STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
The Terrace at Mountain Creek	)	
1005 Mountain Creek Road	)	**Docket #: 17.17-190944A &**
Chattanooga, TN	)	**Case #: 201904075**
	)	
License No. ACLF 00000257	)	

AGREED ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 2nd day of October, 2019, 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. In June 2018, Respondent facility entered into a Consent Order before the Board of Licensing for Health Care Facilities, as the facility was cited for using medication techs to administer medications and sliding scale insulin. The facility was assessed one

thousand five hundred ($1,500.00) in civil monetary penalties for failure to ensure that all drugs and biologicals shall be administered by licensed professionals operating within the scope of their professional license and according to the resident's Plan of Care.

3. On or about August 1, 2018, Department surveyors conducted complaint survey at the Respondent facility.

4. Surveyors observed medical assistant ("MA") #1 performing a blood sugar check on Resident #5. MA #1 indicated that she normally administered Resident #1's blood sugar check and sliding scale insulin. MA #1 is not licensed nurse.

5. A review of the medical records for Resident #1 indicated that MA #1 had given Resident #1 insulin twenty-five (25) times to Resident #1 during the month of July 2018.

6. The former Director Health and Wellness confirmed that the facility had failed to ensure that all drugs and biologicals were administered by a licensed professional operating within the scope of their licensure.

7. Resident #3 was admitted to the facility in May 2018 with diagnoses of Alzheimer's and atrial fibrillation.

8. On or about July 2, 2018, Resident #3 eloped from the facility and fell and hit his head.

9. Resident #3 was admitted to a local emergency room with a scalp laceration which required two staples.

10. Resident #3 was discharged back to Respondent facility on July 3, 2018.

11. The facility failed to have sufficient awareness of Resident #3's whereabouts to provide for Resident #3's safety.

12. On September 7, 2018, the facility submitted an acceptable Plan of Correction. A revisit was performed on September 24, 2018, which resulted in one deficiency being recited.

13. The facility submitted a revised Plan of Correction on October 19, 2018. On or about November 13, 2018, surveyors conducted a second revisit survey, in which they determined that the facility was back in compliance.

14. From on or about August 5, 2019 through August 12, 2019, the Department conducted a complaint survey at the Terrace of Mountain Creek. Surveyors determined that six (6) residents (Residents #6, 7, 8, 9, 10, and 11) failed to meet the definition of an assisted living facility resident, as they required a higher standard of care. These six (6) residents were mainly dependent on staff for all activities of daily living, including requiring feedings, bathing, and toileting.

15. During the August 5-12, 2019 survey surveyors found that the During the August 5-12, 2019 survey, surveyors found that the facility failed to ensure medications were administered for fourteen (14) residents (Residents #1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16) and failed to ensure activities of daily living (ADLS) were met for seven (7) residents (Residents #1, 2, 7, 8, 9, 10, 11). The facility's failure to ensure medications were administered as ordered and failure to perform ADLs created an unsafe environment for any resident who required assistance with medication administration, feeding, or bathing. Surveyors determined that the facility's failure to maintain a sufficient number of employees was the cause of this deficient practice.

16. During the August 5-12, 2019 survey, the facility was cited for the third (3rd) time for failure to ensure that all drugs and biologicals are administered by a licensed healthcare professional operating within the scope of their professional license and according to the resident's plan of care, as the facility failed to ensure all medications were administered for thirteen (13) residents (#1, 2, 3, 5, 7, 8, 9, 10, 11, 13, 14, 15, and 16).

17. During the August 5-12, 2019 survey surveyors found that the facility failed to provide personal services to six (6) residents who required assistance with feeding (Residents #6, 7, 8, 9, 10, 11), toileting (Resident #13), and bathing (Residents #1, #2, #11). For example, medical records contained no documentation that Resident #1 had received baths within a thirty-nine (39) day period. Resident #1 was observed to be surveyors to be unclean, unshaven, and have significant body odor. Resident #1 stated to surveyors that he was not frequently bathed, as they did not have enough staff. Resident #2 received seven (7) showers in forty-five (45) days. From April 2019- July 2019, Resident #11 received one (1) shower out of forty-eight (48) bathing days. The Director of Wellness confirmed that neither Resident #1 nor Resident #2 had received showers as scheduled. When confronted about Resident #11's condition and lack of showers, the former Director of Wellness stated, "It is a process, what do you expect me to do? I can't do it all." The facility was also cited for failure to provide the assistance/care required to comply with Resident #1, #2, and #11's plans of care.

