BEFORE THE TENNESSEE BOARD
FOR LICENSING HEALTH CARE FACILITIES

IN THE MATTER OF:	)	
	)	
Legacy Assisted Living and Memory Care	)	
6551 Knight Arnold Road	)	**Case Number 2017061531**
Memphis, TN 38115	)	
	)	
License No. ACLF 00000279	)	

CONSENT ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 3rd day of April, 2018, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **Legacy Assisted Living & Memory Care at Lenox Park** (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 regarding this matter and any and all rights to judicial review of this matter. This matter is limited to the facts and discipline described in this Consent Order.

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 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. 1200-08-25-.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.*

STIPULATIONS OF FACT

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1. At all times pertinent hereto, Legacy Assisted Living & Memory Care at Lenox Park, located at 6551 Knight Arnold Road, Memphis, TN 38115 has been licensed as an Assisted-Care Living Facility by the Board, having been issued license number **00000279** on June 13, 2006. Respondent has an active license with an expiration date of May 29, 2018.
2. On or about November 1, 2017 through December 4, 2017, surveyors conducted a

complaint survey at Respondent facility.

3. Resident #1 was a sixty-three (63) year old female admitted to the Memory Care Unit in August 2017 with diagnoses of Alzheimer's disease and depression. Upon her arrival at the facility, it was noted that the resident appeared to be unresponsive. However, there was no continuing documentation that the facility monitored the resident's unresponsive condition.

4. From August 19-31, 2017, there was not adequate documentation on Resident #1's medication administration sheet ("MAR") to indicate that Resident #1 had received her prescribed medications.

5. In October 2017, nursing notes revealed that the Resident #1 was not eating and had difficulty walking. There was no additional adequate documentation that the facility assessed and monitored this change in condition.

6. On or about October 11, 2017, a physician visited with Resident #1, but that physician maintained possession of the notes of his visit rather than providing them to the facility.

7. A staff interview revealed that despite the staff caring for the resident, the resident's medical record did not reflect certain observations made by staff.

8. On or about October 15, 2017, nursing notes revealed that Resident #1 was sent and admitted to the hospital.

9. Staff Interviews revealed that staff noticed that Resident #1 was not eating or drinking prior to being sent to the hospital. Staff reported that this information was reported to the Director of Nursing, but there was no evidence of this information in her medical record.

10. Several days after her admission to the hospital, Resident #1 expired. The Medical Examiner determined that Resident #1 had expired of natural causes.

11. Resident #2 was admitted to the facility in April 2017. Resident #2's medical record revealed that she was a medium fall risk.

12. Resident #2 had a fall on December 25, 2017. Resident #2 was discovered sitting on the floor and complaining of arm pain and was observed to have a red bruise on her posterior. Resident #2 was sent to the emergency room and diagnosed with a back sprain. There was no documentation entered into Resident #2's plan of care of staff interventions to prevent falls. There was no documentation that the facility developed a plan of care for Resident #2's continued falls. The facility also failed to update Resident #2's plan of care.

13. Resident #2 was again admitted to the hospital on January 1, 2018 – January 9, 2018. The resident's admitting diagnoses were urinary tract infection ("UTI"), hyperglycemia, and acute kidney injury.

14. There was no documentation found in the nursing notes that nurses had identified any changes in Resident #2's status or provided any interventions for her change in status. There was no documentation of staff identifications or interventions on the plan of care related to poor appetite and decreased food intake.

15. Resident #2 was discharged from the hospital to a skilled nursing facility.

16. Resident #3 was admitted to the facility in July 2017 with a diagnosis of Parkinson's.

17. A physician order dated August 30, 2017 documented that Resident #3's Comtan should be reduced to one tab twice a day for one week, then one tab once every morning for one week, then the medication should be discontinued.

18. Despite the facility having provided medication to Resident #3, no documentation was provided that the facility administered the resident's medication in accordance with the

physician's orders.

19. Resident #3 was discharged from the facility in late October 2017. The Respondent facility failed to provide documentation that the facility had developed a plan of care for Resident #3 during Resident #3's stay.

20. Surveyors conducted an abbreviated survey on February 12, 2018, consisting of three (3) revisit surveys related to complaint investigations. The survey was completed on March 1, 2018. Eight (8) of the complaints received were substantiated with deficiencies cited, and deficiencies that were cited in the December 2017 survey were re-cited on the revisit survey.

21. Residents #4, 5, 7, 8, 9, 10, 11, 12, and 13 had falls. There was documentation of staff interventions on Resident #4's plan of care to prevent further falls and avoid injury, but there was no documentation of staff interventions to prevent further falls and avoid injury on the other residents' plans of care.

