BEFORE THE TENNESSEE BOARD FOR LICENSING HEALTH CARE FACILITIES

In The Matter of:	)	
	)	
LOVING ARMS OF MEMPHIS, INC	)	
License No. 00000158	)	**CASE NO. 202201672**
Residential Home for the Aged	)	
	)	
	)	
Respondent	)	

ORDER OF SUMMARY SUSPENSION

This matter came to be heard before the Board for Licensing Health Care Facilities pursuant to Tennessee Code Annotated section ("T.C.A. §") 4-5-320(c) on June 24, 2024, upon the application of the Tennessee Department of Health, Office of General Counsel ("State"), for a summary suspension of Respondent's license pursuant to pursuant to Tennessee Code Annotated Section ("T.C.A. §") 4-5-320(c). The State presented evidence that the Respondent, Loving Arms of Memphis, Inc., 667 Bethel Avenue, Memphis, Tennessee 38107, ("Respondent"), committed acts that were a serious threat to the health, safety, and welfare of its residents in violation of T.C.A. § 68-11-201 et seq. The Respondent has a history of significant deficiencies including, but not limited to, medication mismanagement, inadequate food supply, an unsanitary kitchen, and failure to provide safe and hygienic housing for residents.

The Board, having heard and considered the position of the Tennessee Department of Health, Office of General Counsel ("State"), finds and concludes the following:

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. T. C. A. § 68-11-202. Further, T. C. A. § 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 T. C. A. § 68-11-201(18) *et. seq.* T. C. A. § 68-11-207(a).

3. In imposing the sanctions authorized in [§ 68-11-207(c)], 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.

FINDINGS OF FACT

6. At all times pertinent hereto, Respondent, **LOVING ARMS OF MEMPHIS, INC.**, 667 Bethel Avenue, Memphis, Tennessee 38107, has been licensed by the Board as a residential home for the aged, having been granted license number 00000158 on August 1, 1985. Respondent's license currently has an expiration date of July 15, 2022.

7. An annual licensure survey was conducted on the premises of the facility on November 6, 2018, resulting in deficiencies cited which affect the health, safety, and welfare, of the residents within the residential home for the aged. The facility's Administrator was unverified, an official resident roll and files were mismanaged, infectious and hazardous waste were improperly handled, and several issues surrounding resident care and dietary concerns were cited.

8. On or about February 14, 2019, a revisit survey was conducted at the facility to determine whether the facility had sufficiently corrected its deficiencies cited on November 6, 2018. The facility failed to submit an adequate Plan of Correction ("POC") to correct the deficiencies recited on the revisit survey.

9. On October 2, 2019, the Board placed the Respondent's license to operate as a residential home for the aged on probation for no less than six (6) months. To date the facility remains on probation. *See* Consent Order as Exhibit 1.

10. On or about February 11, 2022, a life safety inspector with the Tennessee Department of Health, conducted a Life Safety complaint survey. Due to observations and interviews by the inspector, the facility was found to not be in substantial compliance with the requirements of its license due to multiple deficiencies cited. *See* Sworn Life Safety Investigator Affidavit as Exhibit 2.

11. The facility administrator admitted a failure to conduct all required fire drills or provide documentation of fire drills for years 2021 or 2022.

12. The facility failed to maintain functional electrically operated smoke detectors.

13. The facility failed to maintain adequate fire extinguishers.

14. The facility failed to maintain all safety equipment including an operation fire alarm control panel and properly placed exit signs.

15. The facility failed to report disruption of the fire alarm control panel to the Tennessee Department of Health.

16. As a result of the deficiencies cited in paragraphs eleven (11) through fifteen (15) above, Loving Arms of Memphis, Inc. was found to be not in substantial compliance with the requirements of the Tennessee Rules and Regulations 1200-08-11-.08 (2), 1200-08-11-.08 (16), 1200-08-11-.08 (17), 1200-08-11-.08 (21), 1200-08-11-.10 (3), Standards for Residential Home for the Aged, and National Fire Protection Association (NFPA) 101 Life Safety. *See* Division of Health Care Facilities, Statement of Deficiencies, 2/11/2022 as Exhibit 3.

17. On or about May 31, 2022, a life and safety inspector with the Tennessee Department of Health, attempted to conduct a revisit Life Safety Code complaint survey based on the previous February 11, 2022, survey. During this visit, the inspectors were not allowed

access into the facility. The inspector submitted a complaint to Health Care Facilities to initiate a health survey. *See* Division of Health Care Facilities, Statement of Deficiencies, 5/31/2022 as Exhibit 4.

18. On or about June 7, 2022, a health inspector with the Tennessee Department of Health, conducted an unannounced visit to investigate a complaint. Due to observations and interviews by the inspector, the facility was found to not be in substantial compliance with the requirements of its license due to multiple deficiencies cited. *See* Sworn Health Investigator Affidavit as Exhibit 5.