18. The facility also failed to report an allegation of neglect involving Resident #11. In July 2019, the Long Term Care Ombudsman noted and brought to the Executive Director's attention that Resident #11 was pocketing food in her mouth. While surveyors were in the building, the Ombudsman again found Resident #11 with bulging cheeks which contained fluid and medication. She notified staff who removed the medication and fluid. Resident #11 had not been fed her lunch, as she requires assistance with feeding. Further, staff indicated that Resident #11 would not be fed her lunch because the State was in the building. As a result, the former Wellness Director engaged in a heated commentary with RA #5, #8, #9, #10 and CNA #4. The Wellness Director stated, "I threatened you two

weeks ago. It's my license. Feed Resident #11 or I will bring you up on neglect charges myself." A sandwich was later brought to Resident #11, but she could not eat it, as she required assistance with feeding. An interview with the Executive Director confirmed that he had not conducted an investigation into the allegation of neglect of Resident #11 and had not reported the allegation to the State.

19. The management of the facility terminated the prior Director of Health and Wellness on February 11, 2019, and the Executive Director on December 19, 2017. The current Director of Health and Wellness has been at the facility since September 23, 2019. The current Executive Director has been at the facility since May 20, 2019. At all times the Facility had a Director of Health and Wellness and Executive Director.

20. During the August 5-12, 2019 survey, surveyors observed residents drinking out of bowls and foam cups. The facility acknowledged that it had failed to provide residents with proper drinking cups.

21. During the August 5-12, 2019 survey surveyors found that the facility failed to discharge Residents #8 and #12 who displayed verbal and physical behaviors which posed a threat of imminent danger to self and others. As a result, on or about December 19, 2018, Resident #8 kicked one resident assistant, and showed aggression by scratching and squeezing another resident assistant, before hitting a third resident assistant in the face with a closed fist. In January 2019, Resident #8 was also observed spitting, kicking, and biting staff. Medical records from April, May, and July 2019, revealed Resident #8 continued exhibiting combative behavior. Resident #12's medical record revealed that the patient was "not-teachable and unable to participate in self-care." Documentation from May 2019 revealed that Resident #12 exhibited "unsafe behaviors." In June 2019,

Resident #12 was observed yelling and hitting staff when they attempt to assist. The facility failed to discharge Residents #8 and #12.

22. On June 28, 2019 and July 16, 2019, a nurse practitioner recommended that Resident #11 be transferred from the facility, due to the fact that she required a higher level of care. The facility failed to transfer Resident #11. Further, the facility failed to identify additional residents (#6, 7, 8, 9, and 10) whose needs for services required a higher level of care. The facility also could not locate the medical record of Resident #5.

23. During the August 5-12, 2019 survey surveyors found that the facility failed to ensure thirty (30) day notice was given prior to increasing the fee schedule for Residents #1, 2, 5, 6, 7, 9, and 10. The facility also failed to provide Resident #11 with a written admission agreement.

24. During the August 5-12, 2019 survey surveyors found that the facility failed to ensure a clean and sanitary environment. Surveyors observed that the 4th floor clean supply room was filled with trash bags containing resident garbage, including soiled incontinence products. Clean supply room #1 was also observed to have garbage overflowing onto the floor, including sanitary wipes, diapers, and tuck pads. The Executive Director acknowledged that the facility failed to maintain a sanitary environment.

25. During the August 5-12, 2019 survey surveyors found that Resident #1 repeatedly complained of pain under his arms when Resident Care Aides lifted and moved him. Resident #1 also complained that he was not receiving showers because the facility was short staffed. Resident #13 complained that he had to urinate on himself on multiple occasions, after no staff were available to assist him with toileting. During the August 5-

12, 2019 survey surveyors found that the facility also failed to ensure that resident complaints or grievances are recorded and responded to promptly.

26. Because of the findings during the August 5-12, 2019 surveyors found that the facility failed to maintain adequate staffing levels to meet the needs of residents. As a result, the facility failed to administer medications as ordered; failed to ensure residents received showers; and failed to ensure residents were fed in accordance with their plan of care.

27. On or about September 4, 2019, the Commissioner of the Department of Health suspended admissions to The Terrace of Mountain Creek based on the findings of the August 5-12, 2019 survey. The Commissioner also imposed an assessment of twenty-six thousand dollars ($26,000.00) in civil monetary penalties for the facility's failure to remove eight (8) inappropriate residents, who required a higher level of care; failure to ensure medications were administered; failure to maintain a medical record; failure to follow the residents' plans of care; and failure to provide personal services.

