BEFORE THE TENNESSEE BOARD
FOR LICENSING HEALTH CARE FACILITIES

In The Matter of:	)	
	)	
Golden Years	)	
License No. 00000506, Home for the Aged	)	**Docket No. 17.17-132413A**
	)	
Respondent	)	

AGREED ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter the "Board") on the 14th day of January, 2016, pursuant to a Notice of Charges issued against **Golden Years** (hereinafter "Respondent") by the Division of Health Care Facilities of the Tennessee Department of Health, (hereinafter the "State"). The State was represented by Kyonztè Toombs, Assistant General Counsel. Respondent was represented by Gerald Green, Esq. After consideration of the Notice of Charges and presentation of counsel, the Board finds as follows:

1. Respondent agrees that presentation to and consideration of this Agreed 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 this order not be ratified.
2. Respondent understands the nature of the charges herein alleged and that if proved at hearing, such charges and allegations would constitute cause for imposing discipline upon Respondent.

3. Respondent is aware of each of Respondent's rights, including the right to a hearing on the charges and allegations, the right to appear personally and by counsel, the right to confront and cross-examine witnesses who would testify against Respondent, the right to testify and present evidence on Respondent's own behalf, as well as to the issuance of subpoenas to compel the attendance of witnesses and the production of documents, the right to contest the charges and allegations, and other rights which are accorded Respondent pursuant to the Administrative Procedures Act and other applicable laws, including the right to seek reconsideration, review by the Chancery Court and appellate review.

4. In order to avoid the expense and uncertainty of a hearing, Respondent freely and voluntarily waives each and every one of these rights set forth above.

5. Respondent understands that by signing this Agreed Order, Respondent is enabling the Board to issue its order without further process. In the event that the Board rejects this Agreed Order for any reason, it will be of no force or effect for either party.

I. FINDINGS OF FACT

1. At all times pertinent hereto, Golden Years, 942 Hunter's Point, Cordova Tennessee 38018, has been licensed as a home for the aged, having been issued license number 00000506 on July 6, 2005. Respondent has an active license with an expiration date of July 1, 2016.

2. The Department conducted a complaint survey starting on June 2, 2015. During the survey, the surveyors observed conditions that endangered the health, safety and welfare of the residents.

3. Respondent's administrator, Brenda Tucker, failed to maintain financial resources sufficient to provide for the needs of Resident #1 and #5. Based on the surveyors' telephone interview of a relative of Resident #1 as well as of a relative of Resident #5, it was determined that Respondent charged Resident #1 and Resident #5, respectively, for alleged damages to furniture within the facility as well as to the grounds of the facility. For example, Ms. Tucker forced the family of Resident #1 to buy a recliner for the living room and a chair in the resident's room because Resident #1 had allegedly peed on the furniture and consequently, it smelled. Resident #5 was accused of tearing down the fence in the back yard, and the resident was charged for the cost of replacing the fence. Residents should not be required to pay for repairs.

4. Respondent does not have sufficient staff to meet the needs of its residents. At the time of the June 2015 survey, Respondent employed one primary caregiver, Clarence Humphrey, who lived and slept at the Respondent's facility; there were other caregivers who worked periodically at the facility. Mr. Humphrey even slept during his shifts. Respondent cannot demonstrate and/or document that there is adequate personnel to provide care for Respondent's current residents. Further, rather than stay awake and actively care for the wellbeing of the residents, Mr. Humphrey locked the door of one of the rooms from the outside, so that the residents were unable to leave their room at night. On June 2, 2015, one of the Department's surveyors observed a black bungee cord wrapped around the door handle of Room #3. After having the caregiver remove the cord immediately, the surveyor observed Resident #3 and #4 in the room. Mr. Humphrey stated that he used the bungee cord the previous evening because the residents ramble around.

5. Respondent failed to identify that two of its residents required a higher level of care. Surveyors observed Resident #1 on June 1, 2015. The resident was frail, naked, and covered in feces and urine. Mr. Humphrey arrived shortly after the observation to clean the resident. The following morning, Resident #1 was observed sitting in a chair beside the bed wearing only a pair of boxer shorts. Mr. Humphrey arrived with a bowl of rice to feed Resident #1. The caregiver stated that Resident #1was not appropriate for the facility because the resident required too much care. Resident #1 could not feed himself, was too weak to stand, and couldn't walk. The resident was also incontinent and fell a lot.

6. Respondent told Resident #1's family that the daughter of the administrator (the administrator is also the owner of the facility) was a nurse and that she would evaluate Resident #1 when he fell. Neither the administrator, Ms. Tucker, nor the daughter, Katrice Williams, is a nurse. There is no documentation that Respondent reported Resident #1's falls to family members or a physician or that anyone evaluated Resident #1 after any of his falls.

7. On June 2, 2015, Resident #1 was transferred to the hospital where it was determined that Resident #1 was severely malnourished. According to a dietician's progress note obtained by the Department's surveyors, the resident lost 43 pounds between July 7, 2014 and June 2, 2015. There is no record that Respondent reported Resident #1's weight loss to a physician or to a family member. The resident also had multiple bruises and skin tears on his body.