22. Residents # 8, 11, 12, and 13 were diagnosed with dehydration, but there was no documentation of staff interventions to prevent dehydration in the plans of care of Resident # 8, 12, and 13.

23. Resident #4 was admitted to the facility in December 2016 with diagnoses of congestive heart failure, diabetes, hypertension, anemia, history of subdural hemorrhage, and end stage renal disease with dialysis. Resident #4 refused dialysis treatments on January 13, 2018 and January 18, 2018. On January 22, 2018, the resident indicated to staff that her heart was beating rapidly. Review of a nursing note indicated that the facility contacted the physician for the patient who indicated that Resident #4 should be sent to the ER. The holder of the resident's power of attorney refused. There was no documentation the

resident's physician was notified that the resident was not sent to the ER or that the resident was monitored for complications related to the refusals to go to dialysis and ER or the resident's complaints of rapid heartbeat.

24. Resident #5 was admitted to the facility in August 2017 with a diagnosis of dementia. At the time of admission, the resident was ambulatory without assistance.

25. On or about December 26, 2017, Resident #5 was started on Macrobid, an antibiotic, to be administered four (4) times a day for ten days. On or about December 26, 2017, Resident #5 was found on the floor of her room covered in red spots. She stated that she had been itching. Staff indicated that this was likely an allergic reaction to the antibiotics. Staff notified Resident #5's responsible party, but there is no documentation that they notified Resident #5's physician to get orders for proper treatment of the allergic reaction.

26. On or about December 27, 2017, Resident #5 was found to have pain in her shoulders radiating from her neck and cellulitis on her right lower extremity that was very red, warm to the touch, and sensitive. The facility documented calling Resident #5's responsible party and placing a call to Resident #5's physician. No further documentation was found regarding any further follow-up assessments for Resident #5.

27. On or about January 13, 2018, Resident #5 was found to have a temperature. Facility staff administered acetaminophen, which reduced the resident's temperature. No further documentation was found indicating that the resident was monitored or assessed.

28. Resident #7 was admitted to the facility in November 2017 with diagnoses of diabetes and hypertension. As discussed in paragraph 21 above, Resident #7 had falls on November 20, 2017, November 21, 2017, and January 18, 2018 and there was no documentation in the plan of care of staff interventions to protect against further falls or

injury.

29. Resident #8 was admitted to the facility in December 2015 with diagnoses of dementia and Crohn's disease. Resident #8 was found to be vomiting on or about September 18, 2017. The resident was transported to the hospital for symptoms of abdominal pain, nausea, and vomiting. The resident was admitted to the hospital and diagnosed with acute terminal ileitis secondary to Crohn's disease, dehydration with acute kidney injury, and dementia with behavioral disturbances and ileus. Upon return to the facility, there was no documentation that the facility implemented interventions to monitor the resident's medical conditions or prevent further episodes of dehydration.

30. On or about September 30, 2017, Resident #8's right hand was closed in a door. The resident was transported to the hospital and received sutures for lacerations to the hand and discharged back to the assisted living facility. There was no documentation interventions were implemented to prevent resident injuries and provide safety to the resident. Between November 28, 2017 and December 2, 2017, Resident #8 had numerous unexplained injuries. There was no documentation of interventions to prevent further injury. For some of the injuries, there was no documentation that staff assessed the resident's injuries.

31. From January 22 – February 7, 2018, no documentation was found in Resident #8's file that the charge nurse indicated that the facility could provide care to Resident #8 appropriate to meet her needs or changes in her condition. The facility failed to develop and revise Resident #8's plan of care.

32. Resident #9 was admitted to the facility's locked memory care in December 2017 with diagnoses of dementia, diabetes, heart disease, and Parkinson's disease after being

discharged from a behavioral hospital related to sexually aggressive behaviors.

33. Resident #9 used a wheelchair to ambulate. As described in paragraph 21 above, Resident #9 had falls, and there was no documentation of staff interventions in the plan of care.

34. Nurses notes from Resident #9s medical record show that between December 19, 2017 and January 15, 2017, Resident #9 displayed threatening and violent behavior as well as inappropriate sexual behavior towards staff and other residents. Resident #9 was sent to the hospital on or about January 15, 2018, and did not return to the facility. There was no documentation in Resident #9's plan of care to protect Resident #9 or other residents.

