BEFORE THE TENNESSEE BOARD
FOR LICENSING HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Riverdale Assisted Living Facility	)	
6880 E. Raines Road	)	Case No: 2017045931
Memphis, TN 38115	)	
	)	
License No. 00000370	)	

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 **Riverdale Assisted Living Facility** (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.

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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.*

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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, **Riverdale Assisted Living Facility**, 6880 E. Raines Road, Memphis, TN 38115 has been licensed as an assisted care living facility ("ACLF") by the Board, having been issued license number 00000370 on March 14, 2012. Respondent has an active license with an expiration date of March 14, 2018.

2. On August 1, 2017, health surveyors conducted an annual licensure survey at the Respondent facility.

3. During an interview on August 1, 2017, the acting administrator was unable to find a

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copy of the administrator's current license.

4. Respondent facility was unable to provide documentation that the facility employed a qualified dietician.

5 The Directors of Nursing and Food Services were unable to locate a diet manual signed by a qualified dietitian or any documentation of a visit made to the facility by a qualified dietician. Respondent facility also failed to have a current therapeutic diet manual approved by a dietitian readily available to all facility.

6. During the survey, it was determined that the facility failed to provide documentation of a facility-wide performance improvement program.

7. Respondent facility also failed to conduct an evaluation of the influenza program for the facility.

8. On August 1, 2017, upon interview with the Director of Nurses, the Director of Nurses stated that medication was administered by medication technicians ("med techs") and not by licensed nurses. None of the medication technicians employed by the facility are certified by the Board of Nursing. Further interview with the Med Tech Supervisor confirmed that med techs crushed medication and administered it to residents in apple sauce. The acting administrator also admitted that medication was administered by med techs.

9. Medical record revealed that the facility failed to follow physician prescribed diets, and as such, failed to meet the nutritional needs of residents for five (5) of five (5) residents sampled.

10 The facility also failed to provide documentation that hospice care could be appropriately provided within the Respondent facility. Further, the facility failed to write a joint plan of

care with the hospice provider for two (2) of two (2) residents.

11. The facility failed to have documentation that the residents in the facility over the age of sixty-five (65) were vaccinated against pneumococcal disease for two (2) of four (4) residents sampled over the age of sixty-five (65). The Director of Nursing was unable to locate any such documentation.

12. Respondent facility failed to ensure medical records were maintained for each resident which contained orders, recommendations for diet from physicians, and included the time of the receipt of the order, the description of the order, and identification of the individual receiving the order for five (5) of five (5) sampled residents. Five (5) of five (5) charts reviewed revealed that the residents' medical records did not document any physician ordered diet.

13. Respondent facility failed to ensure a medical record was maintained for each resident which included observation, progress, and nursing notes for five (5) of five (5) sampled residents.

14. Respondent facility failed to do an initial resident assessment by direct care staff within (72) hours after a new resident was admitted to the facility. Such assessment is required to determine whether the resident was appropriate for the facility. Surveyors documented that the facility failed to conduct such an assessment after the admission of one (1) of five (5) sampled residents.

15. To date, Respondent facility has failed to submit a Plan of Correction to resolve the cited deficiencies from the August 1, 2017 survey.

16. From on or about August 21, 2017 – August 23, 2017, health surveyors conducted a complaint survey on Respondent facility.

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17. Observation on August 22, 2017 revealed the medication technician supervisor at a medication cart on the 500 hallway. Surveyors observed a resident seated by the medications cart told the medication tech supervisor that she needed Tramadol and Ativan. The resident was holding two (2) tablets in her hand. The medication tech supervisor told the resident she already had her Ativan in her hand. The medication tech supervisor removed a card of medication labeled Tramadol from the locked narcotic drawer of the med cart and stated that she did not have a medication cup to give to the resident.

18. The medication tech then locked the med cart and left the hallway, carrying the card of Tramadol that she had removed from the locked narcotic drawer. The medication tech supervisor then returned to the cart a few minutes later, carrying the card of medication and a med cup containing one pill. The medication tech supervisor instructed the resident to add the two (2) tablets she as holding to the med cup and then to take the medication.

19. The resident then dropped the small round tablet on the floor. The medication tech supervisor picked up the tablet, removed a card of medication labeled Lorazepam from the locked drawer, left the hallway carrying the card of medication, and returned carrying the card and a medication cup containing one (1) tablet and then administered the medication to the resident. There was no observation that the resident was allowed or assisted to punch the medication from the card herself.

