STATE OF TENNESSEE
BEFORE THE HEALTH FACILITIES COMMISSION

In The Matter of:	)	
	)	
AHC Cumberland	)	
Skilled Nursing Facility	)	**Case Nos. 2024042021**
License No. 48,	)	**2025008061**
	)	
Respondent.	)	
	)	
Nashville, Tennessee	)	

CONDITIONAL CHANGE OF OWNERSHIP ORDER

This matter came to be heard before the Health Facilities Commission ("Commission"), by and through the Office of Legal Services, and AHC Cumberland ("Respondent") that the Commission adopt this Conditional Change of Ownership Order, the terms of which have been agreed upon by the parties, as signified by their signatures below.

Respondent, by signature to this Conditional Change of Ownership 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 Conditional Change of Ownership Order by the Commission for ratification and all matters divulged during that process shall not constitute unfair disclosure such that the Commission or any of its members shall be prejudiced to the extent that requires their disqualification from hearing this matter should the Conditional Change of Ownership 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.

I. JURISDICTION

1. The Commission is empowered 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 childcare centers, renal dialysis clinics, ambulatory surgical treatment centers, outpatient diagnostic centers, adult care homes, and traumatic brain injury residential homes. T.C.A. § 68-11-202(a)(1).

2. A "Nursing home" means any institution, place, building or agency represented and held out to the general public for the express or implied purpose of providing care for one (1) or more nonrelated persons who are not acutely ill, but who do require skilled nursing care and related medical services; and "Nursing Home" shall be restricted to facilities providing skilled nursing care and related medical services to individuals, beyond the basic provision of food, shelter and laundry, admitted because of illness, disease or physical infirmity for a period of not less than twenty-four (24) hours per day. T.C.A. § 68-11-201(31).

3. The Commission has the authority to conduct reviews of all facilities licensed under this part in order to determine compliance with fire and life safety code rules as promulgated by the Commission. T.C.A.§ 68-11-202(b)(1)(A).

4. Any person, partnership, association, corporation, any state, county or local governmental unit, or any division, department, board or agency of the governmental unit, in order to lawfully establish, conduct, operate or maintain a hospital, recuperation center, nursing home, home for the aged, residential HIV supportive living facility, assisted-care living facility, home care organization, residential hospice, birthing center, prescribed child care center, renal dialysis clinic, outpatient diagnostic center, ambulatory surgical treatment

center, adult care home or traumatic brain injury residential homes in this state, shall obtain a license from the commission, upon the approval and recommendation of the commission in the following manner:

> (1) The applicant shall submit an application on a form to be prepared by the commission with the approval of the commission, showing that the applicant is of **reputable and responsible character and able to comply with the minimum standards** for a facility and with rules and regulations lawfully promulgated under this part. The application shall contain the following additional information:
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> > (A) The name or names of the applicant or applicants;
> >
> > (B) The type of institution to be operated;
> >
> > (C) The location of the institution;
> >
> > (D) The name of the person or persons to be in charge of the institution or, for adult care home applicants, the name of the resident manager, if applicable;
> >
> > (E) A certification that the applicant has implemented a policy of informing its employees of their obligations under § 71-6-103 to report incidents of abuse or neglect;
> >
> > (F) If an application for a nursing home license, a list of all nursing homes that the applicant, or any person or entity holding a majority legal or equitable interest in the applicant, owns or operates and, if the applicant has not operated a nursing home in this state for a continuous period of twenty-four (24) months preceding the application, the information specified in § 68-11-804(c)(1) for each such nursing home located outside this state; and
> >
> > (G) Such other information as the commission, with the approval of the commission, may require.

T.C.A. § 68-11-206(a)(1).

5. 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).

6. Upon a finding by the Commission that a nursing home has violated any provision of Tenn. Code Ann. §§ 68-11- 201, et seq., 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. T.C.A.§ 68-11-207.

II. STIPULATIONS OF FACT

7. At all times pertinent hereto, Respondent, AHC Cumberland, 4343 Ashland City Highway, Nashville, Tennessee 37218, was licensed by the Commission as a nursing home, having been granted license number 48 on July 1, 1992, which currently has an expiration date of June 1, 2026.

