

**BEFORE THE TENNESSEE BOARD  
FOR LICENSING HEALTH CARE FACILITIES**

**In The Matter of:** )  
 )  
**Midsouth Health & Rehabilitation Center** )  
**License No. 00000248, Nursing Home** )  
 )  
**Respondent** )

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**CONSENT ORDER**

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This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 6<sup>th</sup> day of June, 2018, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and Midsouth Health & Rehabilitation Center, License No. 00000248, (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.

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## JURISDICTION

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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 skilled nursing facilities, 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 skilled nursing 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.*

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**STIPULATIONS OF FACT**

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1. At all times pertinent hereto, Midsouth Health and Rehabilitation Center has been licensed as skilled nursing facility, having been issued license number 00000248 on July 1, 1992. Respondent has an active license with an expiration date of June 8, 2018. During the time period of the allegations giving rise to this Consent Order, the Respondent was operated by Skyline of MidSouth Healthcare and Rehabilitation, LLC (“Operator”) pursuant to a Lease Agreement dated August 25, 2017 with Volunteer James Property, LLC (“Landlord”).

Landlord acquired the property pursuant to a purchase agreement signed on or about September 1, 2017.

2. Midsouth Health and Rehabilitation Center is licensed to provide care for one hundred and fifty-five (155) beds.
3. The facility failed to ensure a safe environment that provided adequate supervision to prevent elopement for four (4) residents (#227, #62, #222, and #78) who were cognitively impaired and exhibited elopement behaviors.
4. Resident #227 was admitted to the facility in February 2018 with diagnoses of hepatocellular cancer, ascites, Hepatitis C, Diabetes, and alcohol and cocaine abuse. Resident #227 was also moderately cognitively impaired and ambulated using a wheelchair. Resident #227 was also frequently confused.
5. On or about March 1, 2018, Resident #227 was found to be missing. The facility took approximately seven (7) hours to discover Resident #227's absence.
6. On or about March 3, 2018, two days later, Resident #227 was located in a hospital in Mississippi. Resident #227 had been admitted to the hospital in Mississippi for shortness of breath, abdominal pain, sepsis, suicidal ideation, and alcohol abuse.
7. Medical records from the hospital in Mississippi indicated that Resident #227 stated to ER staff that he had, "escaped from a nursing home in Memphis."
8. Resident #62 was admitted to the facility in November 2017 with diagnoses of traumatic brain injury, subarachnoid hemorrhage, skull fracture, and alcohol and drug dependence.
9. Resident #62's Responsible Party was his sister. Resident #62's responsible party left instructions that Resident #62 was not to be allowed to leave the facility without his responsible party's authorization.

10. Resident #62 left the facility on multiple occasions without the facility having knowledge of his absence or his whereabouts. Resident #62 was often observed wheeling his wheelchair across the four (4) lane busy highway to the gas station across the street, so that he could purchase alcohol. Upon his return to the facility, Resident #62 was frequently extremely intoxicated.
11. Resident #222 was admitted to the facility in February 2018 with diagnoses of stroke, dysphagia, aphasia, and diabetes. Resident #222 was high risk for elopement due to impaired cognition. Resident #222 was also being treated for Extended Spectrum Beta Lactamases (ESBL) which is a multi-drug resistant infection. Resident #222 was to be isolated and have an indwelling catheter to drain urine into a collection bag.
12. On two (2) occasions, the facility was unaware that Resident #222 was missing. Approximately seven (7) hours passed before the facility could ascertain his location.
13. Resident #78 was admitted to the facility in June 2015 with diagnoses of schizophrenia, dementia, weakness, and history of falling. Resident #78 was severely cognitively impaired and utilized a wheelchair.
14. Resident #78 was also at high risk for elopement and was to be watched closely and redirected from exit doors. Resident #78 also exhibited unsafe smoking behaviors, resulting in burns to the resident's clothing. Staff were to store smoking materials in a safe place and supervise smoke breaks.
15. On or about March 19, 2018, surveyors observed that Resident #78 had propelled himself outside and was observed wandering unattended in the rain for approximately eight minutes while smoking. After he finished smoking, Resident #78 propelled himself into the facility. Staff did not note Resident #78's absence.

