BEFORE THE TENNESSEE BOARD
FOR LICENSING HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Noles Residential Home for the Aged	)	
622 N. Water Avenue	)	**Case No: 2017031301**
Gallatin, TN 37066	)	
	)	
License No. 00000198	)	

CONSENT ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 4th day of October, 2017, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **Noles Residential Home for the Aged** (hereinafter "Respondent") that the Board adopt this Consent Order, the terms of which have been agreed upon by the parties, as signified by their signatures below.

Respondent, by signature to this Consent 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 Consent 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 Consent 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 unless

independently entered into evidence or introduced as admissions.

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 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. § 68-11-202(b)(1)(A) gives the Department of Health ("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 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. 1200-08-11 *et. seq.*

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. 1200-08-11-.03. 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. 1200-08-11-.03.

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. 1200-08-11-.03. 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.*

STIPULATIONS OF FACT

1. At all times pertinent hereto, **Noles Residential Home for the Aged**, 622 N. Water Avenue, Gallatin, TN 37066 has been licensed as a residential home for the aged ("RHA") by the Board, having been issued license number 00000198 on October 6, 1981. Respondent has an active license with an expiration date of June 19, 2018.
2. A complaint and licensure survey were conducted on the premises of the facility on

September 12, 2016.

3. Surveyors cited deficiencies affecting quality of life of the residents, physical environment of the facility, and dietary needs of the residents.

4. Review of the facility revealed a total of six (6) residents residing in the home. At the time of the survey, the administrator was unable to provide a full staffing schedule and list of current employees to the surveyors. Surveyors found that the facility failed to have a sufficient number of employees to meet the needs of residents.

5. The facility failed to ensure that a responsible and awake attendant was on the premises at all times for the six (6) residents residing in the home.

6. The facility failed to provide documentation of an Abuse Registry check for the administrator and all maintenance employees.

7. The facility failed to ensure that liability insurance information was posed in the main entrance to the home.

8. The facility failed to ensure that the pets residing in the home did not pose a health hazard to the residents. The administrator stated that she had no policy or health papers on the three (3) cats found to be in the home.

9. The facility failed to have a policy addressing charity care and failed to ensure that charity care information was posted in an area accessible to the public.

10. The facility failed to ensure, and provide documentation, that all residents were free of communicable disease. Resident #1's medical record did not contain any notations that the resident was free of communicable disease.

11. The facility failed to ensure that Resident #1 received a copy the facility policy regarding resident rights.

12. The facility failed to ensure that medications were self-administered. Surveyors observed the Assistant Administrator to place six (6) medications on a napkin next to Resident #3 at breakfast. The Assistant Administrator then told the resident to take her medications. Neither the Administrator nor Assistant Administrator hold any health-related licensure to administer resident medications.

13. The facility failed to ensure that all medications were stored so that no resident could obtain another resident's medications.

14. The facility failed to ensure appropriate storage areas for soiled linen and clothing shall be provided. Surveyors observed that the facility failed to ensure residents' clothing was appropriately stored in two (2) of six (6) resident rooms and two (2) of seven (7) bathrooms. Resident #2's room was cluttered with piles of clothing on the floor and furniture. Resident #4's room was cluttered with piles of clothing all over the floor. Resident #4's bathroom was cluttered with piles of clothing on the floor. Hall bathroom #1 was observed to have a tub full of resident clothing.

15. The facility failed to ensure that the kitchen shall be maintained in a clean and sanitary condition. Surveyors found a bag, bowl, and litter box for a cat were found under the kitchen table; the kitchen floor was dirty and sticky; the pantry floor was dirty and contained plastic containers and cooking oil; flies were found swarming around the kitchen; the top of the refrigerator and freezer were piled full; the threshold between the kitchen and dining room was held down by duct tape; the carpet outside the kitchen and into the hall was stained, dirty, and threadbare.

16. The facility failed to main the facility in a clean, safe, and sanitary manner. Resident #2's room was found to be cluttered with piles of clothing on the floor and furniture. The

carpets were stained and had a strong urine odor. The resident's bathroom was found to be dirty. A dirty towel and bathpan were found on the floor. The bathroom had a strong urine odor. Resident #4's room and bathroom were cluttered with piles of clothing. The tub in the hall bathroom was full of resident clothing. There were boxes and containers of clothing stacked on the bathroom floor. There was a bowl with plastic forks in the bathroom floor and glasses in the sink. Resident #5's carpets were also found to be stained.

17. The facility failed to ensure that the resident files shall be maintained for each resident in the home. Record review revealed that Resident #1's file did not contain an admission agreement signed and dated by the resident.

18. The facility failed to ensure a tornado and severe weather drill, bomb threat drill, flood drill, severe hot or cold weather drill, earthquake disaster drill, were conducted annually in the home.

19. The facility also failed to ensure participation in the annual Tennessee Emergency Management Agency (TEMA) emergency plan.

20. The facility has not submitted an adequate Plan of Correction ("POC") to correct these deficiencies to date.

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 Residential Home for the Aged license exist. Specifically, Respondent has violated the following statutes and/or rules, for which disciplinary

action by the Board is authorized.

