STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Hickory Hills Alzheimer's Special Care Center	)	
162 Indian Lake Blvd.	)	**Docket #: 17.17-210369A**
Hendersonville, TN 37075	)	
	)	
License No. ACLF 00000432	)	

AGREED ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 5th day of October 2021, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **Hickory Hills Alzheimer's Special Care Center** (hereinafter "Respondent"), by and through counsel, Craig Conley, that the Board adopt this Agreed Order, the terms of which have been agreed upon by the parties, as signified by their signatures below.

Respondent, by signature to this Agreed 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 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 the Agreed 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.

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Moreover, by entering into this Agreed Order, such should not be construed and/or considered as constituting any form of admission of any kind by Respondent of the truth of any facts alleged or the correctness of any conclusions set forth within this Agreed Order. Recognizing the risks and uncertainties involved and solely for the purposes of avoiding the uncertainties and expense involved, Respondent has elected to resolve this matter by entering into this Agreed Order. Likewise, this Agreed Order and the contents thereof shall not be used against Respondent in any other proceeding whatsoever.

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 childcare 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

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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.*

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STIPULATIONS OF FACT

1. At all times pertinent hereto, **Hickory Hills Alzheimer's Special Care Center,** located at 162 Indian Lake Blvd, Hendersonville, TN 37075 has been licensed as an Assisted-Care Living Facility by the Board, having been issued license number **00000432** on August 18, 2016. Respondent has an active license with an expiration date of August 17, 2022.

2. From on or about September 23-25, 2019, the Department conducted complaint surveys at Respondent facility.

3. Resident #1 was admitted to the facility in September 2017 with diagnoses of dementia and hypertension.

4. Resident #2 was admitted to the facility in March 2017 with diagnoses of chronic obstructive pulmonary disease, anxiety, dementia/Alzheimer's, and sexual/aggressive behaviors. Resident #2 was also on psychoactive medication for sexual behaviors.

5. At some point during Resident #2's residency, a personal sitter was put in place and remained in place to address and prevent Resident #2's behaviors.

6. Resident #2 is married to Resident #3. Resident #3 was admitted to the facility in April 2017 with diagnoses of acute respiratory failure with hypoxia, chronic kidney disease, dementia, and shortness of breath.

7. Both Residents #2 and #3 are on hospice.

8. Soon after his admission, Resident #2 attempted sexual advances toward other female residents and staff members which included hugging, petting, and suggestive behavior. The Executive Director documented concerns regarding Resident #2's sexual

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precociousness. A physician then recommended a 24-hour sitter and in-patient psychiatric evaluation for the safety of others.

9. Resident #2's plan of care was amended to reflect that Resident #2 would be transferred to inpatient psychiatric services, per his power of attorney agreement.

10. On or about May 22, 2017, Resident #2 was readmitted to the facility after his psychiatric evaluation.

11. On or about June 26, 2017, nursing staff reported Resident #2 was combative and agitated with verbal aggression toward staff when staff cared for his wife.

12. On or about August 20, 2017, a psychiatric progress note revealed that Resident #2 had been newly diagnosed with major neurocognitive disorder due to Alzheimer's disease with behavioral disturbances, dementia with behavioral disturbances, psychosis with delusions, anxiety, and mood disorders.

13. On or about August 24, 2017, nursing staff documented that Resident #2 exhibited aggressive behavior, including grabbing other residents and making sexual suggestions.

14. On or about September 6, 2017, Resident #2 attempted to hit a caregiver and was observed making sexual references to others.

15. On or about September 7, 2017, Resident #2 was assessed in a psychiatric progress note for mood instability, sun-downing, confusion, and delusions.

16. On or about September 28, 2017, Resident #2 attempted to hit his sitter with a broom.

17. On or about October 2, 2017, a nursing note revealed that Resident #2 exhibited more episodic attention toward another woman in the facility, rather than his wife, Resident #3, and was wandering more frequently.

18. On or about June 5, 2018, Resident #2 was again admitted for inpatient psychiatric

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assessment due to his combative behaviors.

