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

In The Matter of:	)	
	)	
Riverview Terrace	)	
Assisted Care Living Facility	)	
License No. 114,	)	**Case No. 2023015611**
	)	
Respondent.	)	
	)	
McMinnville, Tennessee	)	

CONSENT ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities ("Board"), pursuant to the request of the Tennessee Health Facilities Commission ("Commission"), by and through the Office of Legal Services, and Riverview Terrace ("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.

I. JURISDICTION

1. The Board has the power to license and regulate hospitals, recuperation centers, nursing homes, homes for the aged, residential HIV supportive living facilities, assisted care living facilities, home care organizations, residential hospices, birthing centers, prescribe childcare centers, renal dialysis clinics, ambulatory surgical treatment centers, outpatient diagnostic centers, adult care homes, and traumatic brain injury residential home. T.C.A. § 68-11-202(a)(1).

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

3. An assisted care living facility ("ACLF") is a facility, building, establishment, complex or distinct part thereof that accepts primarily aged persons for domiciliary care and services. T.C.A.§ 68-11-201(4)(A) and Tenn. Comp. R. & Regs. 0720-26-.02(7).

4. "Primarily aged" means at least fifty-one percent (51%) of the population of the facility is at least sixty-two (62) years of age. Tenn. Comp. R. & Regs. 0720-26-.02(34).

5. The ACLF shall provide on-site to its residents' room and board and non-medical living assistance services appropriate to each resident's needs, such as assistance with bathing, dressing, grooming, preparation of meals and other activities of daily living. T.C.A.§ 68-11-201(4)(B) and Tenn. Comp. R. & Regs. 0720-26-.02(2).

6. 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).

7. Upon a finding by the Board that an ACLF 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

8. At all times pertinent hereto, Respondent, Riverview Terrace, 114 Highland Drive McMinnville, Tennessee 37110, was licensed by the Board as an ACLF, having been

granted license number 114 on May 13, 1999, which currently has an expiration date of October 30, 2024.

9. On or about May 2, 2023, the State surveyor reviewed the facility's Resident Rights policy, dated May 2007, which stated that the residents have a right "...To be treated with consideration, respect and full recognition of his or her dignity and individuality...". The State surveyor reviewed the facility's Social Media Policy (undated) and found that it stated, "Employees may not post anything regarding residents..." The State surveyor then reviewed the facility incident report log, which stated that the following event occurred on or about April 18, 2022:

> "It was reported by [Patient Care Assistant-PCA #8], and she proceeded to tell me that she was told by another employee [PCA #9], that after our staff meeting on Tuesday she was shown a video, on [PCA 6's] personal cell phone, of resident [Resident #1]. This video was allegedly depicting the resident walking around in his room with his pants pulled just below the buttocks and on his way to the bathroom. This resident is blind, and we have been working with him to increase independence and toilet independently. I [the facility administrator] have interviewed multiple staff members including [PCA #6], who has admitted that this was true. [suspended pending investigation results and will now be terminated.] Family and Physician have been notified. Mandatory staff in-service has been scheduled to address social media policy as well as HIPPA policy."

The State surveyor conducted an interview with the facility administrator on May 2, 2023, and confirmed that PCA #6 failed to follow the facility policies and was terminated on April 22, 2022.

10. On or about May 2, 2023, the State surveyor reviewed the Plan of Care for Resident #6, who suffers from Alzheimer's and Dementia, which stated that "Staff checks Medication Administration Record and brings the bubble card to the resident who pops out pill and takes it..." Observation that same day in Resident's room revealed two unlicensed or uncertified health care professionals, Personal Care Assistants (PCA's), were present, PCA #6 and #7, with the surveyor. PCA #7, was observed removing medication from the packaging, then placing the pills into a small cup, the small cup and a cup of water was given to Resident #6. PCA #7 then instructed the resident to take their pills, which they did.