19. The facility failed to provide documentation of an administrator who was licensed or certified.

20. The facility failed to maintain a written up-to-date log of all current residents in the event of an emergency.

21. The facility failed to have a written admission agreement, which included a procedure for handling the transfer or discharge of residents and that did not violate the residents' rights under the law or these rules for two of six sampled residents.

22. During an interview with the caregiver on 6/7/2022, the caregiver confirmed there was no evidence to ensure five residents had taken their medications as prescribed on 6/6/2022 or on the morning of 6/7/2022. The caregiver verified the facility did not have a record of observing residents while they took their medications on the dates specified. The facility failed to have systems in place to ensure residents were taking their medication as prescribed for six of six residents reviewed.

23. The inspector observed on 6/7/2022 the facility's refrigerator was inoperable and had flies and gnats in the refrigerator. No perishable food items were in the refrigerator. The

Respondent failed to provide nutritional meals to the residents of the facility over the course of several hours. The facility failed to provide timely and adequate meals to the residents.

24. On 6/7/2022, the inspector observed the kitchen floor had numerous cracks and debris There was dirt and cockroaches in the cabinets and on the dishes. The facility failed to maintain a clean and sanitary kitchen.

25. During the tour of the premises, the inspector opened the refrigerator door, and the freezer compartment both had a putrid odor and bug infestations. During observations on 6/7/2022 there were several cockroaches noted crawling on the cabinets and floors. The women's bathroom was observed with a hole around the commode and the commode was leaning inwards into the hole. There were holes around the bathtub with missing tile. The bathroom closet had a buildup of dirt, dead insects, paper, and residue. The men's restroom was operable; however, the vanity had a buildup of dirt, dead insects, old spray bottles, and debris. The facility failed to maintain a suitable environment, due to bug infestations and inoperable amenities, for the residents of the facility. *See* Division of Health Care Facilities, Surveyor Photographs, 06/07/2022 as Collective Exhibit 6.

26. The facility failed to maintain proper resident files and medical records for all residents.

27. Based on observations and interviews during the survey, Loving Arms of Memphis, Inc. was found not in substantial compliance with the requirements of the Tennessee Rules and Regulations 1200-08-11-.04 (3), 1200-08-11-.04 (6)(f), 1200-08-11-.05 (3)(b), 1200-08-11-.06 (3), 1200-08-11-.06 (10), 1200-08-11-.06 (14), 1200-08-11-.06 (16), 1200-08-11-.10 (1)(a), 1200-08-11-.10 (1)(b), 1200-08-11-.10 (1)(c), 1200-08-11-.10 (1)(d), 1200-08-11-

.10 (1)(e), 1200-08-11-.10 (1)(g), and 1200-08-11-.10 (1)(h). *See* Division of Health Care Facilities, Statement of Deficiencies, 6/09/2022 as Exhibit 7.

28. The Respondent facility's continued deficient practice places its residents in an imminent threat of harm and emergency action is necessary.

CONCLUSIONS OF LAW

The facts stated in the Finding of Facts section, *supra*, are sufficient to establish that grounds for the discipline of Respondent's residential home for the aged license exist. Specifically, Respondent has violated the following statutes and/or rules, for which disciplinary action by the Board authorized.

29. The facts in paragraph eleven (11) are sufficient to constitute a violation of Tenn. Comp. R. and Reg.1200-08-11-.08 (2), the relevant portion of which reads as follows:

> The residential home for the aged shall provide fire protection by the elimination of fire hazards, by the installation of necessary firefighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift for residential home for the aged personnel in each separate building. There shall be one fire drill per quarter during sleeping hours. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years.

30. The facts in paragraph twelve (12) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08-11-.08 (16):

> All facilities must have electrically operated smoke detectors with battery back-up power operating at all times in, at least, sleeping rooms, day rooms, corridors, laundry room, and any other hazardous areas.

31. The facts in paragraph thirteen (13) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08-11-.08 (17):

> Fire extinguishers, complying with NFPA 10, shall be provided and mounted so they are accessible to all residents in the kitchen, laundries and at all exits. Extinguishers in the

kitchen and laundries shall be a minimum of 2-A: 10-BC and an extinguisher with a rating of 20-A shall be adjacent to every hazardous area. The minimum travel distance shall not exceed fifty (50) feet between the extinguishers.

32. The facts in paragraph fourteen (14) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08-11-.08(21):

All safety equipment shall be maintained in good repair and in a safe operating condition.

33. The facts in paragraph fifteen (15) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08- 11-.10 (3), the relevant portion of which reads as follows:

The RHA shall report the following incidents to the Department of Health in accordance with T.CA § 68-11-211. (c) Disruption of any service vital to the continued safe operation of the RHA or to the health and safety of its residents and personnel; and

34. The facts in paragraph nineteen (19) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08-11-.04 (3):

Each home must have an administrator who shall be certified by the board, unless the administrator is currently licensed in Tennessee as a nursing home administrator pursuant to T.C.A. §§ 63-16-101, et seq.

35. The facts in paragraph twenty (20) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08-11-.04 (6)(f), the relevant portion of which reads as follows:

> Each home for the aged shall: (f) Keep a written up-to-date log of all residents and produce the log for the local fire department in the event of an emergency.

