STATE OF TENNESSEE
BEFORE THE HEALTH FACILITIES COMMISSION

In The Matter of:	)	
	)	
Cloverland Park Senior Living,	)	
Assisted Care Living Facility,	)	**Case Nos. 2024017911**
License No. 500,	)	**2024029801**
	)	**2025000931**
Respondent.	)	**2025006751**
	)	
Brentwood, Tennessee	)	

CONDITIONAL CHANGE OF OWNERSHIP ORDER

This matter came to be heard before the Tennessee Health Facilities Commission ("Commission"), by and through the Office of Legal Services, and Cloverland Park Senior Living ("Respondent") that the Commission adopt this Conditional Change of Ownership Order, the terms of which have been agreed upon by the parties, as signified by their signatures below.

Respondent, by signature to this Conditional Change of Ownership 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 Conditional Change of Ownership Order by the Commission for ratification and all matters divulged during that process shall not constitute unfair disclosure such that the Commission or any of its members shall be prejudiced to the extent that requires their disqualification from hearing this matter should the Conditional Change of Ownership 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.

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. Any person, partnership, association, corporation, any state, county or local governmental unit, or any division, department, board or agency of the governmental unit, in order to lawfully establish, conduct, operate or maintain a hospital, recuperation center, nursing home, home for the aged, residential HIV supportive living facility, assisted-care living

facility, home care organization, residential hospice, birthing center, prescribed child care center, renal dialysis clinic, outpatient diagnostic center, ambulatory surgical treatment center, adult care home or traumatic brain injury residential homes in this state, shall obtain a license from the commission, upon the approval and recommendation of the Commission in the following manner:

> (1) The applicant shall submit an application on a form to be prepared by the commission with the approval of the Commission, showing that the applicant is of **reputable and responsible character and able to comply with the minimum standards** for a facility and with rules and regulations lawfully promulgated under this part. The application shall contain the following additional information:
>
> > (A) The name or names of the applicant or applicants;
> >
> > (B) The type of institution to be operated;
> >
> > (C) The location of the institution;
> >
> > (D) The name of the person or persons to be in charge of the institution or, for adult care home applicants, the name of the resident manager, if applicable;
> >
> > (E) A certification that the applicant has implemented a policy of informing its employees of their obligations under § 71-6-103 to report incidents of abuse or neglect;
> >
> > (F) If an application for a nursing home license, a list of all nursing homes that the applicant, or any person or entity holding a majority legal or equitable interest in the applicant, owns or operates and, if the applicant has not operated a nursing home in this state for a continuous period of twenty-four (24) months preceding the application, the information specified in § 68-11-804(c)(1) for each such nursing home located outside this state; and
> >
> > (G) Such other information as the commission, with the approval of the Commission, may require.

T.C.A. § 68-11-206(a)(1).

7. 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).

8. 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.

I. STIPULATIONS OF FACT

9. At all times pertinent hereto, Respondent, Cloverland Park Senior Living, 6030 Cloverland Drive, Brentwood, Tennessee 37027, was licensed by the Commission as an ACLF, having been granted license number 500 on February 24, 2022, which currently has an expiration date of February 23, 2026. The Facility license is currently held by Meridian Nashville ALZ OE, LP.

10. Surveys of the facility were completed on April 30, August 13, and December 17, of 2024. Another survey was completed on February 6 of 2025. Several deficiencies were cited, including multiple repeat deficiencies being cited on all four (4) surveys.

SURVEY 1

11. On or about April 30, 2024, a survey was completed resulting in multiple deficiencies being cited for failure to ensure staff was properly licensed, failure to properly administer resident medications, failure to provide safety when in the facility, failure to have awareness of resident whereabouts, failure to maintain food temperature logs, failure to properly maintain and store food supplies, failure to maintain a clean and sanitary kitchen, failure to prohibit the continued stay of physically aggressive residents, failure to maintain

complete medical records for all residents, and failure to review and/or update resident plans of care.

12. On or about April 16, 2023, LPN #2 (as identified in Survey 1) was hired to provide direct care to residents. On or about October 31, 2023, LPN #2's nursing license expired. As of March 19, 2024, LPN #2 was still providing nursing services to residents without a valid nursing license.

13. The facility failed to administer one (1) medication as prescribed to Resident #1 (as identified in Survey 1) and ten (10) medications as prescribed to Resident #9 (as identified in Survey 1).