SURVEY 1

8. On or about September 5, 2024, through November 7, 2024, Commission surveyors conducted a Life Safety survey at Respondent's facility.

9. Respondent's Administrators failed to assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents by failing to:

   a. Provide oversight of clinical staff, intervene immediately in observed abuse, and to timely report allegations of abuse for Resident #2, #3, #4, #5, #19, and #35 (as identified in SURVEY 1).

   b. Intervene and report a family member who was observed abusing Resident #35 on or about December 21, 2023.

   c. Provide adequate resources to treat Resident #19, who was suffering from a drug addiction and prevent the resident from overdosing while in the facility.

   d. Provide resources to adequately treat and monitor significant weight loss for Residents #45, #46, #63, and #65 (as identified in SURVEY 1).

e. Implement a process to resolve issues and concerns identified by the facility's Nurse Practitioner (NP) when the Assistant Director of Nursing (ADON) is on leave.

10. Respondent failed to ensure an appropriate family representative was notified of a transfer from the facility for Resident #44 (as identified in SURVEY 1).

11. Medical records for Resident #44 on multiple dates from October 5, 2023, through November 7, 2024, lacked documentation that Resident #44's family representative was notified of the Resident's transfer to the hospital on the Hospital Transfer form.

12. Respondent failed to ensure a written order for transfer/discharge was documented in the medical record for residents #43, #52, #53, #54 and #51 (as identified in SURVEY 1).

13. Medical records for Resident #43, #52, #53, #54 and #51 revealed no documentation of physician orders for transfers or discharges initiated from the facility during the survey period reviewed.

14. Respondent failed to ensure that resident #31 and #33 (as identified in SURVEY 2) received nursing care consistent with professional standards of practice to prevent pressure ulcers.

15. Respondent's Wound Assessment Report dated August 27, 2024, for Resident #31 confirmed that the resident had a facility acquired Stage IV pressure ulcer wound which was initially discovered on May 27, 2023.

16. Resident #33's Care plan dated April 1, 2024, confirmed the resident was to receive baths or showers multiple times per week and that the resident was unable to bathe themselves and required assistance.

17. Respondent's Shower records confirmed that Resident #33 received a minimal number of bed baths from March through October of 2024, and received no showers.

18. On or around October 22, 2024, Respondent's Director of Nursing (DON) confirmed that facility Certified Nurse Aides (CNAs) should document bathing daily.

19. Respondent failed to assist vulnerable residents with meals and fluid intake, repeatedly failed to recognize and address residents' nutritional statuses, and failed to implement pertinent interventions, the absence of which resulted in significant weight loss for Residents #67, #65, #63, #45 and #46.

20. Resident medical records confirmed Resident #67 lost approximately nine percent (9%) of their weight over two months, and resident meals were not documented properly.

21. Resident #65 lost approximately nine percent (9%) over two months, meal tickets were not followed, resident meals were not documented properly, and feeding assistance was not provided appropriately.

22. Resident #63 suffered multiple bouts of severe weight loss of approximately twelve percent (12%) on two occasions over three (3) and six (6) month periods. Resident's Care Plan did not provide adjustments for the loss, nor did the Respondent follow the Care Plan to record food intake.

23. Resident #45 lost approximately five percent (5%) of their weight over a month and a half, and resident meals were not documented properly. Resident #45 was incapable of feeding without assistance. Resident #45 was noted in the medical record to have required hospitalization for dehydration.

24. Resident #46 was noted as having lost approximately thirteen percent (13%) in approximately six (6) weeks from December 9, 2023, to January 23, 2024, and resident meals were not documented properly.

25. Facility CNA staff were generally unaware that meal percentages less than twenty-five percent (25%) consumed were to be reported to the nurse for each resident.

