

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

IN THE MATTER OF:

**The Waterford in Sango
300 Sango Drive
Clarksville, Tennessee 37043**

License No. RHA 00000134

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CONSENT ORDER

This matter came to be heard before the Tennessee Board for Licensing Health Care Facilities (hereinafter "the Board") on the _____ day of _____, 2016, pursuant to the request of the Tennessee Department of Health, by and through the Office of General Counsel, and **THE WATERFORD IN SANGO** (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.

JURISDICTION

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.

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).

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. 1200-08-11-.03. 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

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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.*

STIPULATIONS OF FACT

1. At all times pertinent hereto, The Waterford in Sango, 300 Sango Drive, Clarksville, Tennessee, has been licensed as a Home for the Aged by the Board, having been issued license number 00000134 on August 12, 1987. Respondent has an active license with an expiration date of October 10, 2016.
2. On or about February 25, 2016, the Tennessee Department of Health conducted a complaint survey. During the survey, the surveyors observed conditions that endangered the health, safety and welfare of the residents.
3. The Respondent facility failed to ensure 7 of 11 (Staff Member #1, 2, 5, 6, 7, 8, and 9) staff members who provided direct care were free of communicable disease or had a current Tuberculin (TB) Skin Test results.
4. The Respondent facility failed to ensure that a resident who required total care and could not self-administer medication was transferred to a facility with a higher level of care. Resident #7 was totally dependent for all personal care and positioning needs. The resident had to be fed and was unable to self-administer medications.
5. The Respondent facility failed to assume responsibility for the safety of the residents by not ensuring all staff followed infection control procedures to prevent possible cross-contamination. A small unlocked refrigerator in Dining Room #1 contained a specimen cup filled with urine dated 2/10/16 and contained 3 vials of Tubersol (medication injected under the skin to test for TB infection).

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6. The Respondent facility failed to ensure the self-administration of medications or administration by a licensed nurse for 6 of 6 (Resident #1, 5, 6, 8, 9, and 10) residents observed during 3 (1/12/16, 2/16/16 and 2/17/16) medication administration passes. A licensed nurse filled each resident's medication container, and staff would open the appropriate section of the medication container and pour the medication into the residents' hands. There is no indication that any resident was given the incorrect medication.
7. The Respondent facility failed to ensure medications were stored so that no resident could obtain another resident's medication. A Sheriff's Office Incident Report dated 12/28/15 revealed a theft of property call at the facility for missing resident medications. Observations on 1/12/16 revealed a locked narcotic box on a shelf in the administrator's closet with the key on the shelf next to the box. The door to the closet was unlocked. Observations in Dining Room #2 on 2/16/16 revealed 3 vials of Tubersol stored in an unlocked refrigerator accessible by the residents and medications stored in an unsecured cabinet below the refrigerator. Medications were also stored in an unsecured refrigerator in the kitchen as well as an unsecured cabinet above the sink. Observations in the upstairs office on 2/16/16 revealed an unsecured refrigerator which contained a bottle of Meclizine. Beside the refrigerator was the door to the bedroom closet where the aforementioned narcotic box was stored. There was still no lock on the bedroom closet. The narcotic box was again locked, but the key was on a coat hanger just below the narcotic box. The narcotic box contained multiple bottles of controlled medication including narcotics and benzodiazepines. The upstairs office served as the Administrator's bedroom. The Administrator's bedroom was joined to other bedrooms

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and the other part of the building by a hallway. Anyone in the other part of the house or any of the other bedrooms had access to the Administrator's bedroom and the bedroom closet. Observations in the upstairs office on 2/17/16 revealed the narcotics box still on a shelf in the closet. The closet door and the bedroom door were open and accessible to the other bedrooms and hallway upstairs. The narcotics box was locked, but the box was accessible to anyone in the house. The unlocked refrigerator in the Administrator's bedroom/office still contained medications.

8. The owner of the Respondent facility confirmed the facility had not secured medications when the theft of Resident #3's medication.
9. The facility failed to ensure the 9 residents residing in the home were safe from fire hazards observed on 2/16/16 and 2/17/16. The facility used space heaters.
10. The facility failed to ensure the residents' files included current prescriptions. Further, resident files were stored next to the dining room table, unsecured and accessible to anyone in the dining room.

