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BEFORE THE TENNESSEE BOARD FOR LICENSING HEALTH CARE FACILITIES

RECEIVED JUN 06 2018 Health Care Facilities

IN THE MATTER OF: )
Northshore Senior Living )
8804 S. Northshore Drive )
Knoxville, TN 37922 )
License No. 00000467 )

Case #: 201802104

CONSENT ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the 5th day of September, 2018, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and Northshore Senior Living (hereinafter "Respondent") that the Board adopt this Consent Order, the terms of which have been agreed upon by the parties, as signified by their signatures below.

Respondent, by signature to this Consent Order, waives the right to a contested case hearing and any and all rights to judicial review of this matter.

Respondent agrees that presentation to and consideration of this Consent Order by the Board for ratification and all matters divulged during that process shall not constitute unfair disclosure such that the Board or any of its members shall be prejudiced to the extent that requires their disqualification from hearing this matter should the Consent Order not be ratified. Likewise, all matters, admissions, and statements disclosed or exchanged during the attempted ratification process shall not be used against Respondent in any subsequent proceeding unless

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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 of Health (“Department”) the authority to conduct reviews of assisted-care living facilities to determine compliance with fire and life safety code regulations promulgated by the Board.

Tenn. Code Ann. § 68-11-210 provides that the Department shall conduct on-site inspections and investigations as may be necessary to safeguard and ensure at all times, the public's health, safety, and welfare. The Board has the authority to suspend or revoke the license of any facility licensed under Tenn. Code Ann. § 68-11-201 *et. seq.* The Board may also place a facility on probation. Tenn. Code Ann. § 68-11-207(f)(2). If the Board determines during or at the end of the probation that the facility is not taking steps to correct non-compliance or otherwise not responding in good faith pursuant to the plan of correction, the board may take any additional action as authorized by law. Tenn. Code Ann. 68-11-207(f)(8).

The Board is also authorized to establish a system for assessing civil monetary penalties for assisted-care living facilities, adult care homes and traumatic brain injury residential homes that are in serious violation of state laws and regulations, resulting in endangerment to the health,

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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.*

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### STIPULATIONS OF FACT


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1. At all times pertinent hereto, Northshore Senior Living, 8804 S. Northshore Drive, Knoxville TN 37922, has been licensed as an Assisted-Care Living Facility by the Board, having been issued license number 00000467 on December 5, 2016. Respondent has an active license with an expiration date of December 4, 2018.
2. From on or about April 16, 2018 through April 19, 2018, surveyors conducted a

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complaint investigation survey and annual health licensure survey at the Respondent facility. During this survey, the surveyors observed violations of state laws and regulations resulting in endangerment to the health, safety and welfare of residents.

3. Resident #3 was admitted to the facility in October 2017 with the diagnoses of low back pain, tremor, ataxia, osteoarthritis, and cervical disc degeneration.
4. Medical record review indicated that the resident required stand by assistance with walking or mobility and used a walker for ambulation.
5. Further review of the medical record revealed that upon admission, the facility failed to conduct a fall assessment of Resident #3. The facility also failed to assess Resident #3's documented history of falls.
6. On or about November 2017, a fire alarm was initiated at the facility. Staff instructed the residents and patients on how to evacuate. Resident #3 was observed using a walker to ambulate the stair well. Resident #3 fell down the stairwell and was transported via ambulance to the hospital. As result of her fall, Resident #3 sustained a fractured and dislocated shoulder. Resident #3 had to undergo surgery to repair her shoulder.
7. Interview with the Director of Wellness confirmed that the facility had not completed a fall risk assessment on Resident #3. The Director of Wellness also confirmed that Resident #3 had sustained a fall with a fracture during the fire alarm necessitating surgery.
8. The facility failed to ensure the safety of Resident #3.
9. Resident #4 was admitted to the facility in December 2016 with diagnoses of diabetes, chronic renal disease, chronic ischemic heart disease, heart failure, disorientation, amnesia, and dementia.