16. The Quality Assurance committee failed to ensure LPN #1 and LPN #2 properly sanitized a multi-use glucometer to prevent the cross contamination of blood borne pathogens to approximately twenty (20) residents receiving blood glucose checks. The facility had patients who were positive for Human Immune Deficiency Virus (HIV) and hepatitis.
17. The facility used the same blood glucose monitor on Residents #27, #82, #28, and #41. One of these patients had asymptomatic HIV, which placed the remaining residents that received blood glucose monitoring in serious jeopardy if the blood glucose instrument was not properly cleaned with disinfectant wipes between residents. According to the manufacturer's instructions, the glucometer was to be wiped with a disinfectant wipe and allowed to dry for five (5) minutes.
18. LPN #1 and LPN #9 were observed to use their bare hands to handle testing strips from the glucometer. Neither nurse washed her bare hands after handling the strips. Both nurses also failed to wipe down the glucometer with bacterial wipes between uses.
19. Resident #82 was admitted to the facility in March 2011 with diagnoses of diabetes, obesity, depression, and ocular hypertension.
20. Resident #24 was admitted to the facility in January 2011 with diagnoses of convulsions, anemia, schizophrenia, diabetes and hypertension.
21. On or about March 21, 2018, LPN #1 entered Resident #82's room and obtained a blood glucose reading. LPN #1 then went to the medication cart, obtained supplies, and started to enter the room of Resident #24 to perform a blood glucose test without cleaning the blood glucometer.
22. A surveyor stopped LPN #1 and asked if the glucometer had been cleaned between residents. LPN #1 stated that the glucometer should be cleaned with alcohol pads or bleach wipes. The

surveyor then observed LPN #1 clean the blood glucometer with alcohol pads and allowed it to dry.

23. LPN #1 then entered Resident #24's room and performed a blood glucose test.

24. Resident #28 was admitted to the facility in March 2018 with diagnoses of HIV, End Stage Renal Failure, diabetes, hypertension, anemia, and muscle weakness.

25. On or about March 21, 2018, the surveyor observed LPN #9 enter Resident #28's room to perform a glucose test. LPN #9 removed her gloves, picked up the dirty lancet and glucometer with her bare hands, and returned to the medication cart. LPN #9 removed the dirty test strip from the glucometer and placed it and the dirty lancet in the sharps container. She then placed the dirty glucometer in the top drawer of the medication cart. She did not clean the glucometer with an antibacterial wipe. LPN #9 later removed the dirty blood glucometer from the medication cart and went to test Resident #41's blood. LPN #9 was then stopped by the surveyor.

26. When confronted, LPN #9 admitted she did not clean the glucometer after using it on the HIV positive patient. When questioned further, neither LPN #9 nor her supervisor knew whether the glucometer was to be cleaned with alcohol or bacterial wipes. However, while LPN #9 was present, Director of Nursing #1 confirmed that the glucometer should be cleaned with bacterial wipes.

27. On or about March 21, 2018, LPN #9 was observed to use the glucometer on Resident #41. LPN then cleaned off the glucometer with an alcohol pad. When asked if it was acceptable to clean the glucometer with an alcohol pad, LPN #9 confirmed that it was not.

28. When interviewed, LPN #7 indicated that the blood glucometer was used on all diabetic residents. LPN #7 also indicated that it was the facility's normal practice to clean the

glucometer with alcohol, even though this was in derogation to the cleaning instructions from the glucometer's manufacturer. LPN #7 stated that the facility did not stock bacterial wipes due to a "money issue."

29. Interview with the Medical Director also confirmed that cleaning a glucometer with alcohol was unacceptable and that the glucometer was to be cleaned according to the manufacturer's instructions.

30. Review of facility training records revealed a training was held regarding blood borne pathogens and cleaning glucometers after each use. LPN #1 and LPN #9 were not listed on the in-service training sheet.

31. The facility also failed to provide a sanitary environment for medication administration for Residents #4 and 33. On or about March 20, 2018, LPN #7 sanitized his bare hands and gathered medications for administration. Two tablets fell onto the medication cart. LPN #7 proceeded to pick up the tablets with his bare hands, wipe them off with a tissue, then crushed the medications. LPN #7 administered the oral medications to Resident #4 in vanilla pudding.

32. LPN #9 removed three tablets from the medication drawer for Resident #33. The tablets fell out of the package into the drawer. LPN #9 put on a glove, picked up the pills, and placed them in a cup to administer to Resident #33.

33. Resident #2 was admitted to the facility in August 2017 with diagnoses of subarachnoid hemorrhage, attention to gastrostomy, and tracheostomy. Resident #2 was severely cognitively impaired and required suctioning and tracheostomy care.