14. Multiple residents had instances of elopement and/or physically aggressive behavior:

    a. On or about March 19, 2024, Resident #1 eloped from the facility. The resident had demonstrated significant exit-seeking behavior that was not reflected in the resident's care plan.

    b. Between August 29, 2023, and March 17, 2024, Resident #4 (as identified in Survey 1) sustained eleven (11) falls with multiple injuries. The resident's care plan was not revised to reflect the falls or to identify fall interventions.

    c. Between July 26, 2023, and December 18, 2023, Resident #5 (as identified in Survey 1) sustained ten (10) falls with multiple injuries. During the same timeframe Resident #5 had four (4) separate instances of physically aggressive behavior toward staff members and other residents. The resident's care plan was not revised to reflect these incidents or to identify interventions for the resident's conduct.

d. Between February 16, 2023, and April 17, 2023, Resident #6 (as identified in Survey 1) was involved in seven (7) instances of physically aggressive behavior toward other residents. At least one of the instances resulted in physical injury.

e. Between March 16, 2023, and September 4, 2023, Resident #7 (as identified in Survey 1) had multiple instances of physically aggressive behavior, espoused suicidal ideation, was admitted to a psychiatric hospital, and suffered at least one (1) fall. The facility did not appropriately revise the resident's care plan to reflect these incidents or to identify interventions for the resident's conduct.

f. Resident #9 had two falls on May 29, 2022, and June 7, 2022. The facility did not revise the resident's care plan to reflect these incidents or to identify fall interventions.

g. Between November 2, 2022, and November 21, 2022, Resident #10 (as identified in Survey 1) eloped from the facility twice and had multiple instances of physically aggressive and/or inappropriate sexual behavior. The facility did not appropriately revise the resident's care plan to reflect these incidents or to identify interventions for the resident's conduct.

h. Between March 29, 2022, and April 18, 2022, Resident #13 (as identified in Survey 1) eloped from the facility and had multiple instances of physically aggressive behavior. The facility did not appropriately revise the resident's care plan to reflect these incidents or to identify interventions for the resident's conduct.

i. Between December 6, 2023, and March 7, 2024, Resident #14 (as identified in Survey 1) eloped from the facility multiple times and had multiple falls. The facility

did not appropriately revise the resident's care plan to reflect these incidents or to identify interventions for the resident's conduct.

j. On or about Mar 25, 2023, Resident #16 (as identified in Survey 1) sustained multiple skin tears to the arms caused by a facility staff member grabbing the resident to stop the resident from falling. The facility failed to ensure appropriate equipment/techniques were used in this situation.

k. On or about April 9, 2024, three (3) memory care residents, Resident #11 (as identified in Survey 1), Resident #17 (as identified in Survey 1), and Resident #18 (as identified in Survey 1), left the Memory Care Unit without the knowledge of facility staff. The facility failed to conduct a thorough investigation into the incident, including failure to determine how the residents got out of the Memory Care Unit and failure to determine why facility staff was unaware that the residents were not where they were supposed to be.

15. As of March 19, 2924, the facility had failed to maintain food temperature logs for the previous three (3) months. The facility also had several perishable food items opened and undated among the facilities refrigerated and dry foods.

16. The facility's kitchen was not maintained in a clean and sanitary manner. On or about March 18, 2024, and March 19, 2024, the facility's kitchen had ovens with thick, black, build-up, a dirty vent hood, used scoops left in dry ingredient bins, cookware with thick, black, build-up in them.

17. The facility failed to maintain properly updated medical records for Residents #5, #7, #9, #10, and #13, following instances of medical care or intervention coordinated and/or provided by the facility.

18. The facility failed to properly document transfer conditions and circumstances for Residents #2 , #5, and #7, following transfers of those residents to hospital care.

SURVEY 2

19. On or about August 13, 2024, a survey was completed resulting in multiple deficiencies being re-cited, including failure to provide safety when in the facility, failure to have awareness of resident whereabouts, failure to maintain complete medical records for all residents, and failure to review and/or update resident plans of care.

20. On or about May 6, 2024, Resident #2 (as identified in Survey 2) pushed Resident #1 (as identified in Survey 2) causing Resident #1 to fall. On or about May 9, 2024, Resident #1 had x-rays taken and no fractures were identified. The resident's physician was notified. The facility failed to properly update the plans of care of both residents to implement interventions.

    a. On or about May 13, 2024, Resident #1 had another fall. The facility failed to properly assess the resident or timely notify their physician. The resident did not have x-rays taken until May 22, 2024, which revealed a fracture.

    b. The facility failed to properly update the resident's plan of care or medical record to document both falls, implement interventions to prevent future falls, or document the condition and circumstances of the resident's transfers to hospital.