20. Upon interview with the medication tech supervisor, she stated, "We do the meds. We don't administer meds, we just assist." There are two (2) to three (3) medication techs per shift.

21. To date, Respondent facility has failed to submit a Plan of Corrections for the August 23,

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2017 health survey.

22. On or about August 23, 2017, life safety surveyors conducted a survey on the Respondent premises.

23. Life safety surveyors found that the facility failed to maintain the physical environment of the facility, as observation revealed that the 300 hall block fire wall had 1 low voltage cable penetrating a 1" by 8" open hole in the block wall.

24. Observation also revealed that the 400 hall cross-corridor gypsum smoke/fire barrier stenciled wall had seams that were improperly sealed; a 1-1/2" metal conduit sleeve not properly sealed; 1-1" metal flex not properly sealed.

25. The 600 hall cross corridor gypsum smoke/fire barrier stenciled wall had seams that were not properly sealed; five (5) high voltage wires penetrating from the wall that were improperly sealed; 1-1/4" metal conduit sleeve penetrating wall with five (5) low voltage cables running through that was improperly sealed.

26. Surveyors also observed that the resident in room 505 had a toaster oven inside the resident's room that was in-use.

27. Surveyors observed that the following electrical receptacles were not mounted securely:

    a. Floor outlet at nurse's station had been pulled from the floor and was not protected by a cover.

    b. The heating and air unit receptacle in resident room #404.

    c. The receptacle in the hallway by resident room #502.

28. Extension cords were found to be in use in resident rooms 301 and room 407.

29. Documentation review revealed that the facility could not provide documentation of a ninety (90) minute annual test for thirty four (34) of the thirty-four (34) battery operated

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emergency lights.

30. Sprinkler escutcheons were found to be missing in the administrative closet and in the administrative office area.

31. The following smoke detectors were closer than three (3) feet from the air flow registers:

a. #17 by resident room #415;

b. #3 in the 600 hall;

c. #L1-D90 in the administrative office area.

32. Observation revealed that the following sprinklers were damaged, corroded, or leaking:

a. In hall by resident room #602 – damaged sprinkler;

b. Front entrance canopy had ten (10) of forty (40) corroded sprinklers;

c. The front entrance canopy had three (3) of forty (40) leaking sprinklers;

d. The 600 discharge canopy had three (3) of three (3) corroded sprinklers; and

e. Three (3) of three (3) sprinklers in resident room 603 were covered with plastic cups and tape.

33. The post indicator valve ("PIV") did not have directional signage and was hidden from view behind the wooden fence beside the 100 hall exit discharge.

34. The four (4) hour rated block wall located on the 300 hall was not in compliance. The door legend on the facility drawing called for the four (4) hour wall to have three (3) hour rated fire doors. Upon inspection of the doors, it was revealed that one door leaf had a rating of three (3) hours and the other door leaf had a rating of one and a half (1 ½) hours. Panic hardware had been installed instead of fire exit hardware was installed on both doors.

35. Further observation revealed the four (4) hour fire rated block wall located on the 300

hall had panic hardware installed on fire rated doors rather than fire exit hardware.

36. The facility could not provide staff signatures that all employees had received training on the following disaster preparedness drills:

a. Fire drills;

b. Tornado;

c. Bomb;

d. Flood;

e. Earthquake;

f. Severe hot and cold weather;

37. Further record review revealed that the facility could not provide documentation that disaster drills were conducted:

a. Tornado;

b. Bomb;

c. Flood;

d. Earthquake;

e. Severe hot and cold weather.

38. The facility failed to submit a Plan of Correction for the deficiencies cited during the August 23, 2017 life safety survey, as well.

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

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action by the Board is authorized.

39. The facts stated in paragraph three (3) are sufficient to establish that Respondent has violated provisions of Rule 1200-08-25-.03(9)(a)[Licensing Requirements], the relevant portion of which reads as follows:

(9) Certification of Administrator.

(a) Each ACLF must have an administrator who shall be certified by the Board, unless the administrator is currently licensed in Tennessee as a nursing home administrator as required by T.C.A. 63-16-101 *et. seq.*

40. The facts stated in paragraphs four (4) and five (5) are sufficient to establish that Respondent has violated provisions of Rule 1200-08-25-.06(1)(a)(5)[Administration], the relevant portion of which reads as follows:

(1) Each ACLF shall meet the following staffing and procedural standards:

(a) Staffing requirements:

(5) An ACLF shall employ a qualified dietician, full time, part time, or on a consultant basis.

