BEFORE THE TENNESSEE BOARD FOR LICENSING HEALTH CARE FACILITIES

IN THE MATTER OF:	)
	)
Legacy Assisted Living and Memory Care	)
6551 Knight Arnold Road	)
Memphis, TN 38115	)
	)
License No. ACLF 00000279	)

ORDER OF SUMMARY SUSPENSION

This cause came to be heard on the 13th day of March, 2020 at a public meeting, before the Tennessee Board for Licensing Health Care Facilities ("Board"), upon the application of the Tennessee Department of Health, Office of Health Care Facilities, and the Office of General Counsel ("State"), for a summary suspension of Respondent's license pursuant to Tennessee Code Annotated Section ("T.C.A. §") 4-5-320(c). The State presented evidence that the public health, safety, and welfare imperatively require this emergency action in light of the fact that the Respondent, **Legacy Assisted Living and Memory Care, 6651 Knight Arnold Road, Memphis, TN 38115,** in light of the serious deficiencies cited by surveyors during a complaint survey conducted on March 3, 2020. This facility has a lengthy disciplinary history with the Board of Licensing for Health Care Facilities. The Board cannot allow Legacy Assisted Living and Memory Care to continue to operate, as its conduct is detrimental to the welfare of the residents therein.

On or about March 3, 2020, surveyors entered the facility to conduct a complaint survey. Surveyors substantiated the three complaints and re-cited the facility with three new deficiencies. The facility allowed Resident #1, who exhibited physical and verbally aggressive behavior, to continue to reside at the facility despite posing a threat to herself and others on multiple occasions. Further, Resident #1 was

also the alleged victim of an assault, which the facility failed to investigate. At the time of the survey, Resident #1 remains hospitalized.

Finally, the facility was also unable to provide the appropriate care to Resident #3, who had severe dysphagia. Despite a doctor's order for pureed food, the facility failed to provide her with full meals, which resulted in two trips to the Emergency Room. On the second trip, Resident #3 had to have an apple slice removed from her throat via endoscopy. The facility failed to follow physician's orders and to provide safety to Resident #3. The facility's deficient practice resulted in actual harm to Residents #1 and #3.

Given the history of deficiencies and the continued and ongoing violations which result in a threat to the residents therein, the State has taken the extraordinary step of asking the Board to summarily suspend the facility. The Department's position is that the severity of the Respondent's conduct constitutes a serious threat to the public health, safety, and welfare, and that if the Respondent is allowed to maintain its license, the facility may pose a serious threat to the health, safety, and welfare of the facility's residents and the public.

In support of the application for Summary Suspension, the State presented the affidavit of Ann R. Reed, Director for Licensure, and testimony of Sherry Wehner who is a surveyor with the Department of Health.

JURISDICTION

1. The Board for Licensing Health Care Facilities (hereinafter "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. § 68-11-210 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.

2. The Board has the authority to suspend or revoke the license of any facility licensed under Tenn. Code Ann. § 68-11-201 *et. seq.* Tenn. Code Ann. § 68-11-207(a).

3. In imposing the sanctions authorized in [§ 68-11-207], the board may consider all factors that it deems relevant, including, but not limited to, the following:

    1. The degree of sanctions necessary to ensure immediate and continuous compliance;
    2. The character and degree of impact of the violation on the health, safety and welfare of the patients in the facility;
    3. The conduct of the facility against whom the notice of violation is issued in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and
    4. Any prior violations by the facility of statutes, regulations or orders of the board.

4. The board may, in its discretion, after the hearing, hold the case under advisement and make a recommendation as to requirements to be met by the facility in order to avoid either suspension or revocation of license or suspension of admissions.

5. Under T.C.A. § 4-5-320(c), the Board has the authority to summarily suspend a license if it finds that the public health, safety, or welfare imperatively requires emergency action.

FACTS

6. At all times pertinent hereto, Legacy Assisted Living & Memory Care at Lenox Park, located at 6551 Knight Arnold Road, Memphis, TN 38115 has been licensed as an Assisted-Care Living Facility by the Board. having been issued license number 00000279 on June 13, 2006. Respondent has an active license with an expiration date of May 29, 2020.

