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

In The Matter of:	)	
	)	
Cloria Oaks Post-Acute	)	
Rehabilitation Center	)	
Skilled Nursing Facility	)	
License No. 262,	)	**Case No. 2022031141,**
	)	**2023014471**
	)	
Respondent.	)	
	)	
Palmyra, Tennessee	)	

CONSENT ORDER FOR VOLUNTARY SURRENDER

This matter came to be heard before the Tennessee Commission for Licensing Health Care Facilities ("Commission"), pursuant to the request of the Tennessee Health Facilities Commission ("Commission"), by and through the Office of Legal Services, and Cloria Oaks Post-Acute Rehabilitation Center ("Respondent") that the Commission 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 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 child care 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. The Commission has the authority to conduct reviews of nursing homes to determine compliance with fire and life safety code regulations promulgated by the Commission. T.C.A.§ 68-11-202(b)(1)(A).

3. 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).

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

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, Cloria Oaks Post-Acute Rehabilitation Center, 2727 Palmyra Road, Palmyra, Tennessee 37142 has been licensed as a skilled nursing facility, having been issued license number 192 on July 1, 1992, and has an expiration date of June 19, 2025.

8. Cloria Oaks Post-Acute Rehabilitation Center was decertified by CMS on July 30, 2023, and remains under a Suspension of Admissions from the Executive Director of the Health Facilities Commission issued in February 2023[1].

9. Respondent has paid forty-five thousand dollars ($45,000.00) to the Commission in Civil Monetary Penalties (CMP) assessed against the facility and associated with the Suspension of Admissions.

10. From January 11, 2023, through January 30, 2023, Commission surveyors conducted complaint investigations at the Respondent's facility.

11. Respondent failed to provide oversight that established and implemented policies and procedures to ensure a safe and secure environment by failing to protect residents from exposure to chemicals, a broken window with glass shards, an unsealed sharps box containing used dirty/contaminated needles and razors, and unsecured restrooms with construction materials during construction, putting multiple residents in danger.

12. On or about January 30, 2023, Respondent failed to provide a safe and secure environment for Resident #3, #5, #6, #7, #8, #10, #14, #15, and #17. Open restroom areas were observed which were accessible to the residents with wandering behaviors and containers of muriatic acid, Zep Urine remover and an unknown chemical in a clear bottle. One restroom was

[1] https://www.cms.gov/files/document/tennessee-cloria-oaks-post-acute-and-rehabilitation-07282023.pdf

observed with shards of glass exposed on all sides of the window frame, and an open biohazard sharps box lying on its side with contents including used/dirty needles and razors.

13. On or about January 18, 2023, Respondent's former Assistant Director of Nursing (ADON) confirmed that she did not remember who told her about the incident between Resident #5 and Resident #6 and admitted that she did not document a skin assessment after assessing Resident #6's hand. The former ADON described the wound to Resident #6's hand as superficial, a red mark.

14. Respondent's former ADON admitted that the incident warranted more of an investigation considering Resident #5's diagnosis of a transmissible disease, and that she did not report the incident to the acting Administrator. The former ADON confirmed that she did not report the incident to the Commission/State Survey Agency.

15. On or about January 18, 2023, Respondent's former Director of Nursing (DON) admitted that the incident involving injury to Resident #6's hand should have been documented and that they failed to visually inspect Resident #6's hand.

16. On or about January 25, 2023, Respondent's Family Nurse Practitioner (FNP) for the facility, confirmed they were informed of the scratch on the back of Resident #6's right hand on January 2, 2023, and by the time the wound was inspected, it was healing and had a scab on it that would have bled if the scab were peeled.

17. On or about January 30, 2023, Respondent's acting Administrator (AA) confirmed her date of hire was December 14, 2022, and that her first day in the facility was December 22, 2022. Respondent's AA admitted that she did not become aware that Resident #14 and Resident #15, who had severe cognitive impairment, were care planned for sexual relations

until after the arrival of Commission surveyors. She confirmed that the Care Plan for the residents was to be updated regularly, and that in addition to updating BIMS score that sexual relation between residents would be a clinical team decision that should be discussed in Care Plan meetings.

18. Respondent's AA admitted that the incident with Resident #5 scratching Resident #6's hand happened on her first full week at the facility. The AA interviewed Resident #6, shortly after the resident had reported it to the Respondent's MDS and Social Service coordinators. She then reported the incident to the State within an hour of the time she was notified of the incident. At the time of reporting, she was not aware that Resident #5 was positive for a transmissible disease and had threatened to spit on staff and residents.