41. The facts stated in paragraph six (6) are sufficient to establish that Respondent has violated provisions of Rule 1200-08-25-.06(1)(a)(5)[Administration], the relevant portion of which reads as follows:

(1) Each ACLF shall meet the following staffing and procedural standards:

(a) Staffing requirements:

(5) An ACLF shall employ a qualified dietician, full time, part time, or on a consultant basis

42 The facts stated in paragraph five (5) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25- 07(1)(b)(2)[Services Provided], the relevant portion of which reads as follows:

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(1) Each ACLF shall meet the following staffing and procedural standards:\

(b) Policies and Procedures.

(2) An ACLF shall develop and implement an effective facility-wide performance improvement plan that addresses plans for improvement for self-identified deficiencies and documents the outcome of remedial action.

43. The facts stated in paragraph seven (7) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(5)(b)[Administration], the relevant portion of which reads as follows:

> (b) An assisted care living facility shall have an annual influenza vaccination program which shall include at least:
> (1) The offer of influenza vaccination to all staff and independent practitioners at no cost to the person or acceptance of documented evidence of vaccination from another vaccine source or facility. The assisted care living facility will encourage all staff and independent practitioners to obtain an influenza vaccination;
> (2) A signed declination statement on record from all who refuse influenza vaccination for reasons other than medical contradiction (a sample form is available at: http://tennessee.gov/health/topic/hcf-provider);
> (3) Education of all employees about the following:
> (i) Flu vaccination;
> (ii) Non-vaccine control measures, and
> (iii) The diagnosis, transmission, and potential impact of influenza;
> (4) An annual evaluation of the influenza vaccination program and reasons for non-participation; and
> (5) A statement that the requirements to complete vaccinations or declination statements shall be suspended by the administrator in the event of a vaccine shortage as declared by the Commissioner or the Commissioner's designee.

44. The facts stated in paragraphs eight (8), seventeen (17), eighteen (18), nineteen (19), and twenty (20) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(5)(b)[Administration], the relevant portion of which reads as follows

> (5) Resident medication. An ACLF shall:
>
> (b) Ensure that all drugs and biologicals shall be administered by a licensed professional operating within the scope of the professional license

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and according to the resident's plan of care.

45. The facts stated in paragraph nine (9) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(c)(3)(i)[Services Provided], the relevant portion of which reads as follows:

> (c) Dietary Services.
>
> (3) An ACLF shall ensure that menus meet the needs of residents as follows:
>
> (i) The practitioner or practitioners, as qualified within the scope of practice, responsible for the care of residents shall prescribe therapeutic diets as necessary.

46. The facts stated in paragraph five (5) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(c)(3)(iii)[Services Provided], the relevant portion of which reads as follows:

> (c) Dietary Services.
>
> (3) An ACLF shall ensure that menus meet the needs of residents as follows:
>
> (iii) An ACLF shall have a current therapeutic diet manual approved by the dietician readily available to all ACLF personnel.

47. The facts stated in paragraph ten (10) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.08(5)(a)[Admissions, Discharges, and Transfers], the relevant portion of which reads as follows:

> (5) An ACLF resident qualifying for hospice care shall be able to receive hospice care services and continue as a resident if the resident's treating physician certifies that such care can be appropriately provided in the ACLF.
>
> (a) In the event that the resident is able to receive hospice services in an ACLF, the resident's hospice provider and the ACLF shall be jointly responsible for a plan of care that is prepared pursuant to current hospice guidelines promulgated by the Centers for Medicaid and Medicare and

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ensures both the safety and well-being of the resident's living environment and provision of the resident's health care needs.

48. The facts stated in paragraph eleven (11) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.08(6)(j)[Admissions, Discharges, and Transfers], the relevant portion of which reads as follows:

(6) An ACLF shall:

(j) Document evidence of vaccination against pneumococcal disease for all residents who are sixty-five (65) years of age or older, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control at the time of vaccination, unless such vaccination is medically contraindicated or the resident has refused offer of the vaccine. The facility shall provide or arrange pneumococcal vaccination of residents who have not received this immunization prior to or on admission unless the resident refuses the offer of the vaccine.