7. As a result of surveys in November and December 2017, the facility entered into a Consent Order which was approved and ratified by the Board in April 2018. A copy of the Consent Order is attached hereto as Exhibit 1.
8. On or about June 6, 2018, the Board of Licensing for Health Care Facilities heard statements from both the facility and Department of Health surveyors that deficiencies cited on the May 22-23, 2018 survey were serious deficiencies affecting the health, safety, and welfare of the residents.
9. On or about June 7, 2018, the Board suspended the admissions to Respondent facility. A copy of the Suspension of Admissions is attached hereto as Exhibit 2.
10. On July 16, 2018 through August 2018 surveyors were present at the facility for a revisit survey in which three (3) deficiencies were cited. As such, the facility remained under a Suspension of Admissions.
11. On or about August 16, 2018, the facility submitted a Plan of Corrections. A revisit survey was scheduled for September 2018.
12. On or about September 13, 2018 surveyors exited the facility. Surveyors re-cited the facility for failure to correct their deficiencies and one new deficiency.
13. On or about October 3, 2018, the facility appeared before the Board and entered into a new Consent Order. A copy of the Consent Order is attached hereto as Exhibit 3.
14. On or about October 8, 2018, the facility submitted a Plan of Correction which was deemed to be acceptable to correct the September 2018 deficiencies.
15. From November 26, 2018 through December 6, 2018 surveyors conducted a revisit and complaint survey to ensure the September 2018 deficiencies had been corrected. A deficiency was re-cited from the revisit survey and new deficiencies were identified during the complaint investigation.

16. On or about December 11, 2018, pursuant to a petition filed under docket number CH-18-1714 in the Chancery Court of Shelby County, Tennessee for the Thirtieth Judicial District at Memphis, the Chancery Court entered an order appointing KCP Advisory Group, LLC as Receiver (the "Receiver") for Respondent.

17. On or about February 5, 2019 the facility entered into an Agreed Order. Under the terms of the Agreed Order the facility was placed on probation from February 5, 2019 until February 5, 2020 unless earlier lifted by the Board. The facility also submitted a Plan of Correction with certain of the corrective actions being re-cited in the Agreed Order. The facility also agreed to remain under the Suspension of Admissions until the Plan of Correction was accepted and all deficiencies were corrected. The facility agreed a representative would appear at each Board meeting up to and including the February 2020 Board meeting and make progress reports to the Board at such meetings. A copy of the Agreed Order is attached as Exhibit 4.

18. On or about May 9, 2019, as a result of a revisit survey conducted on May 22, 2018 – through May 23, 2018, the Department lifted the Suspension of Admissions. A copy of the Suspension of Admissions Lift Letter is attached as Exhibit 5.

19. On or about October 2, 2019, the facility appeared before the Board and entered into an Agreed Order. In the Agreed Order, the facility agreed that the Department will file a Notice of Charges and set this case for a hearing before the Board in February 2020. A copy of the Agreed Order is attached hereto as Exhibit 6.

20. On or about February 5, 2020, the facility appeared before the Board and entered into an Agreed Order in which the facility agreed to be suspended effective June 3, 2020, if prior to that date, all deficiencies are not cleared, and all of the following conditions are not met by the facility:

    a) The Respondent facility must hire a new management company from a state

approved provider list.

b) The management company must be in the facility five (5) days a week, one day of which must be a Saturday or Sunday. This five day a week requirement can be met if either the facility Administrator or Director of Nursing is a direct employee of the management company, and if another employee of the management company, to whom the Administrator or DON reports, is also on-site at the facility on a reasonably frequent basis, as needed.

c) The receiver or its authorized representative must be in the facility one day a week. The authorized representative must be an individual who is contractually obligated to report directly to Mr. Paul Valentine. This authorized representative of the receiver will provide oversight of the management company, and coordinate with the consultant and the management company, and keep the receiver reasonably apprised as to the facility's compliance.

d) Within fourteen (14) days of the date of this Order, the Respondent facility shall hire a consultant from a State approved list who must submit every other month an acceptable report to Board staff which must contain the following:

1) the facility's staffing ratio;