19. Respondent failed to ensure the Plan of Care was reviewed and revised for Resident #14 and #15 in a timely manner which resulted in harm and danger to both residents who were care planned for intimate relations in the facility on August 17, 2022.

20. Respondent failed to notify Resident #14's conservator to inform them that the resident had been care-planned for sexual relations with Resident #15.

21. On or about December 8, 2022, facility records for Resident #14 confirm that Respondent's Social Service Director, MDS Coordinator, Resident #14, and Resident #14's Court Appointed Conservator were present at the Care Conference Meeting.

22. On or about January 30, 2023, Respondent was unable to demonstrate in the Care Plan meeting notes for Resident #14 that sexual relations with another resident was discussed during the Care Plan meeting. The records noted that Resident #14 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment and verbal behaviors on up to three (3) of seven (7) days.

23. Respondent's facility records dated October 13, 2022, confirmed that Resident #15 had a BIMS score of 6, which included evidence of severe cognitive impairment, with verbal behaviors, other behaviors, rejection of care behaviors, and wandering behaviors on up to three (3) of seven (7) days, and required staff supervision for most ADLS, limited staff assistance for personal hygiene, and was totally dependent on staff for bathing.

24. Respondent's Care Conference Meeting records confirmed that on or around January 19, 2023, Resident #15's daughter, Respondent's Social Service Director, Dietary Manager, and the DON met to discuss Resident #15's Plan of Care.

25. On or about January 30, 2023, Respondent was unable to demonstrate in the Care Plan meeting notes for Resident #15 that sexual relations with another resident had been discussed during the Care Plan meeting.

26. On or about January 20, 2023, Respondent's Medical Director confirmed that residents should have a basic understanding and the capacity to make decisions for themselves before they are allowed to have sexual relations in the facility.

27. On or about January 30th, 2023, Respondent failed to ensure that Residents #5, #6, #7, #14, and #15 were free from abuse and neglect.

28. On or about January 30th, 2023, Respondent failed to protect Resident #14 and Resident #15, who have severe cognitive impairment and were care planned to have sexual relations together in the facility without the requisite capacity to consent.

29. Respondent failed to protect Resident #7 from being kissed by Resident #5, who was positive for a transmissible disease while Resident #5 had an open mouth sore on his lower lip.

30. Respondent failed to protect Resident #6 who was scratched on the back of his hand by Resident #5, which caused bleeding, resulted in a scab and left a scar.

31. Respondent neglected to ensure common restrooms were maintained to ensure the safety of the residents when there were only three (3) restrooms functioning out of six (6) due to renovation at the same time. Of the three (3) functioning restrooms, two (2) common restrooms were unsafe and contained unsecured sharps and hazardous chemicals which put residents in danger.

32. On or about January 25, 2023, Respondent's Licensed Practical Nurse (LPN) #2 admitted that Administration just let Resident #15 have relations with Resident #14, and that the BIMS scores had been manipulated to justify the relations as consensual.

33. Respondent's LPN#2 admitted that Respondent allowed Resident #14 with a BIMS of 3 to have sex with multiple other residents. LPN #2 confirmed this occurred out in the general population and she did not know the names of any residents other than Resident #15, with whom Resident #14 had sexual relations.

34. On or about January 26,2023, Respondent's LPN #2 confirmed that she was aware that Administration was allowing sexual relations to happen between Resident #14 and Resident #15 and that she had been instructed, along with other staff to give them privacy. LPN #2 confirmed the time frame this occurred was around August of 2022. LPN #2 admitted that everyone at the facility knew about the relationship between Resident #14 and Resident #15.

35. On or about January 26, 2023, Respondent's CNA #4 admitted she was aware that Resident #14 and Resident #15 were care planned to have intimate relations. CNA #4

confirmed that Resident #14 and Resident #15 were not cognitively able to make the decision to have intimate relations.

36. Respondent's CNA #4 admitted that Respondent's management was just concerned that the Resident's BIMS score was just high enough that they could make those decisions for themselves. CNA #4 confirmed that she was aware that the former Business Office Manager also voiced concerns about the relationship between Resident #14 and Resident #15.