11. The surveyor reviewed the medical record for Resident #7 and found a diagnosis of Alzheimer's and Dementia. A review by the surveyor of Resident #7's care plan dated January 25, 2023, showed the resident was forgetful and "Dx of Alzheimer's/Dementia." For Medication Assistance the care plan stated, "Staff checks MAR and brings the bubble card to the resident who pops out pill and takes it...Keeps medicines in room and takes independently as desired..." Observation by the surveyor on May 2, 2023, in Resident #7's room, revealed Resident #7 was lying on her bed. PCA #7 and PCA #4, both unlicensed or uncertified health care professionals, told the resident, "I'm here to give you your medicine." PCA #7 was observed assisting the resident to sit up on the side of her bed. PCA #4 opened the double-locked compartment on the rolling cart, which stored controlled medication, and removed one tablet of Tramadol 50 milligram (mg) and placed it into a medicine cup. The PCA went to a locked cabinet in the resident's room and used a magnetic key card to unlock the cabinet door. PCA #4 opened the medication packages and placed Resident #7's medications into the medication cup. The resident took the medicine after the

medicine cup was placed into her hand. The resident admitted, "I don't know-my pills" when the surveyor asked her what she just took. Surveyor review of the e-MAR and the empty medication packages revealed the PCA administered, in addition to the Tramadol, Amlodipine Besylate 5 mg, Aspirin EC 81 mg, Losartan Potassium 100 mg, D3 High Potency Capsule 125 MCG (micrograms), Furosemide 20 mg, and Cetirizine HCL 10 mg. In an interview by the surveyor with PCA #4 and PCA #7 during the medication administration on May 2, 2023, in Resident #7's room, PCA #7 admitted she had been employed at the facility approximately one year, and she had witnessed a decline in Resident #7's physical and cognitive abilities during that time. She further admitted that there was "no way" the resident could take her own medicines.

12. The surveyor reviewed the medical record for Resident #2 and found a diagnosis of Alzheimer's. Resident #2's care plan dated March 22, 2023, showed the resident was forgetful and "Dx of Alzheimer's/Dementia." Observation by the surveyor on May 2, 2023, in Resident #2's room showed PCA #4 and #7, both unlicensed or uncertified health care professionals, assisted the resident to change a soiled brief and back to his chair from his bathroom. The resident was pleasantly confused. PCA #4 stated the resident could not be trusted not to accidentally cut himself with the scissors they used to open the pill packages, and she opened the packages, placed the medicines into a medication cup, and handed the cup of pills to Resident #2. The resident was observed taking the medicine with a glass of water.

The surveyor reviewed the e-MAR printed record and medication packages, which showed the medications administered to Resident #2 were Levothyroxine 75 mcg, Benazepril HCL

10 mg, Omeprazole Capsule Delayed Release 20 mg, Fexofenadine HCL 180 mg, and Memantine HCL 10 mg.

13. The State surveyor reviewed the medical record for Resident #9, which indicated that the resident had a diagnosis of Stroke with Hemiplegia, Tremor, and Altered Mental Status. The surveyor reviewed Resident #9's care plan dated March 1, 2023, which showed the resident was not forgetful and had cognitive communication deficit and history of behavioral issues." The surveyor observed on May 2, 2023, in Resident #9's room, PCA #4 and PCA #7, both unlicensed or uncertified health care professionals. PCA #4 was observed using the narcotic box key to open the double-locked box. PCA #4 obtained and signed out a controlled medication, Gabapentin 300 mg. The PCA placed the medication in a medication cup. PCA #4 then went to a locked cabinet in Resident #9's room and unlocked it to obtain other medications. PCA #7 then checked Resident #9's blood pressure and stated the resident's Lisinopril was ordered by the physician to be held if the resident's blood pressure was below a certain number. PCA #4 opened the packages and placed the medications in a bowl. The resident took the medications.

    The State surveyor reviewed the eMAR printed record and medication packages which showed the medications administered to Resident #9. In addition to the Gabapentin other medications included were Escitalopram Oxalate 20 mg, Depakote delayed release 125 mg, Clopidogrel Bisulfate 75 mg, Metformin HCL 500 mg, Levetiracetam 750 mg, Lisinopril 20 mg, Omeprazole Capsule Delayed Release 40 mg, and Vitamin D3.

14. A review of the medical record by the surveyor showed that Resident #8 was admitted to the facility with diagnoses including Legal Blindness and Depression. A review of Resident #8's care plan dated 3/28/2023 showed the resident was forgetful. Surveyor observation on

May 2, 2023, in Resident #8's room, showed the resident sitting in her chair, nonverbal, with a pleasant affect. PCA #7, an unlicensed or uncertified health care professional, unlocked the medicine cabinet on the wall and removed a clear plastic package containing the resident's medications. The PCA admitted to the surveyor, "She [Resident #8] can't do anything [related to opening the packages or identifying the pills.]" The PCA used scissors to open the package and placed the medication pills into a plastic bowl, handed the bowl to resident #8 who then took the pills. The PCA confirmed she had obtained the pills, checked them on the e-MAR, opened the packages, placed the pills in a bowl, and gave the bowl of pills to Resident #8 who then took the pills.