2) the amount of payment that the facility is paying to the management company;

3) the number of residents in the facility;

4) a clinical assessment of each resident's condition;

5) each resident's payor source; and

6) a transfer plan for each resident which must be updated bi monthly.

e) Each resident shall be issued a notice of discharge thirty (30) days prior to June 3, 2020 in case the facility is unable to comply with these terms.

f) If the Respondent facility is unable to comply with these terms, the facility hereby agrees that all residents will be transferred out of the facility by June 3, 2020.

g) If the facility is able to comply with the terms set forth in [paragraph](d)(1-6) and successfully clear all its deficiencies, the suspension set to take effect June 3, 2020 shall be null and void, and the Respondent facility shall be able to apply to have their probationary status lifted at the June 3, 2020 Board meeting. In order to facilitate Respondent facility's compliance with this Agreed Order, the appropriate representatives of the Department will participate with the receiver and/or its counsel and representatives in a conference call upon the submission of each report by the consultant.

A copy of the Agreed Order is attached hereto as *Exhibit 7.*

21. On or about March 3, 2020, surveyors conducted an investigation into two complaints at the facility.

22. Resident #1, aged 77, was admitted to the facility March 2019 and had diagnoses of Alzheimer's, dementia, diabetes, hypertension, and osteoarthritis. Resident #1 resided in the memory care unit.

23. Nursing notes reveal that Resident #1 exhibited physical and verbal aggression. No documentation was found in her medical record as to how to how the facility planned to prevent physical and verbal aggression in Resident #1.

24. On or about October 1, 2019, Resident #1 attempted to stab a staff member. Resident #1 was then transferred to a psychiatric hospital.

25. On or about October 11, 2019, Resident #1 was readmitted to the facility. The facility could provide no documentation that Resident #1's plan of care was revised with new interventions for prevention of aggressive behaviors.

26. The day after Resident #1 returned, Resident #1 refused to take her medication and again displayed aggressive behavior, as she grabbed another resident by the arm. The facility could provide no documentation that Resident #1's plan of care was revised with new interventions for prevention of aggressive behaviors.

27. On or about October 13, 2019, Resident #1 struck another resident. The facility could provide no documentation that Resident #1's plan of care was revised with new interventions for prevention of aggressive behaviors.

28. On or about October 19, 2019, Resident #1 threatened to assault staff. The facility could provide no documentation that Resident #1's plan of care was revised with new interventions for prevention of aggressive behaviors.

29. On or about October 25, 2019, Resident #1 obtained a spray bleach bottle and attempted to spray staff with bleach. Resident #1 also threw objects at staff. The facility could provide no documentation that Resident #1's plan of care was revised with new interventions for prevention of aggressive behaviors.

30. On or about November 10, 2019, Resident #1 refused to take her medications and was found to have multiple medications in her purse. There was no documentation that Resident #1's physician was notified of her behaviors or her failure to take her medications.

31. On or about December 2, 2019, Resident #1 again refused to take her morning medications. The facility could provide no documentation that Resident #1's plan of care was revised with new interventions for prevention of her behaviors.

32. On or about December 3, 2019, Resident #1 kicked another resident. The facility could provide no documentation that Resident #1's plan of care was revised with new interventions for prevention of aggressive behaviors.

33. On or about January 9, 2020, Resident #1 hit an employee with a broom. The facility could provide no documentation that Resident #1's plan of care was revised with new interventions for prevention of aggressive behaviors.

34. On or about January 10, 2020, Resident #1 was observed to enter other residents' rooms without their permission which resulted in a verbal altercation with another resident. There was no documentation in the resident's plan of care to protect other residents from Resident #1's behaviors.

35. In February 2020, Resident #1 refused her medications on multiple occasions. There facility could not provide any documentation that Resident #1's physician was notified that she was not taking her medications as ordered.

36. On or about February 7, 2020, staff documented that the intervention put in place for Resident #1's noncompliance with her medication regiment was that staff were to coach the resident on the importance of taking her prescribed medication. Resident #1 is a dementia patient.

37. The facility continue to permit Resident #1, who exhibited aggressive behaviors and was a threat toward others, to remain in the assisted living facility.