21. The facility failed to properly and timely update the plan of care for Resident #6 (as identified in Survey 2) following multiple falls with injury between May 4, 2024, and July 21, 2024. The facility also failed to properly document the condition and circumstances of at least one transfer of the resident to hospital.

22. On or about June 20, 2024, facility staff did not have knowledge of the whereabouts of a memory care resident, Resident #4 (as identified in Survey 2). A "code pink" was issued to all staff and the resident was located in a service hall just outside the Memory Care Unit. The facility documented some interventions in the resident's care plan, including an increase in observation of the resident.

a. On or about July 4, 2024, Resident #4 exited the Memory Care Unit via a service entry door and was located elsewhere in the facility. Facility staff did not observe the resident exit the Memory Care Unit. The facility determined that another resident regularly used his key fob to access the Memory Care Unit through the service entry door, without the knowledge of facility staff, allowing Resident #4 to exit the memory care unit.

b. The facility's interventions to prevent Resident #4 from leaving the Memory Care Unit were not sufficient to prevent this subsequent elopement.

SURVEY 3

23. On or about December 17, 2024, a survey was completed resulting in multiple deficiencies being re-cited, including failure to provide safety when in the facility, failure to have awareness of resident whereabouts, and failure to review and/or update resident plans of care.

24. On or about September 30, 2024, Resident #3 (as identified in Survey 3) eloped from the facility. The facility's documented that the cause of the resident's exit was a "failure in the egress" door and that failure was addressed. The facility failed to document the nature of the failure in the egress door, where/when the resident was located, who found the resident, or how long the resident was missing.

25. Between September and November of 2024, multiple residents sustained falls without the facility properly revising the residents' plans of care to implement appropriate interventions:

a. Resident #6 (as identified in Survey 3) sustained falls on September 18, 2024, September 29, 2024, and October 18, 2024, with no injuries documented. The facility failed to update the resident's plan of care with interventions to prevent future falls after any of these three (3) incidents.

b. Resident #9 (as identified in Survey 3) sustained falls with injury on September 14, 2024, September 16, 2024, and November 10, 2024. On September 15, 2024, a facility assessment of the resident indicated that the resident had no history of falls. The facility failed to appropriately update the resident's plan of care with interventions to prevent future falls after any of these three (3) incidents.

c. Between September 6, 2024, and October 3, 2024, Resident #11 (as identified in Survey 3) sustained five (5) falls, with no injuries documented. The facility failed to appropriately update the resident's plan of care with interventions to prevent future falls after any of these five (5) incidents.

d. Between September 4, 2024, and October 16, 2024, Resident #14 (as identified in Survey 3) sustained four (4) falls, with no injuries documented. The facility failed to appropriately update the resident's plan of care with interventions to prevent future falls after any of these four (4) incidents.

e. Between September 13, 2024, and October 26, 2024, Resident #15 (as identified in Survey 3) sustained four (4) falls, with no injuries documented. The facility failed

to appropriately update the resident's plan of care with interventions to prevent future falls after any of these four (4) incidents.

26. On or about September 27, 2024, Care Manager #11 was hired by the facility to provide direct care to residents. At the time of hire the facility did not complete a criminal background check or an abuse registry check. The facility did not complete an abuse registry check on Care Manager #11 until December 10, 2024, over two (2) months after hire. As of December 10, 2024, a criminal background check on Care Manager #11 was initiated but was not completed. These checks were not done until a facility employee shared concerns with the Executive Director that Care Manager #11 had criminal convictions.

27. On or about October 25, 2024, RN #1 was hired by the facility to provide direct care to residents. The facility did not complete an abuse registry check on RN #1 until December 11, 2024.

SURVEY 4

28. On or about February 6, 2025, a survey of the facility was completed resulting in deficiencies being cited for failure to provide safety and failure to have awareness of a patient's whereabouts.

29. On or about January 30, 2025, facility staff called a "code pink" at approximately 4:10 a.m. for Resident #1 (as identified in Survey 4). The resident ran from a caregiver who was providing the resident with one to one care. The caregiver did not follow the resident when he ran but instead went to a different floor of the facility to retrieve her phone to call for help. The caregiver's earlier calls for help over her facility-issued walkie-talkie had gone unanswered. The resident was located outside in the facility parking lot with

signs of injury consistent with falling outside. The facility documented the incident as a fall, but did not document the resident's unobserved exit from the facility.

30. On April 24, 2025, the Health Facilities Commission determined that all prior cited deficiencies at the facility had been corrected and the facility was now in substantial compliance with all licensure requirements. This determination was based on an onsite revisit survey done at the facility on March 22, 2025.