26. Respondent failed to timely report allegations of abuse and neglect for Residents #2, #3, #4, #5, and #19.

27. Respondent's Incident Reporting System (ICS) record confirmed that on or about May 8, 2024, Resident #2 alleged that she was abused by Resident #3. Respondent's ICS confirmed that Respondent's Administrator was not notified of the incident until May 9, 2024, a day after the alleged abuse incident occurred. All night shift facility staff were aware of the abuse on the evening of May 8, 2024, but no staff reported it until May 9, 2024.

28. Medical records for Resident #19 along with ICS reports confirmed that on or around November 8, 2023, Resident #19 overdosed on drugs brought into the facility by outside individuals. Resident #19 required hospitalization as a result of the overdose.

29. Respondent's Director of Nursing (DON) failed to report the incident of abuse/neglect to the State within two (2) hours as required.

30. On or around July 7, 2024 and incident of abuse between Resident #4 and Resident #5 occurred. Respondent's ICS report confirmed that the incident was not reported to the State within the two (2) hours as required.

31. Respondent failed to establish and/or implement policies and procedures setting forth the rights of residents for the protection and preservation of dignity. The facility failed to

follow its own abuse reporting/investigation policies and procedures which resulted in several incidents of resident harm, including deprivation of goods and services by staff, sexual abuse by a resident, physical abuse by a family member, and verbal abuse by staff.

SURVEY 2

32. On or about February 6, 2025, a survey of the facility was completed resulting in a deficiency being cited for failure to adopt safety policies for the protection of residents from accident and injury.

33. On or about January 21, 2025, Resident #1 (as identified in SURVEY 2) fell while being transferred by a Certified Nursing Assistant (CNA). The CNA attempted to transfer the resident from a shower bed to the resident's bed without assistance from another staff member, but failed to lock all the shower bed wheels properly. As a result, Resident #1 falling between the beds and sustained injuries.

34. This incident was not reported, and the resident received no relevant treatment, until January 25, 2025, approximately four (4) days later.

III. GROUNDS FOR CONDITIONS

The facts in Section II, *supra*, are sufficient to establish that grounds exist for the discipline of Respondent's Nursing Home license. Specifically, Respondent has violated the following statutes and/or rules, for which disciplinary action by the Commission is authorized.

35. The facts in paragraphs nine (9) through thirty-four (34) are sufficient to constitute a violation of Tenn. Comp. R. and Regs. 0720-18-.04(1) [Administration], the relevant portion of which reads as follows:

> (1) The nursing home shall have a full-time (working at least 32 hours per week) administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall

designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents.

36. The facts in paragraphs thirty-three (33) and thirty-four (34) are sufficient to constitute a violation of Tenn. Comp. R. and Regs. 0720-18-.04(15) [Administration], the relevant portion of which reads as follows:

> (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury.

37. The facts in paragraphs ten (10) through thirteen (13) are sufficient to constitute a violation of Tenn. Comp. R. and Regs. 0720-18-.05(10) [Admissions, Discharges, and Transfers], the relevant portion of which reads as follows:

> (10) No resident shall be transferred without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any.

38. The facts in paragraphs fourteen (14) and fifteen (15) are sufficient to constitute a violation of Tenn. Comp. R. and Regs. 0720-18-.06(4)(l) [Basic Services], the relevant portion of which reads as follows:

> (4) Nursing Services
>
> (l) Each resident shall be given proper personal attention and care of skin, feet, nails and oral hygiene in addition to the specific professional nursing care as ordered by the resident's physician.

39. The facts in paragraphs sixteen (16) through eighteen (18) are sufficient to constitute a violation of Tenn. Comp. R. and Regs. 0720-18-.06(4)(n) [Basic Services], the relevant portion of which reads as follows:

> (4) Nursing Services
>
> (n) Residents shall have baths or showers at least two (2) times each week, or more often if requested by the resident.

40. The facts in paragraphs nineteen (19) through twenty-five (25) are sufficient to constitute a violation of Tenn. Comp. R. and Regs. 0720-18-.06(4)(aa) [Basic Services], the relevant portion of which reads as follows:

> (4) Nursing Services
>
> (aa) Assistance with eating shall be given to the resident as needed in order for the resident to receive the diet for good health care.