38. On or about February 15, 2020, Resident #1 attempted to strike staff, engaged in an altercation with Resident #1, and became combative with both the Medical Director on staff and her Power of Attorney. Resident #1's Power of Attorney refused to let Resident #1 be transported to the hospital. Staff documented that Resident #1 was a threat to others. However, there was no documentation that the physician assessed Resident #1 for causes of her behavior, amended her treatment plan, or put in place any interventions to protect other residents from Resident #1.

39. Later that evening, Resident obtained a broom and attempted to attack LPN #1. Staff noted that Resident #1 chased LPN #1 down the hall while swinging the broom and yelling profanities. Staff were finally able to get the broom away from Resident #1. The police were called to the facility and Resident #1 was sent to a hospital for assessment.

40. Caregiver #1 documented that Resident #1 was observed to have a scratch under her eye when police arrived. Caregiver #1 documented that Resident #1 accused Caregiver #1 and LPN #1 of assaulting her. However, there was no documentation in the nursing notes regarding the source of the scratch on Resident #1's face. Neither Caregiver #1 nor LPN #1 are now employed at the facility.

41. Hospital records revealed that upon admission to the Emergency Room, Resident #1 had pain in both bilateral lower extremities and a laceration to her eye. Hospital staff documented that Resident #1 stated that she was assaulted at the assisted living facility.

42. Resident #1 was placed in the intensive care unit of the hospital and remained hospitalized at the time of the survey.

43. Staff documented that Resident #1's family member called and stated that the hospital had recommended that Resident #1 not return to the facility, as it was an unsafe environment. Resident #1's family member also again informed the facility that Resident #1 had been assaulted.

44. The facility failed to designate a responsible person to conduct an investigations and failed to conduct an investigation into the allegation of abuse of Resident #1.

45. Resident #3, aged 80, was admitted to the facility in July 2016 with diagnoses of dementia, cerebral vascular accident, hypertension, diabetes, depression, and schizophrenia.

46. A physician's order dated September 2018 ordered that Resident #3 receive nectar thickened liquid to prevent choking and was to be monitored during meal times.

47. In May 2019, nursing notes revealed that Resident #3 was receiving dysphagia management therapy and required pureed foods to prevent aspiration.

48. On or about December 18, 2019, Resident #3 notified staff that she felt like something was stuck in her throat. Resident #3's oxygen levels were observed to be decreased. Resident #3 was placed on oxygen and her physician was contacted. Resident #3 was sent to the local emergency room for evaluation.

49. The medical records from the emergency room noted that Resident #3 had a physician's order for a pureed diet. However, Resident #3 stated to Emergency Room staff she did not receive her pureed diet at breakfast. Instead, Resident #3 had choked while attempting to consume a breakfast sausage. The emergency room was able to resolve the choking incident and discharged Resident #3 back to the facility.

50. Facility notes indicated that Resident #3 was to be monitored after this incident, but no additional safety interventions were put in place to prevent Resident #3 from choking.

51. On or about February 2, 2020, Resident #3 choked while eating an apple slice at lunch.

52. Resident #3 was transported to the Emergency Room with a foreign body in her throat. The Emergency Room conducted an endoscopy and the foreign body, an apple slice, was removed. Resident #3 was then discharged back to the facility.

53. Nursing notes revealed that Resident #3 was to be monitored upon her arrival back to the facility.

54. On or about March 3, 2020, surveyors observed Resident #3 seated in a wheelchair at the dining table. Resident #3 had a lunch plate containing food which was shredded and chopped, but not pureed to nectar consistency. Resident #3 was observed to be coughing while attempting to eat the chopped food.

55. The Dietary Assistant stated to surveyors that the facility could not puree Resident #3's food, as the blender was broken.