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- a. Medical record review revealed that Resident #4 was:
  - b. Often disoriented;
  - c. Had anxiety and agitation;
  - d. Required assistance with activities of daily living;
  - e. Was to be observed every two (2) hours; and
  - f. Required assistance with medications.
10. On or about June 19, 2017, a physician for Resident #4 wrote a prescription for Ativan, 1 milligram oral tablet, to be administered by mouth three (3x) times daily for five (5) days as needed for anxiety. Since the prescription was for five (5) days, the prescription ordered fifteen (15) pills to be dispensed. The medication was to be discarded on or about June 24, 2017.
  11. A July 2017 medication administration record ("MAR") revealed that Ativan 1 mg was administered on July 13, 2017 by licensed practical nurse #2, nineteen (19) days after the physician's order for Ativan expired.
  12. On or about July 14, 2017, licensed practical nurse #1 also administered Resident #4 Ativan. Resident #4 was administered this medication twenty (20) days after the physician's order for Ativan expired.
  13. A facility investigation note dated July 14, 2017 revealed that Resident #4 had been experiencing increased anxiety. The Director of Wellness, who investigated the incident, documented that the order for Ativan was to be discontinued and destroyed after June 24, 2017. The Director of Wellness destroyed the remaining pills and counseled the employee.
  14. Both the Director of Wellness and Clinical Operations Specialized confirmed that both

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LPN #1 and LPN #2 administered Resident #4 Ativan on July 13, 2017 and July 14, 2017 without a valid physician's order. The remaining Ativan were not destroyed by the facility until July 14, 2017.

15. The facility failed to follow physician's orders for the administration of Ativan for Resident #4.

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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 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.

16. The facts stated in paragraphs three (3) through eight (8) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(a)(2) [LIFE SAFETY], the relevant portion of which reads as follows:

(7) An ACLF shall provide personal services as follows:


(a) Each ACLF shall provide each resident with at least the following personal services:

(2) Safety when in the ACLF.

17. The facts stated in paragraphs nine (9) through fifteen (15) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-25-.07(5)(a)[SERVICES PROVIDED], the relevant portion of which reads as follows:

(5) Resident medication. An ACLF shall:

(a) Ensure that medication shall be self-administered in accordance with the

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resident's plan of care.

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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:

7. The assessment of two (2) civil monetary penalties in the amount of five hundred dollars (\$500.00) each for a total assessment of one thousand dollars (\$1,000.00).

Payment shall be submitted to the following address within thirty (30) days of the effective date of this Order:


**Tennessee Department of Health  
Division of Health Care Facilities  
Attn: Eddie J. Stewart  
665 Mainstream Drive, Second Floor  
Nashville, Tennessee 37243**

8. 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.

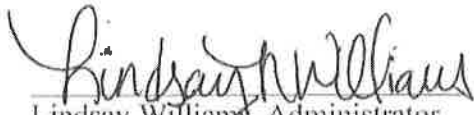
Upon the agreement of the parties, this **CONSENT ORDER** is approved as a **FINAL ORDER** by a majority of a quorum of the Tennessee Board for Licensing Health Care Facilities at a public meeting of the Board and signed this 5<sup>th</sup> day of September, 2018.

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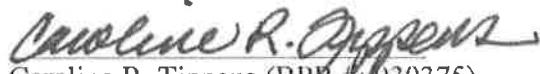
ACCORDINGLY, IT IS ORDERED that the agreement of the parties does hereby become the Final Order of the Board.

  
Chairperson  
Board for Licensing Health Care Facilities

AGREED TO:

  
Lindsay Williams, Administrator  
Northshore Senior Living, LLC.  
Respondent

6-4-18  
Date

  
Caroline R. Tippens (BPR #: 030375)  
Assistant General Counsel  
Department of Health  
665 Main Stream Dr., 2<sup>nd</sup> Floor  
Nashville, Tennessee 37243  
(615) 741-1611

9/5/2018  
Date

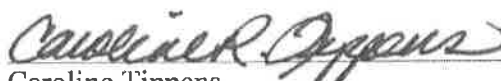
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**CERTIFICATE OF SERVICE**


A true and exact copy of this Consent Order is being served upon Lindsay Williams, Administrator, Northshore Senior Living, LLC, 8804 S. Northshore Drive, Knoxville, TN 37922, by delivering in the United States mail, first class, with sufficient postage thereon to reach its destination and via United States Certified Mail

# 7017 3380 0000 9978 0657

This 16<sup>th</sup> day of September, 2018.



Caroline Tippens  
Assistant General Counsel

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