STATE OF TENNESSEE
BEFORE THE HEALTH FACILITIES COMMISSION

In The Matter of:	)	
	)	
Asbury Cove,	)	
Assisted Care Living,	)	
License No. 195,	)	**Case No. 2025017931**
	)	
Respondent.	)	
	)	
Ripley, Tennessee	)	

CONSENT ORDER

This matter came to be heard before the Tennessee Health Facilities Commission ("Commission"), by and through the Office of Legal Services, and Asbury Cove ("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 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. 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).

3. "Assisted-care living facility" ("ACLF") means 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 that a minimum of 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. An assisted-care living facility 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 Commission 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**,** Asbury Cove, 315 Asbury Avenue, Ripley, Tennessee 38063, was licensed by the Commission as an ACLF, having been granted license number 195 on July 3, 2000, which currently has an expiration date of June 12, 2025.

9. On or about April 15, 2025, a Health survey at Respondent's facility resulted in deficiencies being cited for: failure to ensure a staff member who administered medications

to residents at the facility was a certified Medication Aide and/or licensed staff; failure to store a resident's medications in a locked or closed container for 1 of 6 sampled residents, and failure to keep the medication cart secured for 1 of 1 medication carts reviewed; failure to properly store dry food items, frozen food items, and refrigerated food items; and failure to conduct care plan meetings with the resident/resident's representative and provider and review and/or revise the plan of care as changes in the residents' needs occurred to address hallucinations, wandering, increasing anxiety, wheelchair use, and sleep problems for 4 of 5 (Resident #1, #2, #3, and #8) sampled residents reviewed for care plans and care plan meetings.

10. Respondent's Blood Sugar Monitoring and Insulin Injection TN [Tennessee] policy required the following: "…Only a licensed nurse is qualified to do an insulin injection or a finger stick. A resident can self-inject but unable to draw up insulin should receive help from the nurse…"

11. Respondent's Patient Care Attendant (PCA) job description did not document medication administration as part of the PCA job description.

12. PCA #1's employee file revealed that she was not licensed as a Registered Nurse or LPN, nor was she certified as a Medication Aide in the State of Tennessee.

13. On or about April 7, 2025, PCA #1 obtained strip packages containing a gabapentin tablet, potassium tablet, and hydralazine tablet, cut open the packages, and poured the packages of medications into Resident #8's hand.

14. On or about April 7, 2025, PCA #1 admitted that she did not know what the medications she provided Resident #8 were for.

15. On or about April 7, 2025, PCA #1 prepared to administer Resident #9 a Glipizide tablet, which Respondent's Director of Nursing (DON) confirmed should not be provided to Resident #9 as that was not ordered.

16. On or about April 7, 2025, PCA #1 utilized a glucometer to finger stick Resident #9, and drew up and administered an insulin injection to Resident #9.

17. Review of Respondent's Medication Administration and Storage policy revealed the following: "…all medications (even OTC [Over the Counter] should be kept in a secured area…"

18. On or about April 7, 2025, a bottle of Robitussin, a bottle of Loperamide, and a bottle of Delsym were observed on Resident #8's bedside table. PCA #1 also obtained a Melatonin capsule and Unisom capsule and handed them to Resident #8. When Resident #8 indicated she would take them later, PCA #1 placed the tablets on the bedside table and left the room and confirmed that she left the medications with Resident #8 to take later. Resident #8 had no documentation on file indicating an evaluation to self-medicate.

19. On or about April 7, 2025, PCA #1 left the keys to the medication cart in the lock of the cart, and the cart was left unlocked and unattended.

20. On or about April 14, 2025, the DON confirmed that the medication cart should be locked when unattended and the keys to the cart should not be left in the cart's lock but should remain in staff's possession. The DON also confirmed residents should not have medications unsecured in their rooms or on their bedside tables, and that staff should remain with the resident to ensure all medications are taken during medication assistance.

21. On or about April 7, 2025, Respondent's kitchen, refrigerator, freezer, and dry storage shelves revealed numerous food items open to air, unlabeled and undated, expired and

unrefrigerated. The DON confirmed that these foods should not be open to air, foods should have been refrigerated, properly covered and contained, all opened foods should be labeled and dated, and no expired foods should be in Respondent's food supply.

22. On or about April 15, 2025, Resident #1's record revealed that between October 2024 and February 2025, Resident #1 was hallucinating, having trouble sleeping, very confused and self-propelling with a wheelchair. Resident #1's care plan was not revised to address his hallucinations, use of a wheelchair, or sleeping problems with appropriate interventions. There was no documentation that Resident #1's care plan was reviewed or revised with input from Resident #1's family or physician.

23. On or about April 15, 2025, Resident #2's care plan, reviewed by Respondent, revealed there was no documentation the Care Plan was reviewed or revised with input from Resident #2's family or physician.

24. On or about April 15, 2025, Resident #3's record revealed that between September 2024 and January 2025, Resident #3 experienced increasing anxiety, sleeplessness, and wandering. Resident #3's care plan was not revised to address his increasing anxiety, sleeplessness, and wandering with appropriate interventions. There was no documentation that Resident #3's care plan was reviewed or revised with input from Resident #3's family or physician.