36. The facts in paragraph twenty-one (21) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08-11-.05 (3)(b):

The home shall: (b) Have a written admission agreement that includes a procedure for handling the transfer or discharge of residents and that does not violate the residents ' rights under the law or these rules.

37. The facts in paragraph twenty-two (22) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08-11-.06 (3):

Assistance in reading labels, opening bottles, reminding residents of their medication,

observing the resident while taking medication and checking the self-administered dose against the dosage shown on the prescription are permissible in the self-administration of medications.

38. The facts in paragraph twenty-three (23) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08-11-.06 (10):

Residents shall be provided at least three (3) meals per day. The meals shall constitute an acceptable diet. There shall be no more than fourteen (14) hours between the evening and morning meals. All food served to the residents shall be of good quality and variety, sufficient quantity, attractive and at safe temperatures. Prepared foods shall be kept hot (140°F. or above) or cold (41°F. or less). The food must be adapted to the habits, preferences, needs and physical abilities of the residents.

39. The facts in paragraph twenty-four (24) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08-11-.06 (14):

The kitchen shall be maintained in a clean and sanitary condition.

40. The facts in paragraph twenty-five (25) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08-11-.06 (16):

A suitable and comfortable furnished area shall be provided in the facility for activities and family visits. Furnishings shall include a current calendar and a functioning television set, radio and clock.

41. The facts in paragraph twenty-six (26) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08-11-.10 (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:

(a) Name, Social Security Number, veteran status and number, marital status, age, sex, previous address and any health insurance provider and number, including Medicare and Medicaid numbers;

(b) Name, address and telephone number of next of kin, legal guardian and any other person identified by the resident to contact on his/her behalf;

(c) Name, address and telephone number of any person or agency providing

additional services to the resident;

(d) Date of admission, transfer, discharge and any new forwarding address;

(e) Name and address of the resident's preferred physician, hospital, pharmacist, assisted care living facility and nursing home, and any other instructions from the resident to be followed in case of emergency;

(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 instructions; and

(h) A copy of the admission agreement signed and dated by the resident.

42. When the action of a licensed healthcare facility places its residents, at imminent risk of harm, the Board is authorized by law to take the extraordinary step of summary action. The summary action statute requires a showing that protection of "public health, safety, or welfare imperatively requires emergency action." T.C.A. § 4-5-320(c).

43. Here, the affected members of the public are the residents of Loving Arms of Memphis, Inc., whose safety will be put in jeopardy should the Respondent be allowed to remain licensed. Moreover, allowing Loving Arms the opportunity for continued operation places future residents at risk. This situation is of the type contemplated by the summary action statute. Based on the information, interviews, and statements provided to the Life Safety and Health inspectors it is the State's position that the level of Respondent's disregard for its resident's physical conditions and well-being constitutes a threat to the public health, safety, and welfare. There are dire consequences to Respondent's residents if the Respondent is not summarily suspended. These alarming findings also apply to prospective residents. The State asserts immediate action is necessary to prevent harm to the residents who are living in a dilapidated, hazardous home without access to basic needs such as food and medications. Thus, the Board should act immediately and take summary action to

suspend the Respondent's residential home for the aged license until further hearing before the Board.

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, **Loving Arm of Memphis, Inc**, is so severe that it imperatively requires emergency action to protect the public health, safety and welfare prior to the initiation of formal disciplinary charges.

It is therefore **ORDERED** that:

44. Respondent's license as a residential home for the aged, license no.00000158, is hereby **SUMMARILY SUSPENDED, effective within 7 days of the effective day of this Order.**

45. Upon receipt of this Order, Respondent shall not accept any new residents.

46. Respondent shall safely relocate each resident that is currently residing in its facility within ten (10) days of the effective day of this Order.

47. Respondent shall submit a report to the Board's administrative staff detailing the safe placement of each resident currently residing in the facility.

48. 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 Tennessee Board for Licensing Health Care Facilities.

49. Pursuant to T.C.A. § 4-5-320(d)(1), Respondent may present Respondent's version of the facts to the Board at an informal conference if a timely written request is made by 5:00 p.m. on July 8, 2022, to the Board for Licensing Health Care Facilities, 665 Mainstream Drive, Nashville, Tennessee 37243.

50. 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 24th day of June 2022.

Dr. René Saunders with permission Ann R Kee

Chairperson
Tennessee Board for Licensing Health Care Facilities

PREPARED FOR ENTRY:

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this Order of Summary Suspension has been served upon the Respondent, **LOVING ARMS OF MEMPHIS, INC.**, 667 Bethel Avenue, Memphis, Tennessee 38107, c/o Ms. Mary Chambers and Ms. Timika Chambers, Administrators, Loving Arms of Memphis, Inc., 667 Bethel Avenue, Memphis, Tennessee 38107; via certified mail, certified number Fedex overnight on this the 24th day of June, 2022.

Ronda Webb-Stewart
Deputy General Counsel