STATE OF TENNESSEE
HEALTH FACILITIES COMMISSION
BEFORE THE BOARD FOR LICENISNG HEALTH CARE FACILITIES

In The Matter of:	)	
	)	
LOVING ARMS OF MEMPHIS, INC.	)	**Case No. 202201672**
TENNESSEE LIC. NO. 158	)	
RESPONDENT	)	
	)	
MEMPHIS, TN	)	

ORDER OF SUMMARY SUSPENSION

This matter came to be heard before the Board for Licensing Health Care Facilities ("Board"), pursuant to Tennessee Code Annotated section ("T.C.A. §") 4-5-320(c) on July 29, 2022, upon the application of the Health Facilities Commission, Office of Legal Services ("Commission"), for a summary suspension of Respondent's license pursuant to Tennessee Code Annotated Section ("T.C.A. §") 4-5-320(c).

The Commission 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 Commission, finds and concludes the following:

JURISDICTION

1. 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, prescribe childcare centers, renal dialysis clinics, ambulatory surgical treatment centers, outpatient diagnostic centers, adult care homes, and traumatic brain injury residential home. T.C.A. § 68-11-202.

2. The Commission has the authority to conduct reviews of homes for the aged to determine compliance with fire and life safety code regulations promulgated by the Board. T.C.A.§ 68-11-202(b)(1)(A).

3. A Residential Home for the Aged ("RHA") is a home represented and held out to the general public as a home which accepts primarily aged persons for relatively permanent, domiciliary care. "Primarily aged persons" means at least 51% or more of the census of the home for the aged is primarily aged. The RHA provides room, board, and personal services to at least four (4) or more non-related persons. The term "home" includes any building or part thereof which provides services as defined in the Board's rules. Tenn. Comp. R. & Regs. 1200-08-11-.01(27).

4. The Commission 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. T.C.A. § 68-11-210(c).

5. Upon a finding by the Board that a Residential Home for the Aged has violated any provision of the Board's rules, action may be taken, upon proper notice to the licensee, to impose a civil penalty and/or deny, suspend, or revoke its license. Tenn. Comp. R. & Reg. 1200-08-11-.03. The Board has the authority to suspend or revoke the license of any facility licensed under T.C.A. § 68-11-201(18).

FINDINGS OF FACTS

6. At all times pertinent hereto, Respondent, **Loving Arms of Memphis, Inc.**, was licensed by the Board as a Residential Home for the Aged in the State of Tennessee, having been granted license number 158 on August 1, 1985, which expired on 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 roster 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, as the Respondent has not requested the lifting of the probationary status.

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.

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 Respondent has failed to maintain functional electrically operated smoke detectors.

13. The Respondent has failed to maintain adequate fire extinguishers.

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

15. The Respondent 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 Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety.

17. On or about May 31, 2022, a life 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 inspector was not allowed access into the facility. The inspector submitted a complaint to the Office of Health Care Facilities to initiate a health survey.

18. On or about June 6, 2022, a site visit was conducted by a monitor for the Tennessee Department of Health. The monitor observed that there were several cockroaches 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 tiles. 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. There was

an opened packet of rat poison strewn about under a kitchen cabinet. The facility's thermostat was set to fifty-six (56) degrees, but the thermostat showed that the internal temperature was eighty (80) degrees.

19. 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.

20. The Respondent failed to provide documentation of an administrator who was licensed or certified. As a result of this failure to provide documentation, the Commission verified that the RHA administrator licenses for both facility co-administrators were expired.

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

22. The Respondent failed to have a written admission agreement, which included a procedure for handling the transfer or discharge of residents for two of six sampled residents.

23. During an interview with the caregiver on or about June 7, 2022, the caregiver confirmed there was no evidence to ensure five residents had taken their medications as prescribed on or about June 6, 2022, or on or about the morning of June 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 Respondent failed to have systems in place to ensure residents were taking their medication as prescribed for six of six residents reviewed.

24. On or about June 7, 2022, the inspector observed that 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 timely and adequate meals to the residents.

25. On or about June 7, 2022, the inspector observed the kitchen floor had numerous cracks and debris. There were dirt and cockroaches in the cabinets and on the dishes. The Respondent failed to maintain a clean and sanitary kitchen.

26. During the tour of the premises, the inspector opened the refrigerator door, and the freezer compartment both had a putrid odor and bug infestation.