25. On or about April 15, 2025, Resident #8's care plan, reviewed by Respondent, revealed there was no documentation the Care Plan was reviewed or revised with input from Resident #8's family or physician.

26. Respondent's DON confirmed Care Plans should be reviewed and/or revised twice a year, when they come back from the hospital, or with any significant changes.

27. On or about April 15, 2025, Respondent's Administrator said the family and resident providers should not be involved in developing resident care plans.

III. GROUNDS FOR DISCIPLINE

The facts in Section II, *supra*, 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 Commission is authorized.

28. The facts in paragraphs nine (9) through sixteen (16) are sufficient to constitute a violation of Tenn. Comp. R. and 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.

29. The facts in paragraphs seventeen (17) through twenty (20) are sufficient to constitute a violation of Tenn. Comp. R. and Regs. 0720-26-.07 (5)(d), Services Provided, the relevant portion of which reads as follows:

> (5) Resident Medication. An ACLF shall:
>
> (d) Store all medications via a locked or closed container and/or room which includes, but is not limited to, some type of box, piece of furniture, an individual resident room, and/or a designated room within the facility which maintains resident medication out of the sight of other residents.

30. The facts in paragraph twenty-one (21) are sufficient to constitute a violation of Tenn. Comp. R. and Regs. 0720-26-.07 (7)(c)(4)(i), Services Provided, the relevant portion of which reads as follows:

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

(c) Dietary services.

4. An ACLF shall:

(i) Provide at least three (3) meals constituting an acceptable and/or prescribed diet per day. There shall be no more than fourteen (14) hours between the evening and morning meals. All food served to the residents shall be of good quality and variety, sufficient quantity, attractive and at safe temperatures. Prepared foods shall be kept hot (140ºF. or above) or cold (41ºF. or less) as appropriate. The food must be adapted to the habits, preferences and physical abilities of the residents. Additional nourishment and/or snacks shall be provided to residents with special dietary needs or upon request.

31. The facts in paragraphs twenty-two (22) through twenty-seven (27) are sufficient to constitute a violation of Tenn. Comp. R. and Regs. 0720-26-.12 (5)(a), Resident Records, the relevant portion of which reads as follows:

(5) Plan of care

(a) An ACLF shall develop a plan of care for each resident admitted to the ACLF with input and participation from the resident or the resident's legal representative, treating physician, or other licensed health care professionals or entity delivering patient services within five (5) days of admission. The plan of care shall be reviewed and/or revised as changes in resident needs occur, but not less than semi-annually by the above-appropriate individuals.

IV. REPRESENTATIONS OF RESPONDENT

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

33. 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.

34. Respondent voluntarily waives these rights in order to avoid further administrative action.

35. 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.

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

37. 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.

38. 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:

39. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount of **three-thousand dollars ($3,000.00)**. This CMP is issued for a violation of Tenn. Comp. R. and Regs. 0720-26-.07 (5)(b), Services Provided, for failure to ensure a staff member who

administered medications to residents at the facility was a certified Medication Aide and/or licensed staff.

40. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount of **three-thousand dollars ($3,000.00)**. This CMP is issued for This CMP is issued for a violation of Tenn. Comp. R. and Regs. 0720-26-.07 (5)(d), Services Provided, for failure to store a resident's medications in a locked or closed container for 1 of 6 sampled residents, and failure to keep the medication cart secured for 1 of 1 medication carts reviewed.

41. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount of **one-thousand dollars ($1,000.00)**. This CMP is issued for This CMP is issued for a violation of Tenn. Comp. R. and Regs. 0720-26-.07 (7)(c)(4)(i), Services Provided, for failure to properly store dry food items, frozen food items, and refrigerated food items.

42. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount of **two-thousand dollars ($2,000.00)**. This CMP is issued for This CMP is issued for a violation of Tenn. Comp. R. and Regs. 0720-26-.12 (5)(a), Resident Records, for failure to conduct care plan meetings with the resident/resident's representative and provider and review and/or revise the plan of care as changes in the residents' needs occurred to address hallucinations, wandering, increasing anxiety, wheelchair use, and sleep problems for 4 of 5 (Resident #1, #2, #3, and #8) sampled residents reviewed for care plans and care plan meetings.

43. The total assessed CMP amount is **nine-thousand dollars ($9,000.00).**

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

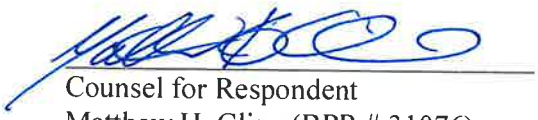
Tennessee Health Facilities Commission
Attention: Disciplinary Coordinator
502 Deaderick St, 9th Floor
Nashville, Tennessee 37243
Email: HFC.Disciplinary@tn.gov

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

45. 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.

[THIS SECTION LEFT INTENTIONALLY BLANK]

APPROVED FOR ENTRY:



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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 Health Facilities Commission 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
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, Asbury Cove, via Respondent's Counsel(s), Matthew Cline, and Dixie Cooper, by delivering same in the United States via electronic mail only, to: matt@cumberlandlitigation.com & dixie@cumberlandlitigation.com.

This _____ day of _____, 202__.

_____
Seth Colón
Associate General Counsel