41. The facts in paragraphs nineteen (19) through twenty-five (25) are sufficient to constitute a violation of Tenn. Comp. R. and Regs. 0720-18-.06(4)(aa) [Basic Services], the relevant portion of which reads as follows:

> (4) Nursing Services
>
> (bb) Abnormal food intake will be evaluated and recorded.

42. The facts in paragraphs twenty-six (26) through thirty-one (31) are sufficient to constitute a violation of Tenn. Comp. R. and Regs. 0720-18-.11(2) [Records and Reports], the relevant portion of which reads as follows:

> (2) The nursing home shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.

43. The facts in paragraphs twenty-six (26) through thirty-one (31) are sufficient to constitute a violation of Tenn. Comp. R. and Regs. 0720-18-.12(1)(g) [Resident Rights], the relevant portion of which reads as follows:

> (1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights:

(g) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified immediately as required in T.C.A. §71-6-103;

IV. STIPULATED DISPOSITION

For the purpose of avoiding further administrative action with respect to this cause, the Commission and Respondent agree to the following settlement terms:

44. Applicant understands the allegations, charges, and stipulations in this Order. Entry into this Consent Order by the Applicant does not constitute an accord on its part as to the accuracy of the Commission's findings and conclusions drawn therefrom.

45. Applicant understands the rights found in the Code, Rules, and the Uniform Administrative Procedures Act, TENN. CODE ANN. §§ 4-5-101 thru 4-5-404, including the right to a hearing, the right to appear personally and by legal counsel, the right to confront and to cross-examine witnesses who would testify against Applicant, the right to testify and to present evidence on Applicant's own behalf, as well as to the issuance of subpoenas to compel the attendance of witnesses and the production of documents, as well as the right to appeal for judicial review. Applicant voluntarily waives these rights in order to avoid further administrative action.

46. Applicant agrees that presentation of this Order to the Commission and the Commission's consideration of it and all matters divulged during that process shall not constitute unfair disclosure such that the Commission or any of its members become prejudiced requiring their disqualification from hearing this matter should this Order not be ratified. All matters, admissions, and statements disclosed during the attempted ratification process shall not be

used against the Applicant in any subsequent proceeding unless independently entered into evidence or introduced as admissions.

47. Applicant agrees that facsimile/PDF copies of this Order, including facsimile/PDF signatures thereto, shall have the same force and effect as originals.

48. Applicant also agrees that the Commission may issue this Order without further process. If the Commission rejects this Order for any reason, it will be of no force or effect for either party.

49. Applicant agrees that the facility has not received any threats or promises of any kind by the State or any agent or representative thereof, except such as is detailed herein.

V. ORDER

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

50. The Change of Ownership Application for license number 48 to operate as a Skilled Nursing Facility in the State of Tennessee is hereby GRANTED subject to the following conditions.

51. Failure to comply with each condition listed in Section V within **ten (10) business days** of ratification of this Order will result in DENIAL of the facility's Change of Ownership (CHOW) application.

52. The effective date of the CHOW shall be February 1, 2025.

53. Respondent shall be placed on **probation** for a period not to exceed **twelve (12) months** from the effective date of this Order.

    a. During the probationary period, the facility **shall submit monthly reports to the Commission's West Tennessee Regional Office, on or before the 15th of each**

month. Each report shall include updates regarding training on abuse, residents' rights, and safety, as well as a roster of non-English speaking residents (including primary language and accommodations provided to those residents).

b. If specifically requested by the Commission during the probationary period, Respondent shall appear in person at a regularly scheduled Commission meeting to discuss any issues of noncompliance.

c. Pursuant to T.C.A. § 68-11-207(e)(6), the Commission is authorized at any time during the probation to remove the probational status of the facility's license, based on information presented to it showing that the conditions identified by the Commission have been corrected and are reasonably likely to remain corrected.

d. The facility shall request an Order of Compliance from Commission staff at the end of its probationary period. **If the facility is in compliance at that time, the Order of Compliance will be prepared by Commission staff and presented at the next regularly scheduled Commission meeting.** The Commission shall make the final determination of whether to terminate the facility's probation.