GROUND FOR DISCIPLINE

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

11. The facts stated in paragraph three (3) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.04 [ADMINISTRATION], the relevant

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portion of which reads as follows:

- (6) No occupant or employee who has a reportable communicable disease , as stipulated by the department, is permitted to reside or work in a home unless the home has a written protocol approved by the department.

- 12. The facts stated in paragraph four (4) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.05 [ADMISSIONS, DISCHARGES AND TRANSFERS], the relevant portion of which reads as follows:

- (5) Individuals who are usually, typically or customarily incapable of self-administering medications or who require medications that are usually, typically or customarily not self-administered shall not be admitted to or retained in the home unless provided by a home care organization or physician.

- 13. The facts stated in paragraph five (5) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.09 [Infectious and Hazardous Waste], the relevant portion of which reads as follows:

- (6) Waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons.

- (a) Waste must be stored in a manner and location which affords protection from animals, precipitation, wind, and direct sunlight, does not present a safety hazard, does not provide a breeding place or food source for insects or rodents, and does create a nuisance.

- 14. The facts stated in paragraph six (6) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06 [PERSONAL SERVICES], the relevant

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portion of which reads as follows:

- (2) Medications shall be self-administered. If the home chooses to employ a currently licensed nurse, medications may be administered by the nurse.

15. The facts stated in paragraph seven (7) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.06[PERSONAL SERVICES], the relevant portion of which reads as follows:

- (4) All medications shall be stored so that no resident can obtain another resident's medication.

16. The facts stated in paragraph nine (9) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.08 [LIFE SAFETY], the relevant portion of which reads as follows:

- (10) Open flame and portable space heaters shall not be permitted in the home.
Cooking appliances other than microwave ovens shall be allowed in rooms.

17. The facts stated in paragraph ten (10) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.10 [RESIDENT RECORDS and REPORTS], the relevant portion of which reads as follows:

- (1) An individual resident file shall be maintained for each resident in the home. Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the resident. These files shall be retained for one (1) year after the resident is transferred or discharged. The resident file shall include:
 - (g) Health information including all current prescriptions, major changes in resident's habits or health status, results of physician's visits, and any

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health care instructions; and

18. The facts stated in paragraph ten (10) are sufficient to establish that Respondent has violated the provisions of Rule 1200-08-11-.11 [RESIDENT RIGHTS], the relevant portion of which reads as follows:

Each resident has at least the following rights:

- (4) To have his or her file kept confidential and private. Written consent by the resident must be obtained prior to release of information except to persons authorized by law;

ORDER

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

19. Respondent's license to operate as a Home for the Aged is hereby placed on **PROBATION** for a period of **no less than six (6) months**.
20. During the probationary period, Respondent must submit an acceptable plan of correction to remedy all deficiencies identified by the state surveyors.
21. Failure to submit an acceptable plan of correction will be considered a violation of this Order and may subject Respondent to further disciplinary action, up to and including, revocation of Respondent's license to operate as a Home for the Aged.
22. This is a public disciplinary action. Upon ratification by the Board, the public discipline, including deficiencies and any civil penalties, will be listed on the Disciplinary Action Report pursuant to T.C.A. § 68-1-114.

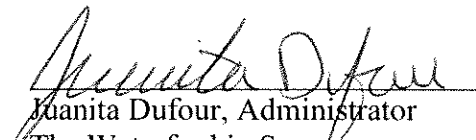
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Upon the agreement of the parties, this **CONSENT ORDER** is approved as a **FINAL ORDER** by a majority of a quorum of the Tennessee Board for Licensing Health Care Facilities at a public meeting of the Board and signed this _____ day of _____, 2016.

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:


Juanita Dufour, Administrator
The Waterford in Sango
Respondent

9-1-2016
Date

Kyonzte Hughes-Toombs, BPR # 023702
Deputy General Counsel
Tennessee Department of Health
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243
(615) 741-1611

Date

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CERTIFICATE OF SERVICE

A true and exact copy of this Consent Order is being served upon Respondent, Juanita Dufour, Administrator, The Waterford in Sango, 300 Sango Drive, Clarksville, Tennessee 37043, by delivering same in the United States mail, first class, with sufficient postage thereon to reach its destination.

This _____ day of _____, 2016.

Kyonzté Hughes-Toombs
Deputy General Counsel

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