BEFORE THE TENNESSEE BOARD
FOR LICENSING HEALTH CARE FACILITIES

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| IN THE MATTER OF: | ) | |
| | ) | |
| The Bridge at Hickory Woods | ) | CASE #: 201803866 |
| 4220 Murfreesboro Pike | ) | |
| Antioch, TN 37013 | ) | |
| | ) | |
| License No. ACLF 00000360 | ) | |

## CONSENT ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 5th day of June, 2019, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and The Bridget at Hickory Woods (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

1. At all times pertinent hereto, The Bridge at Hickory Woods, located at 4220 Murfreesboro Pike, Antioch, TN 37013 has been licensed as an Assisted-Care Living Facility by the Board, having been issued license number 00000360 on October 17, 2014. Respondent has an active license with an expiration date of October 16, 2019.

2. In August 2018, the Department conducted both a health and life safety survey at the

Respondent facility.

3. On or about July 17, 2018, approximately seventy-seven (77) residents were residing in Respondent facility. Of the seventy-seven (77) residents present, thirty-five (35) utilized a walker for ambulation, and twenty (20) residents required a wheelchair for ambulation. Three (3) aides and one nurse were providing care for seventy-seven (77) residents.

4. The facility utilizes Amana Packaged Terminal Air Conditioners and Heat Pumps ("PTACS") which are installed throughout the facility. In March 2018, the U.S. Consumer Product Safety Commission recalled the particular model of PTACs that the facility used due to reports of nine (9) fires and one instance of smoke inhalation. Surveyors found that the facility had recalled PTAC units in rooms 220, 215, 315, 111, and the private dining room.

5. On or about July 17, 2018, a fire alarm went off. The PTAC unit in Room 220 had caught fire. Room 220 had been repurposed from a resident room and was being used for storage of miscellaneous items including holiday decoration and furniture. However, the facility did not gain the Department's approval prior to repurposing a resident room to a storage room.

6. A resident care aide went to Room 220 and noted that she smelled smoke. However, her key fob would not work and she could not enter the room.

7. Thereafter, the facility began to evacuate residents who could walk. Staff moved the residents in wheelchairs to Room 210. The facility were unable to evacuate the residents from the second floor until after the fire department arrived.

8. After the fire department extinguished the PTAC fire in room 220, the fire department evacuated the remaining residents from first, second, and third floors approximately

thirty-five (35) minutes after the fire alarm went off at the facility.

9. The facility failed to repair or replace the PTACS which were recalled due to reports of fire.

10. The facility failed to ensure a sufficient number of staff were on duty to evacuate residents during an emergency situation.

11. The facility failed to follow the facility's written fire control plan to ensure the residents' protection. Staff failed to follow the appropriate facility fire procedures; failed to evacuate the rooms within the area of the smoke compartment; and failed to appropriately evacuate the residents timely and in the order of the evacuation guidelines outlined in the facility's policies and procedures.

12. The facility failed to ensure staff on duty had access to all locked areas in an emergency situation.

13. The facility failed to transfer multiple residents who could not evacuate within thirteen minutes from the facility. As a result, residents were unable to evacuate from the facility until the fire department arrived, approximately eleven (11) minutes after the initial fire alarm activation.

14. The facility failed to provide safety to the residents residing within the facility.

15. The facility submitted a Plan of Correction on August 6, 2018. On or about September 25, 2018, the Department verified that all the cited deficiencies had been corrected.

## 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.

16. The facts stated in paragraphs six (6) through fourteen (14) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.06(1)(b)(3)[Life Safety], the relevant portion of which reads 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 procedures concerning a subject and adhere to its provisions whenever required to do so by these rules. A licensee that violates its own policy established by these rules and regulations also violates the rules and regulations establishing the requirement.

17. The facts stated in paragraphs six (6) through fourteen (14) 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 last the following personal services;

(2) Safety when in the ACLF.

18. The facts stated in paragraphs seven (7), eight (8), ten (10), thirteen (13), and fourteen (14) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.08(8)[Admissions, Discharges, and Transfers], the relevant portion of which reads as follows:

(8) An ACLF may not retain a resident who cannot evacuate within thirteen (13) minutes unless the ACLF complies with Chapter 19 of the 2006 edition of the NFPA Life Safety Code and the Institutional Unrestrained Occupancy of the 2006 edition of the International Building Code.

19. The facts stated in paragraphs four (4), five (5), six (6), and eight (8) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.09(1)[Building Standards], the relevant portion of which reads as follows:

(1) An ACLF shall construct, arrange, and maintain the condition of the physical plant and the overall ACLF living facility environment in such a manner that the safety and well-being of the residents are assured.

20. The facts stated in paragraph five (5) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.09(5)[Building Standards], the relevant portion of which reads as follows:

(5) No new ACLF shall be constructed, nor shall major alterations be made to an existing ACLF without prior approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new ACLF is licensed or before any alteration or expansion of a licensed ACLF can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or a licensed engineer and in accordance with the rules of the Board of Architectural and

Engineering Examiners.

21. The facts stated in paragraphs four (4), five (5), six (6), ten (10), and twelve (12) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.10(2)(a) and (c)[Life Safety], the relevant portion of which reads as follows:

(2) An ACLF shall ensure fire protection for residents by doing at least the following:

(a) Eliminating fire hazards; and

(c) Adopt a written fire control plan.

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## ORDER

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

7. The assessment of six (6) civil monetary penalty in the amount of five hundred dollars ($500.00) for a total assessment of three thousand dollars ($3,000.00).

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.

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 5th day of June, 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:

Sarah Elizabeth Heatwole, Administrator
The Bridge at Hickory Woods
Respondent

5/8/19
Date

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

6/5/19
Date

## CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon The Bridge at Hickory Woods via its Administrator, Sarah Elizabeth Heatwole, 4220 Murfreesboro Pike, Antioch, TN 37013 and to the parent company, Highland Park ALF Operations, LLC., 3570 Keith Street NW, Cleveland, TN 37312 delivering in the United States mail, first class, with sufficient postage thereon to reach its destination and via United States Certified Mail #s 70182290 0001 1403 1887 and 7018 2290 0001 1403 1894

This 6th day of June, 2019.

Caroline Tippens

Caroline Tippens
Assistant General Counsel