56. The Administrator confirmed to the surveyor that Resident #3's food was not pureed, per her physician's orders.

57. The facility failed to provide safety to Resident #3.

CONCLUSIONS OF LAW

The facts stated in the Grounds for Summary Suspension section, *supra*, are sufficient to establish that grounds for the discipline of Respondent's license exist. Specifically, Respondent has violated the following statutes and/or rules, for which disciplinary action by the Board is authorized:

58. The facts stated in paragraphs two (2) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Tenn. Code Ann. § 68-11-207(a)(3), which indicates that the Board may suspend or revoke the license issued under this part based on any of the following grounds:

> (3) Conduct or practice found by the board to be detrimental to the welfare of the patients in such institutions.
>
> (c) In imposing the sanctions authorized in this section, the Board may consider all factors that it deems relevant, including, but not limited to, the following:
>
> (1) The degree of sanctions necessary to ensure immediate and continued compliance;
>
> (2) The character and degree of impact of the violation on the health, safety and welfare of the patients in the facility;
>
> (3) The conduct of the facility against whom the notice of violation is issued in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and

(4) Any prior violations by the facility of statutes, regulations or orders of the Board.

59. The facts stated in paragraphs seventeen (17) through thirty-two (32) 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 threat to self or others, based on behavior, not diagnoses.

60. The facts stated in paragraphs thirty-three (33) through thirty-nine (39) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.06(1)(a)(1)[ADMINISTRATION] the relevant portion of which reads as follows:

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

(a) Staffing Requirements:

(1.) The licensee must designate in writing a capable and responsible person to act on administrative matters and to exercise all the powers and responsibilities of the licensee as set forth in this chapter in the absence of the licensee.

61. The facts stated in paragraphs forty (40) through fifty-two (52) 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 least the following personal services:

(2) Safety when in the ACLF.

POLICY STATEMENT

The summary suspension statute requires a showing that protection of "public health, safety, or welfare imperatively requires emergency action." T.C.A. § 4-5-320(c). The failures of the Respondent and Respondent's staff resulted in a serious threat to the health and safety of the residents residing in the Respondent's facility. The Board's position is that the severity of the Respondent's conduct constitutes a serious threat to the public health, safety, and welfare.

SUSPENSION

In consideration of the evidence presented, and pursuant to the authority granted under T.C.A. § 4-5-320(c), T.C.A. §§ 68-11-207(a), the Board hereby preliminarily finds that the misconduct of Respondent, **Legacy Assisted Living and Memory Care**, is so severe that it imperatively requires emergency action in order to protect the public health, safety and welfare prior to the initiation of formal disciplinary charges.

It is therefore **ORDERED** that:

62. Respondent's license as skilled nursing facility, license #00000279, is hereby SUMMARILY SUSPENDED.
63. Upon receipt of this Order, Respondent shall not accept any new residents.
64. Respondent shall immediately facilitate the transfer of its residents to appropriate facilities. All residents must be removed from the facility prior to April 2, 2020. Respondent shall grant immediate access to the facility to the Tennessee Department of Health and its surveyors.
65. Respondent shall have a monitor, approved by the Division Director, placed in the facility and shall remain in the facility until every remaining resident is transferred to an appropriate facility.

66. Respondent shall be responsible for the costs of any transfers and the cost of any monitoring.

67. Respondent shall immediately submit a plan of correction to the Department.

68. This suspension shall be effective immediately and shall remain in effect until the conclusion of the contested case hearing against Respondent or until otherwise ordered by the Board.

69. Pursuant to Tenn. Code Ann. § 4-5-320(d)(1), Respondent may present its version of the facts to the Board at an informal conference, if a timely request is made by 5 PM on March 20, 2020, to Ann R. Reed, Director of Licensure, 665 Main Stream Drive, 2nd Floor, Nashville, TN 37243.

70. The sole issue at the informal conference mentioned above shall be whether the public health, safety or welfare imperatively required emergency action by the Board.

SO ORDERED, this the 13th day of March, 2020.

Chairperson
Tennessee Board for Licensing Health Care Facilities

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this document has been served upon the Respondent facility, Legacy Assisted Living and Memory Care, by and through their counsel, Emily Taube & Jerry Taylor, Burr & Forman, 222 2nd Ave S., Suite 2000, Nashville, TN 37201by certified mail number 7019 2970 0002 1304 5141 on the 13th day of March, 2020 and by FedEx, tracking number 8152 8504 9772

Caroline R. Tippens
Senior Associate General Counsel