28. On or about September 4, 2019, the Department conducted a life safety complaint survey at Respondent facility.

29. When life safety surveyors entered the premises, ninety-three (93) residents were residing within the building. For the ninety-three (93) residents present, only five (5) staff members were on duty. Life safety surveyors then conducted a fire drill between 4:51 A.M and 5:04 A.M (3rd shift).

30. During the fire drill, the facility failed to ensure fifty-two (52) out of seventy-five (75) residents could be evacuated in thirteen (13) minutes. Five (5) staff were on duty during the fire drill.

31. The third (3rd) floor memory care wing evacuated five (5) of eleven (11) residents in thirteen (13) minutes. After twenty-one (21) minutes, three (3) residents remained in their rooms.

32. The fourth (4th) floor of the facility was only able to evacuate eight (8) of thirty-one (31) residents. One resident in room 406 was improperly evacuated by dragging their mattress.

33. The fifth (5th) floor of the facility was only able to evacuate ten (10) out of thirty-three (33) residents.

34. Staff stated to surveyors that they had received no training on third (3rd) shift fire drills. Five (5) of the patients required a two (2) person assist, but there were not always two (2) staff members on duty to assist.

35. One staff member stated to surveyors that she had been employed at the facility for two (2) years and this was the first real fire drill she had seen on third (3^{rd}) shift.

36. A review of the facility's fire drill report revealed no records of any 2^{nd} or 3^{rd} shift fire drills. The facility could only provide proof that one fire drill was conducted during the day on July 3, 2019.

37. The facility failed to ensure fire drills were conducted during sleeping hours to ensure that residents evacuated the facility in accordance with their fire plan. Further, staff were not familiar with fire plan procedures.

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.

38. The facts stated in paragraph two (2) through eighteen (18) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.08(1)(d))[ADMISSIONS, DISCHARGES, AND TRANSFERS], the relevant portion of which reads as follows:

(1) 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 physically aggressive behavior which poses an imminent physical threat to self or others, based on behavior, not diagnoses.

(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.

39. The facts stated in paragraph two (2) through eighteen (18) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.08(9)(b))[ADMISSIONS, DISCHARGES, AND TRANSFERS], the relevant portion of which reads as follows:

(9) An ACLF utilizing secured units shall provide survey staff with twelve (12) months of the following performance information specific to the secured unit and its residents at its annual survey:

(b) Ongoing and up-to-date documentation that each resident's interdisciplinary team has performed a quarterly review as to the appropriateness of placement in the secured unit.

40. The facts stated in paragraph two (2) through eighteen (18) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.12(5)(a)[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.

41. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.06(1)(a)(3)[Administration], the relevant portion of which reads as follows:

(1) Each ACLF shall meet the following staffing and procedural standards:

(a) Staffing Requirements:

(3) An ACLF shall have an identified responsible attendant who is alert and awake at all times and a sufficient number of employees to meet the residents' needs, including medical services as prescribed. The responsible attendant and direct care staff must be at least eighteen (18) years of age and capable of complying with statutes and rules governing ACLFs.

42. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 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.

43. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 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.

44. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.07(7)(c)(4)(iv)[Services Provided], the relevant portion of which reads as follows:

(c) Dietary Services:

(4) An ACLF shall:

(iv) Provide appropriate, properly-repaired equipment and utensils for cooking and serving food in sufficient quantity to serve all residents.

45. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.08(1)(d)[Admissions, Discharges, and Transfers], the relevant portion of which reads as follows:

(1) 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 physically aggressive behavior which poses an imminent physical threat to self or others based on behavior, not diagnoses.

46. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.08(2)[Admissions, Discharges, and Transfers], the relevant portion of which reads as follows:

(2) An ACLF resident shall be discharged and transferred to another appropriate setting such as a home, a hospital, or a nursing home when the resident, the resident's legal representative, ACLF administrator, or resident's treating physician determine that the ACLF cannot safely and effectively meet the resident's needs, including medical services.

(a) The Board may require that an ACLF resident be discharged or transferred to another level of care if it determines that the resident's needs, including medical services, cannot be safely and effectively met in the ACLF.

47. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-

08-25-.08(6)(a)[Admissions, Discharges, and Transfers], the relevant portion of which reads as follows:

(6) An ACLF shall:

(a) Be able to identify at the time of admission and during continued stay those residents whose needs for services are consistent with these rules and regulations and those residents who should be transferred to a higher level of care.

48. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.08(6)(c)[Admissions, Discharges, and Transfers], the relevant portion of which reads as follows:

(6) An ACLF shall:

(c) Have an accurate written statement regarding fees and services which will be provided to residents upon admission.

49. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.08(6)(d)[Admissions, Discharges, and Transfers], the relevant portion of which reads as follows:

(6) An ACLF shall:

(d) Give a thirty (30) day notice to all residents before making any changes in fee schedules.

50. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-

08-25-.11[Infectious and Hazardous Waste], the relevant portion of which reads as follows:

(1) An ACLF must develop, maintain and implement written policies and procedures for the definition and handling of its infectious waste. These policies and procedures must comply with the standards of this rule.
(2) The following waste shall be considered to be infectious waste:
    (a) Waste contaminated by residents who are isolated due to communicable disease, as provided in the U.S. Centers for Disease Control "Guidelines for Isolation Precautions in Hospitals";
    (b) Cultures and stocks of infectious agents including specimen cultures collected from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures;
    (c) Waste human blood and blood products such as serum, plasma, and other blood components;
    (d) Pathological waste, such as tissues, organs, body parts, and body fluids that are removed during surgery and autopsy;
    (e) All discarded sharps (e.g., hypodermic needles, syringes, Pasteur pipettes, broken glass, scalpel blades) used in resident care or which have come into contact with infectious agents during use in medical, research, or industrial laboratories; and
    (f) Other waste determined to be infectious by the ACLF in its written policy.
(3) Infectious and hazardous waste must be segregated from other waste at the point of generation (i.e., the point at which the material becomes a waste) within the ACLF.

51. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.12(1)[Resident Records, the relevant portion of which reads as follows:

(1) An ACLF shall develop and maintain an organized record for each resident and ensure that all entries shall be written legible in ink, typed, or kept electronically, and signed, and dated.

52. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.12(5)(b)[Resident Records, the relevant portion of which reads as follows:

(5) Plan of Care.

(b) The plan of care shall describe:

(1) The needs of the resident, including the activities of daily living and medical service for which the resident requires assistance, i.e., what assistance/care, how much, who will provide the assistance/care, how often, and when.

53. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.1(1)[Reports], the relevant portion of which reads as follows:

(1) The ACLF shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.

54. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.14(1)(b)[Resident Rights], the relevant portion of which reads as follows:

(1) An ACLF shall ensure at least the following rights for each resident:

(b) To be free from mental and physical abuse. Should this right be violated, the ACLF shall notify the Department and the Tennessee Department of Human Services, Adult Protective Services at 1-888-277-8366.

55. The facts stated in paragraph fourteen (14) through twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.14(1)(h)[Resident Rights], the relevant portion of which reads as follows:

(1) An ACLF shall ensure at least the following rights for each resident:

(h) To voice grievances and recommend changes in policies and services of the ACLF without restraint, interference, coercion, discrimination or reprisal. An ACLF shall inform the resident of procedures to voice grievances and for registering complaints confidentially.

56. The facts stated in paragraph twenty-seven (27) through thirty-six (36) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 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.

57. The facts stated in paragraph twenty-seven (27) through thirty-six (36) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.10(3)(a)[Life Safety], the relevant portion of which reads as follows:

(2) An ACLF shall conduct fire drills in accordance with the following:

(a) Fire drills shall be held for each ACLF work shift in each separate ACLF building at least quarterly.

58. The facts stated in paragraph twenty-seven (27) through thirty-six (36) are sufficient to establish that Respondent has violated the provisions of Tenn. Comp. R & Regs. 1200-08-25-.10(3)(b)[Life Safety], the relevant portion of which reads as follows:

(3) An ACLF shall conduct fire drills in accordance with the following:

(b) There shall be one (1) fire drill per quarter during sleeping hours.

ORDER

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

59. Respondent's license to operate as an Assisted Care Living Facility shall be placed on probation for no less than six (6) months and up to one (1) calendar year. The facility may make a request to have their probationary status lifted, in writing, when the facility can prove compliance all terms of this Order. In order to do so, the facility must show that all deficiencies are corrected and no new deficiencies have been cited. The request to lift probation must be heard at the Board's regularly scheduled Board meeting.

60. Within ten (10) days of the ratification of the Board's Order, the Respondent shall submit a completed Plan of Correction for approval.