8. Resident #5 was admitted into the facility with diagnoses of dementia, depression, hypertension, coronary artery disease, and osteoarthritis. The resident was combative

toward staff. He used profanity and attempted to hit staff. He refused to take his medications. He also refused to follow any instructions given by staff. No one evaluated Resident #5 to determine if he needed a higher level of care. Resident #5 was ultimately discharged from the facility.

9. While Resident #5 was present in Respondent's facility, Respondent failed to provide protective care for and maintain the safety of Resident #5. Prior to discharge, Resident #5 was allegedly abused by the primary caregiver, Mr. Humphrey. According to an account given by Resident #3, one evening, both Resident #3 and #5, who shared a room at the time, needed to go to the bathroom. Since their bedroom door was locked from the outside, they attempted to get the caregiver's attention. The caregiver did not come to the door. Resident #5 became agitated and attempted to use the bathroom in the closet. The resident yanked the closet door open, which caused the door to come off of its hinges and fall on Resident #5. Mr. Humphrey heard the noise from the door falling and entered the room. Mr. Humphrey instructed Resident #3 to return to bed and then attempted to help Resident #5 get up off of the floor. As Mr. Humphrey was helping Resident #5 get up from the floor, Resident #3 witnessed Resident #5's elbow hit the caregiver in the stomach. Mr. Humphrey then hit Resident #5 in the back of the head and slammed his face into the concrete floor. Resident #3 witnessed Mr. Humphrey punch Resident #5 in the face.

10. On the Sunday after the aforementioned incident, Resident #5's relative arrived to the facility to visit the resident. Katrice Williams, the administrator's daughter stated that Resident #5 fell. Further, she stated that she had examined the resident and the resident was fine. She stated that nothing was broken. Ms. Williams is not a nurse. The relative

stated to the surveyor that Resident #5's nose was busted and swollen and that both eyes were bruised and blood shot. The relative returned to the facility the following day, and Resident #5 looked worse. The relative then took the resident to the hospital where the resident was examined. Resident #5's nose was broken.

11. Resident #5's relative stated to the surveyors that the resident is calm as long as he has his medication. According to the surveyors' report, the relative did not believe that the facility was giving the resident his medicine.

12. Respondent does not have appropriately licensed personnel administering medications to its residents. Residents in a home for the aged must self-administer medications unless a licensed nurse administers the medications. Mr. Humphrey, who is not a licensed healthcare professional, admitted to the surveyors that he administered medications to the residents. Neither Mr. Humphrey nor the Respondent's administrator appropriately maintained medication administration records for any of the residents.

13. Respondent did not store medications so that residents could not obtain the medications of other residents. All resident medications were kept in separate, unlocked black tackle boxes about the washer and dryer in the open laundry room. The laundry room was accessible to all residents.

14. Respondent did not adequately feed the residents. Relatives of at least two residents (Resident #1 and #4) brought food to the facility because the resident appeared to be hungry. Further, Respondent did not maintain a 48-hour supply of food or follow the facility's documented meal plan. A former employee, Caregiver #2, contacted the surveyor to state that Respondent's facility often ran out of food.

15. Respondent did not maintain adequate lighting in resident rooms or in the living area. One resident's room was only illuminated by a night light. Neither the ceiling light nor the lamp on the nightstand worked. Drapes were kept closed during the day, so that there was little light in the resident's rooms or in the common living area.

16. Based on a verbal report of the findings of the Department's surveyors, local police arrived to Respondent's facility on June 2, 2015 to investigate allegations of elder abuse. Based on the conditions observed, the police facilitated the transfer of all residents present at the time, which effectively shut the facility down. The Respondent was later allowed to reopen.

17. Based on the findings from the June 2, 2015 survey as well as a follow-up visit conducted on July 27, 2015 follow up visit, the Respondent's license to operate was summarily suspended on July 31, 2015.

18. Respondent's license to operate remains suspended.

19. The Respondent has submitted a plan of corrections to the regional survey office.

II. GROUNDS FOR DISCIPLINE

The facts as stated in Section I constitute violations of Rules 1200-08-25 et *seq.* of the TENN. COMP. R. & REGS. [STANDARDS FOR ASSISTED-CARE LIVING FACILITIES], for which disciplinary action is authorized.

1. The facts stated in paragraph eight (8) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04 [ADMINISTRATION], the relevant portion of which reads as follows:

(1) The licensee shall be at least eighteen (18) years of age, of reputable and responsible character, able to comply with these rules, and must maintain financial resources and income sufficient to provide for the needs of the residents, including their room, board and personal services.

2. The facts stated in paragraphs nine (9) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04 [ADMINISTRATION], the relevant portion of which reads as follows:

(5) Each home for the aged shall:

(a) Have an identified responsible attendant and a sufficient number of employees to meet the needs of the residents. The responsible attendant must be at least eighteen (18) years of age and able to comply with these rules.