27. The Respondent failed to maintain proper resident files and medical records for all residents.

28. On July 1, 2022, authority for the regulation of all Tennessee RHAs was transferred from the Tennessee Department of Health to the Commission, pursuant to Public Chapter 1119 (2022).

29. From July 1, 2022, until July 19, 2022, multiple site visits were conducted by a monitor for the Commission. The monitor observed that the full-size refrigerator in the kitchen was not operational, and the food inside was warm. The monitor notified the caregiver that was present, and the food was disposed of.

30. The commode in the women's bathroom was removed from its fixture leaving an exposed hole through the floor and into the crawlspace below.

31. The facility was not maintaining the required forty-eight (48) hours of food on the premises and the facility was instead relying on charitable donations of food from a non-profit organization. Resident #2 has a diagnosis of throat cancer and was fed mashed potatoes, an inappropriate meal for a resident with this diagnosis.

32. The monitor observed that Resident #1 did not have required incontinence supplies, and the monitor personally acquired incontinence supplies for Resident #1.

33. The monitor observed that the caregiver that was present spoke aggressively to multiple residents. The caregiver harshly rebuked Resident #2 who was trying to communicate via a written note. The caregiver then followed Resident #2 into his room and closed the door behind them after the resident walked away.

CONCLUSIONS OF LAW

The facts listed above are sufficient to establish that the Respondent has violated the following statutes or rules for which disciplinary action, including summary suspension, by the Board is authorized:

34. The facts in paragraphs eleven (11) and sixteen (16) 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.

35. The facts in paragraphs twelve (12) and sixteen (16) 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.

36. The facts in paragraphs thirteen (13) and sixteen (16) 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.

37. The facts in paragraphs fourteen (14) and sixteen (16) 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.

38. The facts in paragraphs fifteen (15) and sixteen (16) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08- 11-.10 (3)(c), 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: Disruption of any service vital to the continued safe operation of the RHA or to the health and safety of its residents and personnel.

39. The facts in paragraphs nineteen (19) and twenty (20) 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.

40. The facts in paragraphs nineteen (19) and twenty-one (21) 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 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.

41. The facts in paragraphs nineteen (19) and twenty-two (22) are sufficient to constitute a violation of Tenn. Comp. R. and Reg. 1200-08-11-.05 (3)(b):

> The home shall 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.

42. The facts in paragraphs nineteen (19) and twenty-three (23) 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.

43. The facts in paragraphs nineteen (19) and twenty-four (24) 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.

44. The facts in paragraphs nineteen (19) and twenty-five (25) 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.

45. The facts in paragraph nineteen (19) 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.

46. The facts in paragraphs nineteen (19) and twenty-seven (27) 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.

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), and the Rules of the Board 1200-08-11-.01, *et seq.*, 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:

47. Respondent's license as a Residential Home for the Aged, License No. 158, is hereby **SUMMARILY SUSPENDED**, effective immediately.

48. Upon receipt of this Order, Respondent **SHALL NOT** accept any new residents.

49. Respondent **SHALL** immediately facilitate the safe transfer of its residents to appropriate and licensed facilities. All residents must be removed from the facility by **August 15, 2022**. If there is a delay in a resident obtaining insurance benefits, the removal date may be extended, after proof of the benefit delay is submitted and approved by the Commission.

50. Respondent **SHALL** grant immediate access to the facility to the Health Facilities Commission, Commission surveyors, the Ombudsman, and Aging Commission of the Mid-South to conduct benefit assessments.

51. Respondent **SHALL** provide, in writing, the name and contact information of the individual who shall hold daily calls with Board administrative staff. These daily calls shall be to assist with the safe removal of the residents.

52. Respondent **SHALL** have a monitor, approved by the Health Facilities Commission Director of Licensure, placed in the facility and shall remain in the facility until each and every resident is transferred to an appropriate and licensed facility. The cost of the monitor shall be billed to the Respondent.

53. Respondent **SHALL** submit a final report to the Board's administrative staff detailing the safe placement of each resident currently residing in the facility.

54. 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.

SO ORDERED, this the 29th day of July 2022.

René Saunders MD

Chairperson
Tennessee Board for Licensing Health Care Facilities

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 FedEx, number 8127 8161 7401.

On this the 29th day of July, 2022.

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