34. On or about March 22, 2018, Respiratory Therapist #1 ("RT #1") entered Resident #2's room to perform tracheostomy care. RT #1 washed hands, donned, clean gloves, tapped the

resident's chest for breath sounds, and opened the trach ties and the suction catheter. Then RT #1 changed gloves twice without performing handwashing during tracheostomy care for Resident #2.

35. Resident #66 was admitted to the facility in December 2018 with diagnoses of depression, diabetes, anemia, dysphagia, anxiety, anorexia, chronic kidney disease, and Parkinson's disease.
36. A review of the facility's policies indicated that a five percent change in weight in one month may require nutritional interventions.
37. In February 2018, a nutrition note indicated that Resident #66's weight had decreased 5.4 % from February 6, 2018 through February 14, 2018. The nutritionist noted that the registered dietician would be consulted.
38. A nursing note dated February 15, 2018, indicated that the nurse was without concerns regarding Resident #66's health. The facility was unable to provide documentation that the physician was ever notified that Resident #66 had experienced a significant weight change.
39. The Quality Assurance committee failed to ensure that residents at risk for weight loss and residents who appeared to have significant weight loss were properly assessed, which resulted in actual harm to Resident #66.
40. Resident #18 was admitted to the facility in September 2017 with diagnoses of HIV, stroke, aphasia, gastrostomy, and hypertension. Resident #18 was severely cognitively impaired and required assistance with dressing and bathing.
41. Review of the facility's shower schedule indicated that Resident #18 was to receive showers on Monday, Wednesdays, and Thursdays. Review of the shower schedule revealed that Resident #18 had not been receiving showers on Monday, Wednesdays, or Fridays. When

- interviewed, Resident #18 confirmed he had only been receiving showers two (2) days a week.
42. The Director of Nursing, when interviewed, confirmed that Resident #18 was not being bathed appropriately according to schedule.
  43. Resident #28 was admitted to the facility in September 2017 with diagnoses of HIV, end stage renal disease, COPD, heart disease, anemia, muscle weakness, and history of falling. Resident #28 had moderate cognitive impairment, was incontinent of bladder and bowel, and needed assistance with personal hygiene and bathing.
  44. Resident #28 was to receive showers on Tuesday, Thursday, and Saturday between 7 AM – 3 PM.
  45. Review of the shower schedule revealed Resident #28 received only two (2) showers between January 4, 2018 and January 11, 2018.
  46. Review of the shower schedule for February 2018 showed Resident #28 received one shower on February 19, 2018.
  47. Review of the shower schedule for March 2018 revealed Resident #28 received only one shower on March 8, 2018.
  48. When the DON was interviewed, she indicated Resident #28 should receive showers on Tuesday, Thursday, and Saturday before going to dialysis and that Resident #28 had not been bathed appropriately.
  49. Resident #70 is severely cognitively impaired and required extensive assistance for dressing, personal hygiene, and bathing. Resident #70 is incontinent of bowel and bladder.
  50. Review of the shower schedule revealed that Resident #70 was scheduled for showers on Tuesday, Thursday, and Friday between 3-11 PM.

51. There was no documentation that a shower was provided on Tuesdays or Fridays in February 2018.
52. Surveyors observed Resident #70 on March 14, 2018. Resident #70 had a strong odor of bowel movement. The surveyor asked if Resident #70 needed assistance. Resident #70 nodded yes and touched his call light for assistance. Unit Manager #1 answer the call and indicated to Resident #70 that he was next for a shower and left the room without changing Resident #70's soiled diaper.
53. When the DON was interviewed about the unit manager's behavior, she indicated that it was unacceptable to leave soiled residents in their feces without changing them.
54. Resident #53 was admitted to the facility in May 2017 with diagnoses of arthritis, lupus, anxiety, weakness, heart failure, diabetes, schizophrenia, and dementia. Resident #53 was moderately cognitively impaired and required supervision for eating due weight loss.
55. Resident #53's care plan was amended to reflect that if Resident #53 experienced significant weight loss, the resident was to be weighed and interventions such as supplements were to be ordered.
56. Nutrition notes revealed in February 2018, the resident had a 6% loss of body weight, and a physician ordered that Resident #53 receive nutritional shakes at lunch and dinner.
57. Nutrition notes in March 2018 revealed that Resident #53 continued to experience significant weight loss.
58. However, review of medication administration records revealed that in January through March 2018, Resident #53 was only receiving one (1) nutritional shake, despite the order for increased shakes.