Further review of the e-MAR printed record and medication packages showed the medications administered to Resident #8 were Aller-Chlor 4 mg, Amlodipine 10 mg, Bupropion 100 mg, Lisinopril 10 mg, one Multi-Vitamin, Atenolol 50 mg, Potassium Chloride 10 MEQ (milliequivalent), and Sertraline 50 mg.

15. The surveyor reviewed the facility job description for a Personal Care Attendant (PCA), which revealed no description of any duties related to medication administration, distribution, facilitation, or observation.

16. On or about May 2, 2023, in interviews with the Director of Nursing and the facility Administrator, both admitted to the surveyor that there are no licensed staff assigned to administer medication to the facility residents and that the unlicensed PCA's were administering the medications.

III. GROUNDS FOR DISCIPLINE

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

17. The facts in paragraph nine (9) are sufficient to constitute one (1) violations of TENN. COMP. R. & REGS. 0720-26-.06 (1)(b)(3) Administration, the relevant portion of which reads as follows:

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

        (b) Policies and Procedures:

            3. An ACLF shall develop a written policy, plan or procedure concerning a subject and adhere to its provisions whenever required to do so by these rules. A licensee that violates its own policy established as required by these rules and regulations also violates the rules and regulations establishing the requirement.

18. The facts in paragraphs ten (10) through seventeen (17) are sufficient to constitute one (1) collective violation of Tenn. Comp. R. & Regs. 0720-26-.07 (5)(b) Services Provided, 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 or certified health care professional operating within the scope of the professional license or certification and according to the resident ' s plan of care.

IV. REPRESENTATIONS OF RESPONDENT

19. Respondent understands and admits the allegations, charges, and stipulations in this Order.

20. Respondent 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 Respondent, the right to testify and to present evidence on Respondent'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. Respondent voluntarily waives these rights in order to avoid further administrative action.

21. Respondent agrees that presentation of this Order to the Board and the Board's consideration of it and all matters divulged during that process shall not constitute unfair disclosure such that the Board 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 Respondent in any subsequent proceeding unless independently entered into evidence or introduced as admissions.

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

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

24. Respondent 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:

25. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount of **five-thousand dollars ($5,000.00)** for violation of the facility's Social Media Policy. This CMP is issued for the deficiency cited on May 2, 2023.
26. Respondent is hereby assessed one (1) collective Civil Monetary Penalty in the amount of **five-thousand dollars ($5,000.00)** for failure to ensure the proper and licensed administration of medication for five (5) of nine (9) residents sampled. This CMP is issued for the deficiency cited on May 2, 2023.
27. Payment shall be submitted to the following address within **thirty (30) calendar days** of the effective date of this Order.

Tennessee Health Facilities Commission
Attention: Disciplinary Coordinator
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243

PLEASE DO NOT REMIT PAYMENT UNTIL THE CONSENT ORDER HAS BEEN RATIFIED AND APPROVED BY THE BOARD

28. Each condition of discipline herein 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:

Amanda L Nichols

Riverview Terrace
Representative
License No. 114
Signature of Authorized Representative
Respondent

AMANDA L. NICHOLS

Printed Name of Authorized

ADMINISTRATOR

Title of Authorized Representative

Jeremy Gourley (BPR # 022812)
Senior Associate General Counsel
Health Facilities Commission
665 Mainstream Dr. 2nd Floor
Nashville, Tennessee 37243
Office: (615) 741-7221
Fax: (615) 741-7051
Jeremy.J.Gourley@tn.gov

Approval by the Board

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 Tennessee Board for Licensing Health Care Facilities at a public meeting of the Board and signed this 7th day of February, 2024.

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

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this document has been served upon the Respondent, Riverview Terrace, c/o Administrator, Aremanda Lennora Nichols, 114 Highland Drive McMinnville, Tennessee 37110, by delivering same in the United States regular mail and United States certified mail, number 7022 3330 0001 2193 5229, return receipt requested, with sufficient postage thereon to reach its destination. A copy was sent via electronic mail to: mcminn@americareusa.net.

This 7th day of February, 2024.

Jeremy Gourley
Senior Associate General Counsel