19. Resident #2 continued to be seen by his physician on a regular basis for sexual inappropriateness and aggressive behaviors.

20. On or about June 24, 2019, a hospice nurse documented that Resident #2 refused to have his blood pressure taken and was swatting the nurse's hand away. Despite his agitation, Resident #2 was pleasant, but exhibiting confusion.

21. On or about July 25, 2019, Resident #2 grabbed at staff.

22. On or about August 10, 2019, the charge nurse and caregiver on duty heard screaming in the hallway. Residents #1 and #2 were engaged in a physical altercation on the floor of the hallway. Resident #2 was hitting Resident #1 in the face, nose, and chin. Resident #2 continually repeated that Resident #1 was a thief.

23. As a result of the altercation, Resident #1 had lacerations to his nose and abrasions to his forehead. Resident #2 had skin tears on his upper arm, right side of his back, right hand, and forearm.

24. Interview with the Executive Director revealed that on the night of August 11, 2019, when Resident #2 attacked Resident #1, an EMT was in the building and assessed Resident #1 and Resident # 2 for their injuries. The EMT decided that neither needed to be transferred to the hospital as a result of their injuries. The Executive Director indicated that Charge Nurse #1 on duty did not send Resident #2 out for psychiatric evaluation, she had moved Resident #1 to another room. Because both residents were on hospice, Charge Nurse #1 contacted both hospice companies 24-hour on call service to request immediate evaluation, and she notified the Director of Nursing that night. Charge Nurse #1 monitored both residents throughout the night, and there were no further

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incidences involving either resident that evening.

25. On or about August 12, 2019, Resident #2 was observed trying to make his wife, Resident #3, forcibly get out of her chair.

26. On or about August 13, 2019, Resident #2 pushed another resident, then slapped his wife, Resident #3, in the face and pulled off her oxygen. Resident #2 was then separated from other residents.

27. On or about August 14, 2019, Resident #2 slapped his wife, Resident #3, in the face twice and pulled her oxygen off again. He then attempted to hit his sitter.

28. On or about August 14, 2019, Resident #2 was transferred to a psychiatric facility for evaluation and treatment.

29. On or about August 31, 2019, while hospitalized for a psychiatric admission, hospital staff documented that Resident #2 became agitated when respiratory therapy attempted a breathing treatment and slapped at staff.

30. On or about September 1, 2019, while hospitalized for a psychiatric admission, hospital staff documented that Resident #2 was combative during assistance with activities of daily living. Resident #2 often wandered.

31. On or about September 3, 2019, while hospitalized for a psychiatric admission, hospital staff documented that Resident #2 became agitated and kicked and punched at staff when taken to the bathroom.

32. On or about September 5, 2019, while hospitalized for a psychiatric admission, hospital staff documented that Resident #2 became aggressive with staff and attempted to punch the technician assisting him. Resident #2 was unable to be redirected and was administered medication as needed.

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33. On or about September 8, 2019, while hospitalized for a psychiatric admission, hospital staff documented that Resident #2 was pacing and became combative with activities of daily living and punched staff members.

34. On or about September 9, 2019, while hospitalized for a psychiatric admission, hospital staff documented that Resident #2 upon waking was confused, combative, and uncooperative.

35. Despite the behavior Resident #2 exhibited while hospitalized, on or about September 11, 2019, Resident #2 was readmitted to Respondent facility.

36. On or about September 19, 2019, Resident #2 approached Resident #4 and threatened to hit her. Resident #2 then attempted to raise his right hand and arm to strike Resident #4. Resident #4 said "no" very sternly and Resident #2 placed his hand back in his pocket.

37. On or about September 23, 2019, LPN #1 confirmed that Resident #2 was aggressive with other residents and grabbed and hit them. LPN #1 stated that Resident #2 was often confused and thought that other patients were his wife. Resident #2 had also hit a female resident in the chest leaving a red mark. At the time of the incident, he indicated he thought the resident was his wife. LPN #1 indicated Resident #2's dementia had advanced a lot.

38. LPN #2 also confirmed that Resident #2 often struck his wife, Resident #3, tried to take off her oxygen, and slapped her on the arms, but never hit her with a closed fist. LPN #2 stated that Resident #2's wife is hard of hearing and Resident #2's behavior would often escalate when she would not respond.