49. The facts stated in paragraph twelve (12) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.12(3)(c)[Resident Records], the relevant portion of which reads as follows:

(3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires healthcare services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum:

(c) Orders and recommendations for all medication, medical and other care, services, procedures, and diet from physicians or other authorized healthcare providers, which shall be completed prior to, or at the time of admission, and subsequently, as warranted. Verbal orders received shall include the description of the order, and identification of the individual receiving the order.

50. The facts stated in paragraph thirteen (13) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.12(3)(g)[Resident Records], the relevant portion of which reads as follows:

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(3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires healthcare services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum:

(g) Notes, including, but not limited to, observation notes, progress notes, and nursing notes.

51. The facts stated in paragraph fourteen (14) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.12(4)[Resident Records], the relevant portion of which reads as follows:

(4) An ACLF shall complete a written assessment of the resident to be conducted by a direct care staff member within a time-period determined by the ACLF, but no later than seventy-two (72) hours after admission.

52. The facts stated in paragraphs twenty-three (23), twenty-four (24), and twenty-five (25) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25- 09(1)[Building Standards] the relevant portion of which reads as follows:

(1) An ACLF shall construct, arrange, and maintain the condition of the physical plant and the overall ACLF living facility environment in such a manner that the safety and well-being of residents are assured.

53. The facts stated in paragraph twenty-six (26) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.10(2)(i)[Life Safety] the relevant portion of which reads as follows:

(2) An ACLF shall ensure fire protection for residents by doing at least the following:

(i) Prohibit cooking appliances other than microwave ovens other that microwave ovens in resident sleeping units.

54. The facts stated in paragraph twenty-seven (27) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.10(5)(c)[Life Safety] the relevant portion of which reads as follows:

(5) An ACLF shall take the following precautions regarding electrical equipment to

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ensure the safety of residents.

(c) Maintain all electrical equipment in good repair and safe operating condition.

55 The facts stated in paragraph twenty-eight (28) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.10(5)(g)[Life Safety] the relevant portion of which reads as follows:

(5) An ACLF shall take the following precautions regarding electrical equipment to ensure the safety of residents.

(g) Prohibit use of extension cords.

56 The facts stated in paragraphs twenty-nine (29) through thirty-five (35) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.10(8)(a)[Life Safety] the relevant portion of which reads as follows:

(8) An ACLF shall ensure that:

(a) The ACLF maintains all safety equipment in good repair and in a safe operating condition.

57. The facts stated in paragraphs thirty-six (36) through thirty-eight (38) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.16(2)[Disaster Preparedness] the relevant portion of which reads as follows:

(8) An ACLF shall comply with the following:

(a) Maintain a detailed log with staff signatures designating training each employee receives regarding disaster preparedness.

(b) Train all employees annually as required in the plans listed above and keep each employee informed with respect to the employee's duties under the plans.

(c) Exercise each of the plans listed above annually

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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:

58. Respondent's license to operate as an assisted living shall be **placed on probation for no less than six (6) months.**

59. If Respondent is administering medication to residents, only a licensed nurse or medication technician certified by the Board of Nursing shall dispense medications. Such licensed nurse or certified medication aide will maintain the records of all prescriptions, medication administration records, and progress notes within each resident's file.

60. Respondent shall ensure that all staff undergo training on proper medication administration and disposal. Respondent shall provide written proof of such training to the Board.

61. Respondent is also hereby assessed one (1) civil monetary penalty in the amount of five hundred dollars ($500.00) for a total assessment of five hundred dollars ($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: Eddie J. Stewart
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243

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62 Failure to complete the requirements cited in paragraphs fifty-eight (58) through sixty-two (62) or the citation of any further serious violations affecting the health, safety, and welfare of the facility's residents shall result in Suspension of Admissions pending a prompt hearing by the Board.

63. Upon ratification by the Board, the listing of the public discipline, including deficiencies, 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:

Rhonda Westbrooks, Administrator
Riverdale Assisted Living Facility
Respondent

October 3, 2017
Date

Caroline R. Tippens (BPR # 035375)
Assistant General Counsel
Department of Health
665 Main Stream Dr., 2nd Floor
Nashville, Tennessee 37243
(615) 741-1611

10/4/2017
Date

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CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon Respondent, Riverdale Assisted Living Facility, ATTN: Administrator, Rhonda Westbrooks, 6880 E. Raines Road, Memphis, TN 38115, 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