetic diet, but had not been receiving a low concentrated sweets diet.
 6. Resident #4 was later observed eating from a bag of Mexican food that a friend had brought her. Resident #4 was observed to have legs swollen from edema. There was no documentation in the medical record from the facility indicating that anyone from the facility had discussed with Resident #4 her sugar or her sodium levels.
 7. Interview with the Administrator revealed that the facility had failed to follow the plan of correction, as no list had been provided to the kitchen manager regarding residents with therapeutic diets. Further, the Administrator confirmed that neither the Director of Nursing nor Dietary Manager had reviewed resident medical records to ensure that proper diets were offered, pursuant to the requirements in the facility's plan of corrections.
 8. The facility was recited for failure to meet the nutritional needs of residents in accordance

with the orders of the practitioner responsible for the care of Resident #4.

9. Surveyors performed a second revisit survey on or about May 23, 2019.
10. Resident #1, a diabetic, had a physician prescribed diet, effective February 2019, which required low concentrated sweets and no added salts.
11. Resident #2, who also had diagnoses of diabetes and heart disease, was ordered to have a diet change in February 2018 which required a low concentrated sweets diet.
12. On or about May 23, 2019, the surveyor asked the cook responsible for the breakfast meal, to show the surveyor how to prepare and serve low concentrated sweet diets. The cook stated that she just asked all the residents what they wanted to eat and drink and that's what they were served. As such, Residents #1 and #2 were not receiving their low concentrated sweets diet.
13. An interview with the Charge Nurse confirmed that both Resident #1 and #2 should be on a low concentrated sweets diet.
14. The facility was recited for failure to meet the nutritional needs of residents in accordance with the orders of the practitioner responsible for the care of Residents #1 and #2.

GROUND 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.

15. The facts stated in paragraphs two (2) through fourteen (14) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(7)(c)(3)(ii) [SERVICES

PROVIDED], the relevant portion of which reads as follows:

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

(c) Dietary services.

(3) An ACLF shall ensure that menus meet the needs of the residents as follows:

(ii) An ACLF shall meet nutritional needs, in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of residents.

ORDER

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

7. The assessment of two (2) civil monetary penalties, one in the amount of five hundred dollars (\$500.00), and one civil monetary penalty in the amount of one thousand dollars (\$1,000.00), for a total assessment of one thousand five hundred dollars (\$1,500.00).

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**

8. 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.

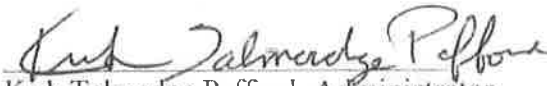
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Upon the agreement of the parties, this **CONSENT ORDER** is approved as a **FINAL ORDER** by a majority of a quorum of the Tennessee Board for Licensing Health Care Facilities at a public meeting of the Board and signed this 2nd day of October, 2019.

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:


Kirk Talmadge Pafford, Administrator
Schilling Gardens Assisted Living by Americare
Respondent

9/6/19
Date


Caroline R. Tippens (BPR #: 050375)
Assistant General Counsel
Department of Health
665 Main Stream Dr., 2nd Floor
Nashville, Tennessee 37243
(615) 741-1611

10.2.2019
Date

 Initial

CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon Schilling Gardens Assisted Living by America c/o Kirk Talmadge Pafford, 15 Schilling Bend Commons, Collierville, TN 38017 and Southridge Nursing, LLC, 15 Schilling Bend Commons, Collierville, TN 38017 by delivering in the United States mail, first class, with sufficient postage thereon to reach its destination and via United States Certified Mail # 7018 1830 0000 5102 5999 and 7018 1830 0000 5102 6002

This 3rd day of October, 2019.


Caroline Tippens
Assistant General Counsel

KP Initial