54. Respondent is hereby assessed and shall pay a Civil Monetary Penalty (CMP) in the amount of **five-hundred dollars ($500.00)** for the violation(s) referenced in paragraph thirty-five (35) above.

55. Respondent is hereby assessed and shall pay a Civil Monetary Penalty (CMP) in the amount of **one thousand dollars, five-hundred dollars ($1,500.00)** for the violation(s) referenced in paragraph thirty-six (36) above.

56. Respondent is hereby assessed and shall pay a Civil Monetary Penalty (CMP) in the amount of **five-hundred dollars ($500.00)** for the violation(s) referenced in paragraph thirty-seven (37) above.

57. Respondent is hereby assessed and shall pay a Civil Monetary Penalty (CMP) in the amount of **five-hundred dollars ($500.00)** for the violation(s) referenced in paragraph thirty-eight (38) above.

58. Respondent is hereby assessed and shall pay a Civil Monetary Penalty (CMP) in the amount of **five-hundred dollars ($500.00)** for the violation(s) referenced in paragraph thirty-nine (39) above.

59. Respondent is hereby assessed and shall pay a Civil Monetary Penalty (CMP) in the amount of **five-hundred dollars ($500.00)** for the violation(s) referenced in paragraph forty (40) above.

60. Respondent is hereby assessed and shall pay a Civil Monetary Penalty (CMP) in the amount of **five-hundred dollars ($500.00)** for the violation(s) referenced in paragraph forty-one (41) above.

61. Respondent is hereby assessed and shall pay a Civil Monetary Penalty (CMP) in the amount of **four-hundred dollars ($400.00)** for the violation(s) referenced in paragraph forty-two (42) above.

62. Respondent is hereby assessed and shall pay a Civil Monetary Penalty (CMP) in the amount of **one thousand dollars, five-hundred dollars ($1,500.00)** for the violation(s) referenced in paragraph forty-three (43) above.

63. **The total amount of all Civil Monetary Penalties imposed is six-thousand, four-hundred dollars ($6,400.00).**

64. If not paid prior to ratification of this Order, Respondent must pay any outstanding Civil Monetary Penalties and State Monitoring Fees within **ten (10) business days** of ratification of this Order. Payment shall be submitted to the following address:

Tennessee Health Facilities Commission, 9th Floor
Attention: Disciplinary Coordinator
502 Deaderick Street
Nashville, Tennessee 37243

65. Each condition of this Order is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

APPROVED FOR ENTRY:

Signature of Authorized Representative
Nashville SNF Healthcare, LLC dba Eaton Creek
License No. 48
Respondent/Applicant

John Mitchell
Printed Name of Authorized Representative

Secretary
Title of Authorized Representative

Vishan J. Ramcharan (BPR # 034403)
Associate General Counsel
Health Facilities Commission
Office of Legal Services
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243
Office: (615) 741-2364
Fax: (615) 741-9884
Email: Vishan.J.Ramcharan@tn.gov

Approval by the Commission

Upon the agreement of the parties and the record as a whole, this **CONSENT ORDER** was approved as a **FINAL ORDER** by a majority of a quorum of the Health Facilities Commission at a public meeting of the Commission and signed this 22nd day of October, 2025.

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

Chairperson
Health Facilities Commission

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this document has been served upon the Respondent, AHC Cumberland, c/o Administrator, Jessica Thomas, 6480 Quince Road Memphis, Tennessee 38119, and AHC Cumberland, c/o Registered Agent, Capitol Corporate Services, 992 Davidson Drive, Suite B, Nashville, Tennessee 37205-1051 by delivering same in the United States regular mail and United States certified mail, numbers **7020 0640 0001 4807 5996** and **7020 0640 0001 4807 5989**, return receipts requested, with sufficient postage thereon to reach its destination. A copy was sent via electronic mail to: savakian@polsinelli.com and ccrider@bakerdonelson.com.

This 22 day of October, 2025.

Vishan J. Ramcharan
Associate General Counsel