59. On or about March 25, 2018, surveyors observed Resident #53 eating both lunch and dinner. A meal card documented the resident was to receive a nutritional shake. Surveyors did not see a nutritional shake on the resident's tray.
60. The facility's Registered Dietician admitted that it was unacceptable that the resident did not receive any shakes.
61. Resident #21 was admitted in June 2017 with diagnoses of paraplegia, bladder dysfunction, and need for assistance with personal care and coordination. Resident #21 was not cognitively impaired, but required extensive assistance for activities of daily living.
62. On or about February 15, 2018, Resident #21 alleged that C.N.A. #29 was verbally abusive to Resident #21. The facility failed to investigate the incident and did not obtain statements from Resident #21 or C.N.A. #29. The facility also failed to complete an incident report or take any action to prevent Resident #21 from verbal abuse by staff.
63. When interviewed, Director of Nursing #2 (DON #2) confirmed that DON #1 had not completed the investigation. DON #2 confirmed that C.N.A. #29 had actually resigned following the allegation of verbal abuse of Resident #21. DON#2 also confirmed she did not in-service staff on abuse prevention, detection, or reporting of abuse.
64. Review of Certified Nursing Assistant Training records also revealed that twenty one (21) of fifty two (52) Certified Nurse Aides did not receive at least ten (10) hours of in-service training related to each C.N.A.'s responsibilities.
65. Interview with Quality Assurance Nurse confirmed that the Certified Nurse Aides had not received their training requirements and that the facility had failed to follow their policy regarding providing in-service training.

66. While surveyors were in the facility, surveyors observed that the facility's equipment appeared to be in poor repair and that multiple resident beds had broken bed rails.
67. Surveyors also discovered that the facility failed to pay for the care of twenty-two (22) residents who had been transferred to another skilled nursing facility due to a gas leak at Midsouth Health and Rehabilitation facility. Despite multiple calls from the skilled nursing facility that had taken the twenty-two (22) residents in, no payment was ever received. Surveyors also confirmed with the repair company that no payment was ever received for the repairs made to the gas line.
68. Effective April 5, 2018, the Centers for Medicare and Medicaid Services ("CMS") decertified the facility, after finding that the facility was not in substantial compliance with the participation requirements and that conditions in the facility constituted immediate jeopardy and substandard quality of care. The immediate jeopardy was considered ongoing since February 16, 2018.
69. Effective May 30, 2018, the Landlord of the Respondent terminated its relationship with the Operator due to the Operator's performance related to the issues raised in this Consent Order, entered into a new lease agreement with James Place Rehabilitation Center, LLC ("New Operator") and submitted a change of ownership application for the New Operator to take over operations of the facility.

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### **GROUNDS FOR DISCIPLINE**

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

70. The facts stated in paragraphs two (2) through sixty-eight (68) are sufficient to establish that Respondent has violated the provisions of 1200-8-6-.04(15)[Administration] have been violated, 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.

71. The facts stated in paragraphs two (2) through sixty-seven (67) are sufficient to establish that Respondent has violated the provisions of 1200-8-6-.04(15)[Administration] have been violated, 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.

72. The facts stated in paragraphs sixteen (16), thirty-nine (39), and sixty-five (65) are sufficient to establish that Respondent has violated the provisions of 1200-08-06-.06(1)(a) [Basic Services][Performance Improvement], the relevant portions of which read as follows:

- (1) Performance Improvement.
  - (a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization.

73. The facts stated in paragraphs sixteen (16) through thirty (30), thirty-three (33) through thirty-nine (39), and fifty-four (54) through fifty-seven (57) are sufficient to establish that Respondent has violated the provisions 1200-08-06-.06(2)(d)(4) [ Basic Services] [Physician Services], the relevant portion of which reads as follows:

- (2) Physician Services.

- (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall:
  - (4) Make periodic visits to the nursing home to evaluate the existing conditions and make recommendations for improvements;

74. The facts stated in paragraphs sixteen (16) through thirty-four (34) are sufficient to establish that Respondent has violated provisions of 1200-08-06-.06(3)(a) [Basic Services][Infection Control], the relevant portion of which reads as follows:

- (3) Infection Control.
  - (a) The nursing home must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

75. The facts stated in paragraphs three (3) through sixty-three (63) are sufficient to establish that Respondent has violated provisions of 1200-08-06-.06(4)(a) [Basic Services][Nursing Services], the relevant portion of which reads as follows:

- (4) Nursing Services.
  - (a) Each home shall have a licensed practical nurse or registered nurse on duty at all times and at least two (2) nursing personnel on duty each shift.