35. Resident #10 was admitted to the facility in December 2015 with diagnoses of end stage renal failure, bipolar disorder, and gastric reflux. As described above in paragraph 21, following two falls, the facility also failed to develop and revise Resident #10's plan of care.

36. Resident #11 was admitted to the facility in September 2017 with diagnoses that included degenerative joint disease, arthritis, dementia, and schizophrenia. As discussed above in Paragraph 21, resident had several falls, and there was no documentation in the plan of care of staff interventions to prevent further falls or avoid injury.

37. On or about January 10, 2018, Resident #11's daughter expressed concerns that the resident was not eating or drinking and requested that she be notified if the resident failed to eat or drink. On or about January 12, 2018, nursing notes indicate that the resident did not eat breakfast or lunch.

38. Resident #12 was admitted to the facility in 2015 with a diagnosis of a stroke. As discussed above in paragraph 21, after falls on November 21, 2017, January 11, 2018, and February 19, 2018, there was no documentation in Resident #12's plan of care of

staff interventions to prevent falls or avoid injury.

39. Resident #12 had a physician's order for Miralax to be given once a day. Documentation indicated that Resident #12 complained of constipation and feeling unwell on November 24, 25, and 27, 2017. There was no documentation of staff interventions on the plan of care regarding these complaints. Nursing notes indicated that on November 25 and November 26, 2017, Resident #12 was given an additional dose of Miralax. There was no documentation of the physician order for this additional Miralax, and there was no documentation of this additional Miralax in the MAR.

40. Resident #13 was admitted to the facility in 2015 with diagnoses of diabetes and arthritis. Medical record review revealed a physician's order for Clonidine .1mg every 6 hours as needed for blood pressure greater than 180/100. Nursing notes for December 18, 2017 documented that clonidine was given for Resident # 13's high blood pressure. Resident #13's blood pressure was documented in the MAR as 180/70. There was no documentation that Resident #13's diastolic blood pressure was greater than 100. There was no documentation of a physician's order calling for Clonidine when the diastolic blood pressure was less than 100.

41. Medication records revealed that on January 11, 2018, Resident #13 was started on Doxycycline 100 mg two times a day for 10 days, Mucinex 600 mg 1 time a day for 10 days, and Tamiflu 56 mg 1 capsule 2 times a day for five days. There was no documentation as to why the resident was started on the medication or that the resident was monitored.

42. On or about February 5, 2018, nursing notes indicated that Resident #13 was not as active as before and was prone to diarrhea. However, nursing notes indicated that no

medications for diarrhea were administered.

43. On or about February 9, 2018, nursing notes revealed that much encouragement was required to get Resident #13 to eat or drink. The facility failed to develop and revise Resident #13's plan of care.

44. The facility failed to develop and implement an effective facility wide performance improvement plan for the months of January 2018 and February 2018 that identified and corrected problems with falls, injuries of unknown origins, dehydration, changes in residents' status, narcotics diversions, and resident behaviors.

45. For the month of December 2017, there was insufficient documentation in the MAR to show that Resident #1 and Resident #2 received their medication.

46. Since the time of many of the above allegations, Respondent facility has hired a new Director of Nursing in January 2018.

47. The new Director of Nursing and two designated nurses have reassessed all residents in the facility and revised plans of care for all residents using a new form and format.

48. Since the time of the above allegations, Respondent facility's employees have received and will continue to receive training regarding proper documentation and any needed amendment of plans of care.

49. Respondent facility has begun the process of reviewing its policies and procedures for any needed updates to ensure proper documentation, including with respect to the inclusion of documentation from outside providers coming into the facility to provide services.

50. Observations during the survey revealed that there were no call lights in residents' rooms for residents to call for assistance. There was no observation of any type of equipment

that a resident could use to call for help if needed. In an interview with the Director of Nursing on or about February 22, 2018, the Director of Nursing stated that some of the residents have a pendant to call for assistance, but that the batteries are dead. The DON was unable to provide a list of residents with a functioning pendant to enable a resident to call for assistance.

51. Subsequent to the survey, the facility has contracted with LifeStation to install and administer a system of wearable call pendants. The pendants have been purchased, and the system is expected to be operational on or before May 1, 2018. Until the pendants are operational, facility staff are conducting hourly wellbeing checks with all residents.

52. Observation at the facility on February 21, 2018 revealed that residents were not eating what was on the planned menu for that day, and it was unclear if special diets were utilized.

53. Interview with the dietary manager confirmed that she did not have a therapeutic diet manual signed by a dietitian. The dietary manager stated she was not aware of any residents on a chopped mechanical diet and had no recipes to puree food.