21. The facts stated in paragraph four (4) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(5)(a)[Administration], the relevant portion of which reads as follows:

(6) 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.

22. The facts stated in paragraph five (5) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(5)(b) [Administration], the relevant portion of which reads as follows:

(6) Each home for the aged shall:

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

23. The facts stated in paragraph six (6) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(5)(c) [Administration], the relevant portion of which reads as follows:

(6) Each home for the aged shall:

(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.

24. The facts stated in paragraph seven (7) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(5)(e)[Administration], the relevant portion of which reads as follows:

(6) Each home for the aged shall:

(e) Post whether they have liability insurance, the identity of their primary

insurance carrier, and if self-insured, the corporate entity responsible for payment of any claims. It shall be posted on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height and displayed at the main public entrance.

25. The facts stated in paragraph eight (8) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(5)(l)[Administration], the relevant portion of which reads as follows:

(6) Each home for the aged shall:

(l) Allow pets in the home only when they are not a nuisance or do not pose a health hazard.

26. The facts stated in paragraph nine (9) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(6)(n)[Administration], the relevant portion of which reads as follows:

(n) The facility shall develop a concise statement of its charity care policies and shall post such statement in a place accessible to the public.

27. The facts stated in paragraph ten (10) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04(6)[Administration], the relevant portion of which reads as follows:

(6) No occupant or employee who has a reportable communicable disease, as stipulated by the department, is permitted to reside or work in a home unless the home has a written protocol approved by the department.

28. The facts stated in paragraph eleven (11) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.05(3)(g)[Admissions, Discharges, and Transfers], the relevant portion of which reads as follows:

(3) The home shall:

(g) Provide to the resident at the time of admission a copy of the Resident's Rights for the resident's review and signature. A signed copy must be

provided to the resident at the time of admission.

29. The facts stated in paragraph twelve (12) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06(2)[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 may be administered by the nurse.

30. The facts stated in paragraph thirteen (13) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06(4)[Personal Services], the relevant portion of which reads as follows:

(4) All medications shall be stored so that no resident can obtain another resident's medication.

31. The facts stated in paragraph fourteen (14) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06(7)[Personal Services], the relevant portion of which reads as follows:

(7) Appropriate storage areas for soiled linen and residents' clothing shall be provided.

32. The facts stated in paragraph fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06(14)[Personal Services], the relevant portion of which reads as follows:

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

33. The facts stated in paragraph sixteen (16) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06(26)[Personal Services], the relevant portion of which reads as follows:

(26) The physical environment shall be maintained in a safe, clean and sanitary manner.

34. The facts stated in paragraph seventeen (17) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.10(1)(h)[Personal Services], 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:

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

35. The facts stated in paragraphs eighteen (18) and nineteen (19) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.13[Disaster Preparedness], the relevant portion of which reads as follows:

(1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually:

(a) Fire Safety Procedures Plan shall include:
1. Minor fires;
2. Major fires;
3. Fighting the fire;
4. Evacuation procedures; and
5. Staff functions.

(b) Tornado/Severe Weather Procedures Plan shall include:
1. Staff duties; and
2. Evacuation procedures.

(c) Bomb Threat Procedures Plan:
1. Staff duties;

2. Search team, searching the premises;

3. Notification of authorities;
4. Location of suspicious objects; and
5. Evacuation procedures.

(d) Flood Procedure Plan, if applicable:
1. Staff duties;
2. Evacuation procedures; and
3. Safety procedures following the flood.

(e) Severe Cold Weather and Severe Hot Weather Procedure Plans:
1. Staff duties;
2. Equipment failures;
3. Evacuation procedures; and
4. Emergency food service.

(f) Earthquake Disaster Procedures Plan:
1. Staff duties;
2. Evacuation procedures;
3. Safety procedures; and
4. Emergency services.

(2) All facilities shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation must be maintained and shall be made available to survey staff as proof of participation.

ORDER

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

36. Respondent's license to operate as a Residential Home for the Aged shall be **placed on probation for no less than six (6) months.** During the period of probation, the Respondent shall submit an **acceptable** Plan of Correction.

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37. Any serious violation affecting the health, safety, and welfare of residents within the facility shall result in a suspension of admissions pending a prompt hearing by the Board.

38. 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 **CONSENT 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 4 day of October, 2017.

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

Chairperson
Board for Licensing Health Care Facilities

AGREED TO:

Estera Calin, Administrator
Noles Residential Home for the Aged
Respondent

8-5-17
Date

Caroline R. Tippens (BPR #: 030375)
Assistant General Counsel
Department of Health
665 Main Stream Dr., 2nd Floor
Nashville, Tennessee 37243
(615) 741-1611

10-4-2017
Date

CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon Respondent, Noles Residential Home for the Aged, by and through its Administrator, Estera Calin, 622 N. Water Avenue, Gallatin, TN 37066-2310, by delivering same in the United States mail, first class, with sufficient postage thereon to reach its destination.

This 5th day of October, 2017.

Caroline R. Tippens

Caroline Tippens
Assistant General Counsel

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