39. Interview with the facility's dietary manager also revealed that Resident #2 slapped his wife, Resident #3, in the face, pushed her table into her, and pull her oxygen off.

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40. Interview with Caregiver #1 revealed that Resident #2 was often frequently upset. Resident #2 threated to hit Caregiver #1 and frequently swore at her. Resident #2 had also tried to grab Caregiver #1 by the throat. Caregiver #1 confirmed that Resident #2 had also pinched his wife, Resident #3, on September 22, 2019 and threatened to "slap the hell out of her." Caregiver #1 indicated Resident #2 threatened to hit staff and spit on them. Caregiver #1 also indicated that Resident #2 and his wife had to be separated, as Resident #2 was fixated on his wife.

41. Interview with the Activities Director revealed that she had not witnessed Resident #2 hit his wife in a while now. Instead, Resident #2 would pinch or thump his wife in the head when she did not pay attention to him. The Activities Director stated that Resident #2 would hit staff when they intervened to stop him from hitting his wife.

42. On or about September 23, 2019, while conducting the survey, surveyors were informed by the Executive Director that LPN #2 witnessed Resident #2 slap his wife, Resident #3, in the face. The Executive Director indicated that Resident #2 would be sent out for a psychiatric evaluation.

43. On or about September 23, 2019, Resident #2 was transferred to a hospital to be evaluated for potential geri-psych admission. Resident #2 never returned to the facility from this transfer.

44. Resident #2's needs could not safely and effectively be met in an assisted care living facility.

45. The facility also failed to ensure that the other thirty-three (33) residents of the building were free from Resident #2's physical abuse.

46. In response to the survey findings, the facility submitted its Plan of Correction on

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October 7, 2019.

47. The Department conducted its revisit on November 20, 2019, at which time the facility was determined to be in full compliance.

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 paragraph three (3) through forty-five (45) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(a)(1)[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:

(1) Protective care.

49. The facts stated in paragraph three (3) through forty-five (45) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(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:

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(2) Safety when in the ACLF.

50. The facts stated in paragraph three (3) through forty-five (45) 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.

51. The facts stated in paragraph three (3) through forty-five (45) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.08(1)(f)[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:

(f) Has needs that cannot be safely and effectively met in the ACLF.

52. The facts stated in paragraph three (3) through forty-five (45) are sufficient to establish that Respondent has violated the provisions of Rule 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.

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ORDER

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

53. The assessment of five (5) civil monetary penalties in the amount of one thousand five hundred dollars ($1,500.00) each for a total assessment of seven thousand five hundred dollars ($7,500.00).

Payment shall be submitted to the following address within thirty (30) days of the effective date of this Order:

Tennessee Department of Health
Division of Health Care Facilities
Attn: Niraj Soni
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243

54. 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 **AGREED 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 October 2021.

ACCORDINGLY, IT IS ORDERED that the agreement of the parties does hereby become the Final Order of the Board.

René Saunders MD
Chairperson
Board for Licensing Health Care Facilities

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AGREED TO:

Craig Conley, BPR # 019341
Attorney for Respondent
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
165 Madison Avenue, Suite 2000
Memphis, Tennessee 38103
(901) 577-2290

10-4-21
Date

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

10/5/2021
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 7 day of October, 2021.

Director
Administrative Procedures Division

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CERTIFICATE OF SERVICE

A true and exact copy of this Agreed Order is being served upon Respondent, HICKORY HILLS ALZHEIMER'S SPECIAL CARE CENTER, by and through counsel, Craig Conley, Attorney for Respondent, Baker, Donelson, Bearman, Caldwell & Berkowitz, PC, 165 Madison Avenue, Suite 2000, Memphis, Tennessee 38103 by delivering same in the United States mail, via United States Postal Service first class, with sufficient postage thereon to reach its destination and via electronic correspondence at cconley@bakerdonelson.com

This 7th day of October, 2021.

Kyonzté Hughes-Toombs
Deputy General Counsel

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