61. Respondent hereby agrees to remain under the Board's assessed Suspension of Admissions until the facility's Plan of Correction is accepted and all deficiencies have been corrected.

62. The Department of Health agrees to resurvey the facility for correction of the underlying conditions and that the facility or licensee complies with the conditions for the

suspension to be lifted as set forth in the commissioner's order as provided by T.C.A. §68-11-252(k), unless otherwise waived by Respondent.

63. As part of its corrective action, Respondent must do each of the following:

a. Respondent must provide training to all staff on medication administration procedures; and

b. Respondent must provide training to all staff on fire safety evacuation procedures; and

c. Respondent conduct and document fire drills for each shift every quarter as well as a fire drill during sleeping hours as required.

d. Respondent must provide documentation that all training and fire drills have been completed to the Board in its progress report during the Board's regularly scheduled meetings.

64. Respondent, through its controlling entity Kayne Anderson, voluntarily agrees to identify, in consultation with the Tennessee Department of Health, a new manager for the facility to replace Discovery Senior Living, the current manager in place from September 1, 2017 to present. Respondent agrees this new management will replace the current manager and operate the Facility no later than ninety (90) days after the effective date of this order. Kayne Anderson agrees to maintain a representative at the Facility for at least 20 hours per week until a new manager is in place to oversee the operation of the management of the Facility.

65. Notwithstanding the provisions of paragraph [59] and [70], upon Respondent identifying and putting in place a new manager replacing the current manager (Discovery Senior

Living), it may petition the Board to have its probationary status lifted by submitting a petition in written form to be considered at next regularly scheduled Board meeting.

66. (66) Respondent will remit payment of the penalties by the Commissioner's Suspension of Admissions Order dated September 30, 2019, which imposed twelve (12) civil monetary penalties [eight (8) civil monetary penalties of three thousand dollars ($3,000.00) each for the eight (8) inappropriate residents and four (4) civil monetary penalties of five hundred dollars ($500.00) each for failure to ensure all medications were administered, maintain a medical record, follow the plan of care, and provide personal services] for a total amount of twenty six thousand dollars ($26,000.00). The facility also agrees to pay three (3) civil monetary penalties in the amount of one thousand dollars ($1,000.00) each for the failure to properly evacuate residents and conduct fire drills. As such, the total assessment of civil monetary penalties will be twenty-nine thousand dollars ($29,000.00). 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

67. A representative of the Respondent shall appear at the October 2019, February 2020, June 2020, and October 2020 Board of Licensing for Healthcare Facilities' Board meetings and provide an update to the Board regarding whether or not the cited deficiencies have been corrected. Respondent must show adherence to the Plan of Correction and that any outstanding deficiencies from the August 2018, August 2019, and September 2019 surveys have been corrected. Upon completion, Respondent shall also

provide to the Board evidence of the aforementioned training in medication administration, fire evacuation procedures, completion of fire drills, and staffing ratios. Failure to conduct the aforementioned training and provide documentation to the Board are violations of the Board's Order.

68. Respondent agrees to pay costs for all revisit surveys incurred by the Department after September 4, 2019. The Department will prepare an assessment of cost in this matter. Such costs shall not exceed ten thousand dollars ($10,000.00). The facility may pay this amount in installment payments. A payment plan may be set up by contacting Eddie J. Stewart, at the address listed above.

69. The terms listed in paragraphs fifty-eight (58) through sixty-eight (68) must be met before the facility may petition the Board to have its probationary status lifted. The facility shall submit its petition in written form to be considered at a regularly scheduled Board meeting.

70. Any violation of this Order shall constitute a violation of this Agreed Order and will be grounds for additional discipline by the Board, up to and including, revocation of the facility's licensure. If there are any new serious deficiencies cited after October 2019, the Department will file a Notice of Charges, and pursue a contest case hearing in February 2020.

71. 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 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:

For Licensee - The Terrace at Mountain Creek Respondent

10/02/2019
Date

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

10/02/2019
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

10.2.2019
Date

CERTIFICATE OF FILING

This Order was received for filing in the Office of the Tennessee Secretary of State, Administrative Procedures Division, and became effective on the 7th day of October, 2019.

Stephanie Shackleford, Director
Administrative Procedures Division

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 7018 3090 0002 0150 9731 and via United States Postal Service first class, with sufficient postage thereon to reach its destination.

This 7th day of October, 2019.

Caroline R. Tippens
Senior Associate General Counsel