STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
The Terrace at Mountain Creek	)	
1005 Mountain Creek Road	)	**Case #: 201905524**
Chattanooga, TN	)	
	)	
License No. ACLF 00000257	)	

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 February, 2020, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **THE TERRACE AT MOUNTAIN CREEK** (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

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1. At all times pertinent hereto, The Terrace at Mountain Creek, 1005 Mountain Creek Road, Chattanooga, TN 37405, has been licensed as an Assisted-Care Living Facility by the Board, having been issued license number 00000257 on July 22, 2004. Respondent has an active license with an expiration date of September 3, 2020.
2. On or about October 31, 2018, surveyors entered the facility to ensure that deficiencies cited in the facility's annual survey from April 2019 were corrected. In addition, the surveyors conducted a revisit survey for deficiencies cited in August 2019 and an

investigation of four complaints received from October 28, 2019 through October 31, 2019. The facility was recited for previously cited deficiencies for failure to implement corrective actions under the facility's previously submitted plan of correction.

3. Resident #1 was admitted to the facility in November 2017 with diagnoses of cerebral infarction, hemiplegia, COPD, diabetes, heart failure, depression, and dementia.

4. From October 16, 2019 through October 30, 2019, Resident #1 missed administration of his Symbicort (used to treat COPD) on two (2) occasions on October 21, 2019.

5. The facility could provide no documentation as to the follow-up for Resident #1's missed medications.

6. Resident #27 was admitted to the facility in April 2017 with a diagnosis of schizophrenia.

7. From October 17, 2019 through October 24, 2019, Resident #27 missed doses of Isosorbide MN ER (medication to prevent chest pain caused by heart disease) on two (2) occasions and Restasis (prescription eye drops).

8. On or about October 29, 2019, Resident #27 missed one dose of Furosemide, a diuretic.

9. No documentation was provided as to the missed dose or follow-up for the missed medication.

10. Resident #33 was admitted in September 2009 with diagnoses of dementia, hypertension, hypothyroidism, diabetes, weakness, COPD, and pain.

11. On or about October 21, 2019, Resident #33 missed one (1) dose of Memantine HCL, a medication for moderate to severe confusion. The facility could provide no documentation for the missed dose.

12. Resident #34 was admitted to the facility in June 2014 with diagnoses of dementia, Alzheimer's, diabetes, stroke, history of blood clots, heart disease, and chronic pain.

Resident #34 was ordered to receive Morphine Sulfate ER 15 mg twice daily for chronic pain.

13. From October 19, 2019 through October 22, 2019, Resident #34 missed six (6) doses of morphine sulfate. The facility documented that the reason Resident #35 missed his pain medication was that the medication had not yet been delivered by the pharmacy.

14. Resident #39 was admitted to the facility in June 2016 with diagnoses of hypertension, diabetes, anemia, hypothyroidism, and hypokalemia.

15. On or about October 17, 2019, Resident #39 missed a dose of metoprolol tartrate, a medication for high blood pressure.

16. The facility could provide no documentation as to follow-up for the missed medication dose.

17. Resident #40 was admitted to the facility in March 2018 with diagnoses of traumatic brain injury, difficulty walking, altered mental status, dementia, hypertension, diabetes, vascular disease, hypothyroidism, and acute kidney injury.

18. Between October 17 and 18, Resident #34 missed three (3) doses of Biotene, a liquid medication for dry mouth. The facility could provide no documentation as to the follow-up for the missed medications.

19. Resident #53 was admitted to the facility in October 2015 with diagnoses of anxiety, dementia, depression, fibromyalgia, and kidney disease.

20. Resident #53 missed three (3) doses of Gabapentin, a controlled substance used to treat nerve pain, between October 20, 2019 at:00 p.m. and October 21, 2019 at 1:00 p.m.

21. The facility noted that the medication had been re-ordered, but not yet delivered by the pharmacy. However, the facility failed to document follow-up for the missed medications.

22. On or about April 27, 2016, Resident #54 was admitted to the facility with diagnoses of dementia, hypothyroidism, hypertension, asthma, and hypertension.

23. On or about October 22, 2019, Resident #54 missed doses of Levothyroxine, a prescription medication used to treat underactive thyroid.

24. The facility failed to provide documentation for follow-up on the missed medications.

25. On or about April 1, 2015, Resident #55 was admitted to the facility in April 2015 with diagnoses of anxiety, hypertension, vascular dementia, diabetes, Parkinson's, and kidney diseases.