(b) Have a responsible awake attendant on the premises at all times

(c) Maintain documentation of the checks of the "Registry of Persons who have Abused or Intentionally Neglected Elderly or Vulnerable Individuals" prior to hiring any employee.

3. The facts stated in paragraphs ten (10) through thirteen (13) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.05 [ADMISSIONS, DISCHARGES AND TRANSFERS], the relevant portion of which reads as follows:

(3) The home 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 those residents who shall be transferred to a higher level of care.

4. The facts stated in paragraphs eleven (11) and fourteen (14) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.05 [ADMISSIONS, DISCHARGES AND TRANSFERS], the relevant portion of which reads as follows:

(3) The home shall:

(e) Ensure that residents see a physician for acute illness or injury and are transferred in accordance with any physician's orders.

5. The facts stated in paragraph fourteen (14) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06 [PERSONAL SERVICES], the relevant portion of which reads as follows:

(1) Personal services must include protective care of the resident, responsibility for the safety of the resident when in the facility, daily awareness of the resident's whereabouts and the ability and readiness to intervene if crises arise. Personal services do not include nursing or medical care. Personal services must be provided by employees of the home.

6. The facts stated in paragraph seventeen (17) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06 [PERSONAL SERVICES], the relevant portion of which reads as follows:

(2) Medications shall be self-administered. If the home chooses to employ a currently licensed nurse, medications can be administered by the nurse.

7. The facts stated in paragraph nine (9) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.08 [LIFE SAFETY], the relevant portion of which reads as follows:

(4) Each resident's room shall have a door that opens directly to the outside or a corridor which leads directly to an exit door and must always be capable of being unlocked by the resident.

8. The facts stated in paragraph seventeen (17) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.10 [RECORDS AND REPORTS], the relevant portion of which reads as follows:

(1) An individual resident file shall be maintained for each resident in the home. Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the resident. These files shall be retained for one (1) year after the resident is transferred or discharged. The resident file shall include:

(g) Health information including all current prescriptions, major changes in resident's habits or health status, results of physician's visits, and any health care instruction.

III. AGREED DISPOSITION

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

1. Respondent's license to operate as a home for the aged in the state of Tennessee shall be **SUSPENDED** for **forty-five (45) calendar days**, effective immediately. At the conclusion of the forty-five (45) calendar days, administrative staff shall place the Respondent's license on **PROBATION** for at least **two (2) years**.

2. Respondent agrees that the regional survey office may complete at least four (4) unannounced, random survey visits per year. At least one survey shall occur after normal business hours. Further, at the discretion of the regional survey office, additional unannounced survey visits may be conducted. These surveys shall be in addition to the annual survey.

3. Respondent agrees to 100% COMPLIANCE with the rules and regulations related to homes for the aged related to resident care. Respondent shall ensure that no survey visit results in deficiencies related to care issues.

4. Respondent agrees that there shall be no repeated deficiencies from the June 2015 survey.

5. Respondent agrees that any violation of the aforementioned terms will result in Respondent being in violation of this Order and subject to additional disciplinary action up to and including **REVOCATION** of Respondent's license to operate a home for the aged in Tennessee.

6. Respondent shall include notification of this disciplinary action in its contract with new residents. Respondent shall submit the notification language to counsel for the state for approval prior to including the language in its admissions contract. No resident shall be admitted prior to the approval of the notification language. The notification language shall include notice that violation of the Board's Order may result in suspension or revocation of the Respondent's license, which would require residents to transfer to another facility.

7. This action constitutes disciplinary action and will be reported to all applicable databases.

8. Respondent shall reappear before the Board before the probation may be lifted.

IV. APPROVAL BY THE BOARD

Upon the agreement of the parties, this **AGREED ORDER** was 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 14th day of January, 2016.

Chairperson
Board for Licensing Health Care Facilities

Agreed to:

Gerald S. Green, BPR # 009470
Attorney for Respondent
142 N. Third Street, 3rd Floor
Memphis, Tennessee 38103

1/14/16
Date

Brenda Tucker, Administrator
Golden Years
942 Hunter's Point
Cordova, TN 38018

1/14/16
Date

Kyonzte Hughes-Toombs, BPR # 023702
Assistant General Counsel
Tennessee Department of Health
Office of General Counsel
665 Mainstream Drive – Second Floor
Nashville, Tennessee 37243
(615) 741-1611

1/14/16
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 15th day of January, 2016.

J. Richard Collier

Richard Collier, Director
Administrative Procedures Division

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this document has been served upon the Respondent, Golden Years, c/o Brenda Tucker, Administrator, 942 Hunter's Point, Cordova, TN 38018 by US fist class mail, and also upon Respondent's attorney, Gerald S. Green, Attorney at Law, 142 N. Third Street, 3rd Floor, Memphis, Tennessee 38103 by first class mail.

This 20th day of January, 2016.

Kyonzté Hughes-Toombs
Assistant General Counsel