54. Subsequent to the survey, the facility has engaged a dietitian, who has worked with the Dietary Manager to establish a new diet manual and specialized meal plans where needed for particular residents. The facility has also implemented a system of tray cards to ensure that residents are served the appropriate diet at each meal.

55. Based on observation and interview, the facility also failed to follow the planned menu for February 20, 2018.

56. Review of the facility's medication disposal policy revealed that that policy did not separately address the disposal of scheduled narcotic medications. Subsequent to the

survey. the facility has implemented a new policy to govern the disposal of scheduled narcotic medications and has worked with its pharmacy vendor to implement a secure disposal process consistent with that policy.

57. On or about February 26, 2018, life safety surveyors conducted a survey on Respondent facility. The facility was unable to provide the records of fire drills conducted in 2017 at the time of the survey, possibly due to a flood that the facility suffered in December which displaced and damaged many facility records. The administrator acknowledged that the records could not be located. Subsequent to the survey, the facility located the records of the 2017 fire drills and advised the State that they are now available for review.

58. Further observation also revealed that the sprinklers were not in correct alignment and were hanging below the ceiling level in hall 4, hall 2, and hall 1, and in apartments #49, 51, 55, 56, and in the memory care dining area. Apartments #26 and #28 had insufficient sprinkler coverage. A sprinkler assembly from each room had been removed and the ceiling patched. Interview with the administrator revealed that sprinklers had not been removed during her tenure as administrator and she had been at the facility for six (6) months.

59. Subsequent to this survey, these sprinkler heads were repaired and are now operational.

60. The maintenance supervisor also indicated that frozen sprinkler lines had recently caused problems. Observation revealed that there were multiple red service tags from November 2017 – February 2018 on the facility's sprinkler riser system and multiple green service tags from December 2017 – February 2018 on the facility's sprinkler riser system.

61. Subsequent to the survey, the sprinkler system was fixed and a full, facility-wide safety review was conducted, with a satisfactory result. This documentation was subsequently

provided to the State.

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.

62. The facts stated in paragraphs four (4), seventeen (17), eighteen (18), forty-one(41), forty-two (42), and forty-five (45) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(5)(a) and/or (b) [SERVICES PROVIDED], the relevant portions of which read as follows:

> (5) Resident medication. An ACLF shall:
>
> (a) Ensure that medication shall be self-administered in accordance with the resident's plan of care.
>
> (b) Ensure that all drugs and biologicals shall be administered by a licensed professional operating within the scope of the professional license and according to the resident's plan of care.

63. The facts stated in paragraphs seven (7), nine(9), eleven (11), twelve (12), fourteen(14), eighteen (18), nineteen(19), twenty-one (21), twenty-two (22), twenty-three (23), twenty-eight (28), thirty (30), thirty-one (31), thirty-three (33), thirty-four (34), thirty-five (35), thirty-six(36), thirty-eight (38), thirty-nine (39), forty-three (43) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.12(5)(a) [PLAN OF CARE], the relevant portion of which reads as follows:

> (5)(a) An ACLF shall develop a plan of care for each resident admitted to the ACLF with input and participation from the resident or the resident's legal representative.

treating physician. or other licensed health care professionals or entity delivery patient services within five (5) days of admission. The plan of care shall be reviewed and/or revised as changes in resident needs occur, but not less than semi-annually by the above appropriate individuals.

64. The facts stated in paragraph fifty-seven (57) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(6)(g) [SERVICES PROVIDED], the relevant portion of which reads as follows:¶

(6) An ACLF shall dispose of medications as follows:

(g) The ACLF's medication disposal policy shall also address the disposal of scheduled drugs, non-scheduled drugs, and devices that are misbranded, expired, deteriorated, not kept under proper conditions, and kept in containers with illegible or missing labels.

65. The facts stated in paragraphs forty-nine (49) through fifty-two (52) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(7)(c)3(ii)-(iv)[SERVICES PROVIDED], the relevant portion of which reads as follows:

(7) An ACLF shall provide personal services as follows:
(c) Dietary Services.
3. An ACLF shall ensure that menus meet the needs of the residents as follows:
(i) The practitioner or practitioners, as qualified within the scope of practice, responsible for the care of the residents shall prescribe therapeutic diets as necessary.
(ii) An ACLF shall meet nutritional needs, in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of residents.
(iii) An ACLF shall have a current therapeutic diet manual approved by the dietitian readily available to all ACLF personnel.
(iv) Menus shall be planned one week in advance.