26. On or about October 17, 2019 at 8:00 p.m., Resident #55 missed one (1) dose of Quetiapine fumarate, an antipsychotic medication. Documentation revealed that Resident #55 was out of medication and new medication had not been received from the pharmacy.

27. The facility failed to provide documentation for follow-up on the missed dose for Resident #55.

28. In April 2017, Resident #56 was admitted to the facility with diagnoses of Bell's Palsy, bipolar disorder, depression, and a history of stroke.

29. On or about October 24, 2019, Resident #56 missed doses of Quetiapine fumarate, an antipsychotic medication, which had recently been ordered for Resident #56.

30. The facility failed to provide documentation for follow-up for the missed medication.

31. Resident #61 was admitted to the facility in March 2014 with diagnoses of diabetes.

32. On or about October 29, 2019, Resident #61 missed one (1) dose of arthritis pain relief medication. Staff documented that the medication had not yet been delivered by the pharmacy.

33. The facility failed to provide documentation of follow-up for the missed medication.

34. Resident #62 was admitted to the facility in June 2017 with diagnoses of arthritis, asthma, cancer, hypertension, and thyroid disease.

35. On or about October 20-21, 2019, Resident #62 missed four (4) doses of Gabapentin.

36. The facility failed to document follow-up for the missed medication for Resident #62.

37. In May 2014, Resident #65 was admitted to the facility with diagnoses of hypertension, hypercholesterolemia, occipitoposterior position, and spinal fracture.

38. From October 19-21, 2019, Resident #65 missed three (3) doses of Bacitracin, an antibiotic eye drop. The facility documented that Resident #65's medication was on back order.

39. The facility failed to document follow-up for the missed medication.

40. Interview with the Director of Health and Wellness revealed the facility had failed to complete Medication Administration Omissions Reports from October 17, 20-19 through October 24, 2019. As a result, the facility failed to follow-up and list any corrective plans related to missed medications.

41. The facility failed to ensure all medications were administered according to physician's orders and failed to implement the corrective action plan as required in the facility's plan of correction.

42. Resident #28 was admitted to the facility in July 2018 with diagnoses of a history of falls with fractures to his pelvis and arms, lumbar disc disease, and osteopenia.

43. Prior to being admitted to Respondent facility, Resident #28 resided in a rehabilitation facility for two months due to a pelvic fracture from a prior fall. Documentation revealed that Resident #28 had an unsteady gait and numbness in her feet.

44. Review of Resident #28's medical record revealed that no fall risk assessment was conducted when Resident #28 was admitted to the facility. As a result, there were no interventions put in place to address Resident #28's risks for falls.

45. On or about September 23, 2019, Resident #28 stated that she had fallen and broken her wrist. Resident #28 was sent out via ambulance and was diagnosed with a broken wrist.

46. Staff confirmed to the surveyor that Resident #28 had not had a fall risk assessment performed at the time of her admission. Staff also confirmed no interventions had been put in place to address Resident #28's falls. Further, at the time of Resident #28's fall, the facility did not have a fall management policy in place.

47. The facility was cited for failure to adequately and completely assess for fall risks for Resident #28.

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.

48. The facts stated in paragraphs three (3) through forty-one (41) are sufficient to establish that Respondent has violated the 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 health care professional operating within the scope of the professional license or certification and according to the resident's plan of care.

49. The facts stated in paragraphs forty-two (42) through forty-seven (47) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(7)(a)[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.

ORDER

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

50. Respondent will remit payment for three (3) civil monetary penalties, one for one thousand dollars ($1,000) for failure to ensure all medications were administered, and one for five hundred dollars ($500.00) for failure to provide safety while in the assisted care living facility, for a total civil monetary penalty of one thousand five hundred dollars ($1,500.00). The 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

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 February, 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:

S. David Selznick, Vice President
For Licensee - The Terrace at Mountain Creek
Respondent

2/4/2020
Date

Christopher C. Puri
Counsel
Bradley Arant Boult Cummings, LLP
1600 Division Street, Suite 700
Nashville, TN 37203

2/5/2020
Date

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

2/05/2020
Date

CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon Respondent, The Terrace of Mountain Creek, by and through its Counsel, Christopher C. Puri, Counsel, Bradley Arant Boult Cummings, LLP, 1600 Division Street, Suite 700, Nashville, TN 37203 by delivering same in the United States mail, certified return receipt 7019 0700 0001 2470 9384 and via United States Postal Service first class, with sufficient postage thereon to reach its destination.

This 6th day of February, 2020.

Caroline R. Tippens

Caroline R. Tippens
Senior Associate General Counsel