37. On or about January 27, 2023, Respondent's Regional Nurse Consultant (RNC) confirmed that she joined the company the last week of October 2022. The RNC admitted that an MDS assessment of Resident #14 was not done, only a BIMS assessment which was conducted October of 2022. RNC admitted that a BIMS would have been done to evaluate whether Resident #14 was able to consent to sexual relations with Resident #15.

38. Respondent's RNC confirmed that Resident #14's BIMS score had declined to a level of 3 or below since September 1, 2022, and that the Care Plan should have been revised to not allow sexual relations.

39. On or about January 27, 2023, Respondent's former Business Office Manager (FBOM) confirmed that she worked at the facility from June of 2022 to October of 2022. The FBOM admitted that Resident #15 is care planned to have sexual relations with Resident #14 and became aware that Resident #14 may not be appropriately care planned due to her mental acuity level.

40. FBOM stated she had notified the Respondent's Administrator of her concerns but was rebuffed and dismissed about her concerns and the possibility of sexual abuse and exploitation. She further admitted that Resident #14 in her opinion was not in a state of

mind where the resident can make informed decisions and decide based on the resident's mental acuity.

41. On or about May 17, 2023, Commission surveyors conducted a life safety survey at Respondent's facility.

42. Respondent failed to maintain compliance with NFPA 101 Life Safety Code (2012 Ed.) by failing to provide smoke detectors in the resident sleeping quarters, failing to monitor locked areas to provide safety and prevent resident harm, failing to maintain properly operating emergency egress doors, and improperly locking all doors as a secured facility without prior approval from the Commission.

43. On or about May 17, 2023, Respondent's Administrator and Compliance Manager admitted the above deficiencies cited on May 17, 2023, were true.

44. Respondent failed to correct the cited deficiencies and ceased operation on or about July 30, 2023, and both federal and State Plans of Correction remain outstanding.

III. STIPULATED GROUNDS FOR DISCIPLINE

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.

45. The facts stated in paragraphs eleven (11) through forty-four (44) are sufficient to establish that Respondent has violated the provisions of:

- Tenn. Comp. Rules & Regs. 0720-18-.04(1) [formerly cited as 1200-8-06-.04(1)] Administration;
- Tenn. Comp. Rules & Regs. 0720-18-.04(15) [formerly cited as 1200-8-06.04(15)]

Administration;

- Tenn. Comp. Rules & Regs. 0720-18-.06(1)(a) [formerly cited as 1200-08-06-.06(1)(a)] Basic Services;
- Tenn. Comp. Rules & Regs. 0720-18-.06(3)(a) [formerly cited as 1200-08-06-.06(3)(a)] Basic Services;
- Tenn. Comp. Rules & Regs. 0720-18-.06(4)(f) [formerly cited as 1200-08-06-.06(4)(f)] Basic Services;
- Tenn. Comp. Rules & Regs. 0720-18-.12(1)(g) [formerly cited as 1200-8-6-.12(1)(g)] Resident Rights.

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:

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

47. 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.

48. Respondent 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 Respondent in any subsequent proceeding unless independently entered into evidence or introduced as admissions.

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

50. Respondent 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.

51. 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:

52. Respondent's license to operate as a Nursing Home shall be and is hereby **VOLUNTARILY SURRENDERED,** beginning the effective date of this Order. A voluntary surrender has the same effect as revocation.

53. Respondent **SHALL NOT** accept any new residents.

54. 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.

55. Upon the agreement of the parties, this **CONSENT ORDER** shall be presented to the Commission for approval as a **FINAL ORDER**

APPROVED FOR ENTRY:

Matthew Kafka
Signature of Authorized Representative
Cloria Oaks Post-Acute Rehabilitation Center
S.N.F. License No. 262
Respondent

Matthew Kafka, Esq.
Printed Name of Authorized Representative

General Counsel
Title of Authorized Representative

Jeremy Gourley (BPR # 022812)
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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 Tennessee Commission for Licensing Health Care Facilities at a public meeting of the Commission and signed this _____ day of _____, 202__.

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

_____
Chairperson
Commission 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, Cloria Oaks Post-Acute Rehabilitation Center, c/o Matthew Kafka, Esquire, 100 Merrick Road Suite 418 E , Rockville Center NY 11570-4800 by delivering same in the United States regular mail and United States certified mail, number **7020 0640 0001 4807 7310**, return receipt requested, with sufficient postage thereon to reach its destination. A copy was sent via electronic mail to: mkafka@everviewgroup.com.

This _____ day of _____, 202__.

_____
Jeremy Gourley
Senior General Counsel