66. The facts stated in paragraphs thirty-two (32) and thirty-four (34) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.08(1)(d) [SERVICES PROVIDED], the relevant portion of which reads as follows:

(8) 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 physical aggressive behavior which poses an imminent physical threat to self or others, based on behavior, not diagnosis.

67. The facts stated in paragraphs seven (7), nine (9), eleven (11), twelve (12), fourteen (14), eighteen (18), nineteen (19), twenty-one (21), twenty-two (22), twenty-three (23), twenty-eight (28), thirty (30), thirty-one (31) through thirty-six (36), thirty-eight (38), thirty-nine (39), forty (40), forty-one (41), and forty-three (43) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.12(3)(e)[RESIDENT RECORDS], the relevant portion of which reads as follows:

(3) Medical record. An ACLF shall ensue 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 from an outside source, which shall include at a minimum:

(e) Medications administered and procedures followed if an error is made.

68. The facts stated in seven (7), nine (9), eleven (11). eighteen (18), thirty-three (33), and forty (40) 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:

(3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care 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.

69. The facts stated in paragraph fifty-eight (58) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.10(3)(a)[Life Safety], the relevant portion of which reads as follows:

(3) An ACLF shall conduct fire drills in accordance with the following:

(a) Fire drills shall be held for each ACLF work shift in each separate ACLF building at least quarterly.

70. The facts stated in paragraph fifty-nine (59) through sixty-two (62) 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.

ORDER

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

71. Respondent shall hire a qualified consultant, at its expense, to enter the facility and work with the facility for a period of six (6) months to cure any remaining deficiencies and to submit an acceptable Plan of Correction (POC). At the outset of this period, the consultant will work with the facility to establish a work plan for curing any remaining deficiencies with specific, measureable goals. A copy of the work plan will be shared

with the State within forty-five (45) days of the entry of this Consent Order. The acceptable POC must be submitted within six (6) months of the Board's Order.

72. For the first two (2) months following the entry of this Consent Order, this consultant will work on site at the facility for a minimum of two (2) days per week and shall be available and involved in the operation of the facility even when not on site including direct contact with the Administrator and Director of Nursing ("DON"). This consultant will report to the owner-operators on a daily basis. The consultant will also submit a weekly report to the owner-operators addressing issues of concern or areas of improvement. The facility will update the State every two (2) weeks with a report that has been approved by the consultant.

73. After the first two (2) months, the owner-operators and consultant will reassess the level of achievement in moving through the performance improvement plan and determine what level of continued involvement is appropriate to achieve any remaining objectives on the performance improvement plan. However, the consultant will continue to work on site at the facility for a minimum of one day per week and shall continue to be available and involved in the operation of the facility even when not on site. The consultant will also continue to submit a weekly report to the owner-operators addressing issues of concern or areas of improvement. The facility will continue to update the State every month with a report that has been approved by the consultant.

74. During the six (6) month period, any new 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.

75. Following the initial six (6) month period, Respondent shall appear before the Board and submit quarterly reports until the end of calendar year 2019, prepared by the Respondent, regarding the adherence of the facility to the regulations cited in the December 2017, February 2018, and March 2018 Statement of Deficiencies.

76. Respondent shall ensure that all staff undergo in-service training regarding recognition of changes in patient condition, updates to the plan of care, and medical record-keeping and documentation. Respondent shall provide written proof of completion of such training to the Board within the six (6) months of the date of the Board's Order.

77. The assessment of nine (9) civil monetary penalties in the amount of five hundred dollars ($500.00) each for a total assessment of four thousand five hundred ($4,500.00) dollars. 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

78. 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 3rd day of April, 2018.

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:

Pearl Woodruff, Administrator
Legacy Assisted Living & Memory Care
at Lenox Park
Respondent

4/3/18
Date

Lisa S. Rivera
Member
Attorney for the Respondent
Bass, Berry & Sims PLC
150 Third Avenue South, Suite 2800
Nashville, TN 37201

4/3/18
Date

Caroline R. Tippens, BPR # 030375
Assistant General Counsel
Tennessee Department of Health
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243
(615) 741-1611

4/3/2018
Date

CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon Respondent, by and through their attorney, Lisa S. Rivera, Bass, Berry & Sims PLC , 150 Third Avenue South, Suite 2800, Nashville, TN 37201 by delivering same in the United States mail certified mailing # 7017 0190 0001 0037 2879, and via USPS first class, with sufficient postage thereon to reach its destination.

This 4th day of April, 2018.

Caroline R. Tippens
Assistant General Counsel

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