II. 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 Commission is authorized.

31. The facts in paragraphs ten (10) and eleven (11) are sufficient to constitute a violation of Tenn. Comp. R. and Reg.0720-26-.07(2), the relevant portion of which reads as follows:

> (2) Medical services in an ACLF shall be provided by:
> (a) Appropriately licensed or qualified staff of an ACLF;
> (b) Appropriately licensed or qualified contractors of an ACLF;
> (c) A licensed home care organization;
> (d) Another appropriately licensed entity; or
> (e) Appropriately licensed staff of a nursing home.

32. The facts in paragraphs ten (10) and twelve (12) are sufficient to constitute a violation of Tenn. Comp. R. and Reg.0720-26-.07(5)(b), 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.

33. The facts in paragraphs ten (10), thirteen (13), nineteen (19), twenty (20), twenty-five

(25) through twenty-seven (27), and twenty-nine (29), are sufficient to constitute violations of Tenn. Comp. R. and Reg.0720-26-.07(7)(a)(2), the relevant portion of which reads as follows:

(a) Each ACLF shall provide each resident with at least the following personal services:
(2) Safety when in the ACLF[.]

34. The facts in paragraphs ten (10), thirteen (13), twenty-one (21), twenty-three (23), and twenty-nine (29), are sufficient to constitute violations of Tenn. Comp. R. and Reg.0720-26-.07(7)(a)(3), the relevant portion of which reads as follows:

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

(3) Daily awareness of the individual's whereabouts[.]

35. The facts in paragraphs ten (10) and fourteen (14) are sufficient to constitute a violation of Tenn. Comp. R. and Reg.0720-26-.07(7)(c)(4)(i), the relevant portion of which reads as follows:

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 (140°F. or above) or cold (41°F. 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.

36. The facts in paragraphs ten (10) and fourteen (14) are sufficient to constitute a violation of Tenn. Comp. R. and Reg.0720-26-.07(7)(c)(4)(iii), the relevant portion of which reads as follows:

4. An ACLF shall:

(iii) Maintain and properly store a forty-eight hour food supply at all times.

37. The facts in paragraphs ten (10) and fifteen (15) are sufficient to constitute a violation

of Tenn. Comp. R. and Reg.0720-26-.07(7)(c)(5), the relevant portion of which reads as follows:

(5) An ACLF shall maintain a clean and sanitary kitchen.

38. The facts in paragraphs ten (10) and thirteen (13) are sufficient to constitute a violation of Tenn. Comp. R. and Reg.0720-26-.08(1)(d), the relevant portion of which reads as follows:

(1) An ACLF shall not admit or permit the continued stay of any ACLF resident who has any of the following conditions:

. . .

(d) Exhibits verbal or physical aggressive behavior which poses an imminent physical threat to self or others, based on behavior, not diagnosis.

39. The facts in paragraphs ten (10) and sixteen (16) are sufficient to constitute a violation of Tenn. Comp. R. and Reg.0720-26-.12(3)(g), the relevant portion of which reads as follows:

(3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the CLF or by arrangement with an outside source, which shall include at a minimum:

. . .

(g) Notes, including, but not limited to, observation notes, progress notes, and nursing notes.

40. The facts in paragraphs ten (10), seventeen (17), nineteen (19), and twenty (20) are sufficient to constitute a violation of Tenn. Comp. R. and Reg.0720-26-.12(3)(i), the relevant portion of which reads as follows:

(3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the CLF or by arrangement with an outside source, which shall include at a minimum:

. . .

(i) Time and circumstances of discharge or transfer, including condition at discharge or transfer, or death.

41. The facts in paragraphs ten (10), thirteen (13), nineteen (19), twenty (20), twenty-one (21), and twenty-four (24) are sufficient to constitute violations of Tenn. Comp. R. and

Reg.0720-26-.12(5)(a), the relevant portion of which reads as follows:

(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.

III. REPRESENTATIONS OF RESPONDENT

42. Respondent understands the allegations, charges, and stipulations in this Order within this Order. By entering in the Agreement, Meridian Nashville ALZ OE, LP does not concede to, admit, or adopt, and expressly denies any and all allegations made by the Health Facilities Commission concerning the findings of non-compliance. This Agreement contains a compromise of claims asserted by the HFC and execution of this Agreement does not constitute any acknowledgment or admission of liability by Meridian Nashville ALZ OE, LP any regard.

43. 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.

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

45. 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.

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

47. 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.

48. 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.