76. The facts stated in paragraphs three (3) through sixty-three (63) are sufficient to establish that Respondent has violated provisions of 1200-08-06-.06(4)(c)(4)[Basic Services][Nursing Services], the relevant portion of which reads as follows:

- (4) Nursing Services.
  - (c) The Director of Nursing shall have the following responsibilities:
    - (4) Notify the resident's physician when medically indicated.

77. The facts stated in paragraphs fifty-four (54) through sixty (60) are sufficient to establish that Respondent has violated provisions of 1200-08-06-.06(9)(d)[Basic Services][Food & Dietetic Services], the relevant portion of which reads as follows:

(9) Food & Dietetic Services.

(d) Menus must meet the needs of the residents.

78. The facts stated in paragraphs forty (40) through fifty-three (53) are sufficient to establish that Respondent has violated provisions of 1200-08-06-.06(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 possible, independence. Residents and their families or other representative's 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.

79. The facts stated in paragraphs sixty-four (64) and sixty-five (65) are sufficient to establish that Respondent has violated provisions of 1200-08-06-.06(15)(4)[Nurse Aide Training and Competency Evaluation]

(4) Continued Competency.

The facility must complete a performance review of each nurse aide employee at least once every 12 months and must provide regular in-service education based on the outcome of these reviews.

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**ORDER**

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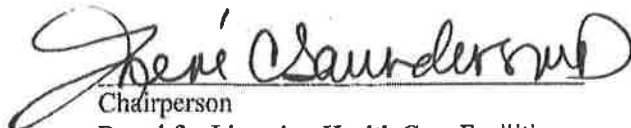
**NOW THEREFORE**, Respondent, for the purpose of avoiding further administrative action with respect to this cause, agrees to the following:

80. Respondent's license to operate as a skilled nursing facility shall be placed on probation for six (6) months.
81. Respondent shall hire a qualified consultant or management company, 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 or management company, 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. An acceptable Plan of Correction must be submitted within six (6) months of the Board's Order.
82. A representative from Respondent facility shall appear before the Board at the October 2018 Board meeting and provide a report regarding the adherence of the facility to the regulations cited in both the health and life safety statement of deficiencies from March 2018.
83. If the facility chooses to actively be in operation and accept residents during the six (6) month probationary 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.

84. If the facility chooses to actively be in operation and accept residents during the six (6) month probationary period, Respondent shall ensure that all staff undergo in-service training regarding infection control protocols, 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.
85. Once an acceptable Plan of Correction has been submitted, the facility has been surveyed and has been deemed to be in compliance with the Plan of Correction, and proof is provided to the Board of completion of all in-service training requirements, the Respondent may petition to have the probationary period lifted.
86. 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 6 day of June, 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:**



William Rothner, President  
Signing on behalf of  
Landlord, Volunteer James Property, LLC due to  
Termination of Operator, Skyline of MidSouth Healthcare and  
Rehabilitation, LLC  
Responden

6/5/18  
Date

*Danielle M. Sloane*

Danielle Sloane

Member

Bass, Berry & Sims PLC

150 Third Avenue South, Suite 2800

Nashville, TN 37201

June 5, 2018

*Anna M. Grizzle*

Anna Grizzle

Member

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6-5-2018

*Caroline R. Tippens*

Caroline R. Tippens, BPR # 030375

Assistant General Counsel

Tennessee Department of Health

665 Mainstream Drive, Second Floor

Nashville, Tennessee 37243

(615) 741-1611

June 6, 2018  
Date

**CERTIFICATE OF SERVICE**

A true and exact copy of this Consent Order is being served upon Respondent, by and through their attorney, Danielle Sloane, Bass, Berry & Sims PLC , 150 Third Avenue South, Suite 2800, Nashville, TN 37201 by delivering same in the United States mail certified mailing # 70173380000099780027 via USPS first class, with sufficient postage thereon to reach its destination.

This 7<sup>th</sup> day of June, 2018.

Caroline R. Tippens  
Caroline R. Tippens  
Assistant General Counsel