IV. ORDER

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

45. The Change of Ownership Application for license number 500 to operate as an Assisted Care Living Facility in the State of Tennessee is hereby **GRANTED subject to the contingencies outlined in this section.**

46. Failure to comply with the contingency listed in paragraph 63 of Section V of this order **within thirty (30) days of the effective date of this order will result in DENIAL** of the facility's Change of Ownership (CHOW) application.

CIVIL MONETARY PENALTIES FOR SURVEY 1

47. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount of **two-hundred dollars ($200.00)**, for the deficiency(ies) identified above in paragraph thirty (30).

48. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount of **four-hundred dollars ($400.00)**, for the deficiency(ies) identified above in paragraph thirty-one (31).

49. Respondent is hereby assessed one (1) Civil Monetary Penalty totaling **two-thousand dollars ($2,000.00)**, for the deficiency(ies) identified above in paragraph thirty-two (32).

50. Respondent is hereby assessed one (1) Civil Monetary Penalty totaling **one thousand, two-hundred dollars ($1,200.00)**, for the deficiency(ies) identified above in paragraph thirty-three (33).

51. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount **one thousand, five-hundred dollars ($1,500.00)**, for the deficiency(ies) identified above in paragraph thirty-four (34).

52. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount **one thousand, five-hundred dollars ($1,500.00)**, for the deficiency(ies) identified above in paragraph thirty-five (35).

53. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount **one thousand, five-hundred dollars ($1,500.00)**, for the deficiency(ies) identified above in paragraph thirty-six (36).

54. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount **one thousand dollars ($1,000.00)**, for the deficiency(ies) identified above in paragraph thirty-seven (37).

55. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount **one thousand, five-hundred dollars ($1,500.00)**, for the deficiency(ies) identified above in paragraph thirty-eight (38).

56. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount **one thousand, five-hundred dollars ($1,500.00)**, for the deficiency(ies) identified above in

paragraph thirty-nine (39).

57. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount **one thousand, eight-hundred dollars ($1,800.00)**, for the deficiency(ies) identified above in paragraph forty (40).

CIVIL MONETARY PENALTIES FOR SURVEY 2

58. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount **three thousand dollars ($3,000.00)**, for the deficiency(ies) identified above in paragraph thirty-two (32).

59. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount **one thousand dollars ($1,000.00)**, for the deficiency(ies) identified above in paragraph thirty-three (33).Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount **two thousand dollars ($2,000.00)**, for the deficiency(ies) identified above in paragraph thirty-nine (39).

60. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount **three thousand dollars ($3,000.00)**, for the deficiency(ies) identified above in paragraph forty (40).

CIVIL MONETARY PENALTIES FOR SURVEY 4

61. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount of **three thousand dollars ($3,000.00)**, for the deficiency(ies) identified above in paragraph thirty-two (32).

62. Respondent is hereby assessed one (1) Civil Monetary Penalty in the amount of **three thousand dollars ($3,000.00)**, for the deficiency(ies) identified above in paragraph thirty-three (33).

63. **The total assessed CMP amount is twenty-nine thousand, one hundred dollars**

($29,100.00). 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
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

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

64. 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:

Cloverland Park Senior Living
License No. 500
Signature of Authorized Representative
Respondent

Mark Davis ED
Printed Name of Authorized Representative

Executive Director
Title of Authorized Representative

Vishan J. Ramcharan (BPR # 034403)
Associate General Counsel
Health Facilities Commission
Office of Legal Services
Andrew Jackson Building, 9th Floor
502 Deaderick Street

Nashville, Tennessee 37243
Office: (615) 741-2364
Fax: (615) 741-9884
Email: vishan.j.ramcharan@tn.gov

Approval by the Commission

Upon the agreement of the parties, and the record as a whole, this **CONDITIONAL CHANGE OF OWNERSHIP 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 10th day of December, 2025.

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, Cloverland Park Senior Living, c/o Administrator, Sheila L McArdle, 6030 Cloverland Drive Brentwood, Tennessee 37027, and Cloverland Park Senior Living, c/o Registered Agent, Meridian Nashville ALZ OE, LP, Owner, 3811 Turtle Creek Bouvelard Suite # 875 Dallas, Texas 75219 by delivering same in the United States regular mail and United States certified mail, numbers **70200640000148075286** and **70200640000148075293,** return receipts requested, with sufficient postage thereon to reach its destination.

Copies were sent via electronic mail to: cpuri@bradley.com, ABennett@DiscoveryMgt.com and dschonfeldt@hansonbridgett.com.

This 10th day of December, 2025.

Vishan J. Ramcharan
Associate General Counsel