

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Senator Ben Atchley State Veterans' Home		STREET ADDRESS, CITY, STATE, ZIP CODE One Veterans Way Knoxville, TN 37931	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations and interviews, the facility failed to prevent resident to resident sexual abuse for 2 residents (Residents #1 and #2) of five residents reviewed for abuse when Resident #1 was observed with a hand inside Resident #2's brief on [DATE].</p> <p>The facility was cited at F-600 at a Scope and Severity of D and was cited as past non-compliance. Noncompliance began on [DATE], was corrected and ended on [DATE]. The facility is not required to submit a Plan of Correction.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Abuse and Neglect of Resident and Misappropriation of Resident's Property, dated [DATE], revealed .Sexual Abuse includes but is not limited to sexual harassment, sexual coercion or assault .</p> <p>Medical record review revealed Resident #1 was admitted to the facility [DATE] with diagnoses including Displaced Left Femur Fracture, Adjustment Disorder with Anxiety and Depressed Mood, Urinary Tract Infection, Unspecified Altered Mental Status, Insomnia, Chronic Kidney Disease, Multiple Rib Fractures, History of Falls, and Unspecified Dementia with Psychosis.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 10 on the Brief Interview of Mental Status (BIMS) assessment which indicated moderate cognitive impairment. Continued review revealed Resident #1 had a history of wandering 1 to 3 days weekly which had improved since the last quarterly MDS assessment. Resident #1 utilized a wheelchair for ambulation and required assistance of 1 or 2 persons for activities of daily living (ADLs).</p> <p>Review of a repeat BIMS assessment dated [DATE], revealed Resident #1 scored an 8 on the assessment which indicated moderate cognitive impairment.</p> <p>Review of the care plan for Resident #1 revised [DATE], revealed the resident was considered at risk for bouts of confusion, wandering and anxiety with interventions in place on admission. Continued review revealed .touched female resident [Resident #2], 1:1 [one to one] observation, staff monitor proximity to others .BIMS 8/15 [8 out of 15 which indicated moderate cognitive impairment] .</p> <p>Medical record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Anxiety Disorder, Dementia with Behaviors, and Hypertension.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 445484	If continuation sheet Page 1 of 6

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission MDS assessment dated [DATE], revealed Resident #2 scored a 3 on the BIMS assessment which indicated severe cognitive impairment. Resident #2 had no history of behaviors, symptoms of depression, or signs of psychosis and required assistance of 1 or 2 persons for ADLs.</p> <p>Review of the care plan for Resident #2 dated [DATE], revealed the resident was considered at risk for wandering or bouts of confusion with interventions in place. The care plan was revised on [DATE] and revealed residents [Resident #1 and Resident #2] had an intimate encounter staff to provide supportive measures, staff to monitor resident's proximity to others .has code alert [a device to worn which uses radio frequency signals to lock doors in the event of attempted exit] .staff to orient to surroundings .NP [Nurse Practitioner] signed psych [psychiatric] rec [record] .no recommendations at this time .</p> <p>Review of the facility investigation dated [DATE], revealed at approximately 6:45 PM, Certified Nurse Aides (CNAs A and B) found Resident #1 in Resident #2's room. Resident #2 was in the bed in the supine position, with sheets pulled down, legs bent at the knee, her clothing pulled up, and her brief loosened on the right side. Resident #1 was observed seated beside the bed in a wheelchair with the right hand inside the front of Resident #2's loosened brief. As staff approached and entered the room, the female resident (Resident #2) stated . here they [staff] come . to the male resident (Resident #1) and Resident #1 withdrew his hand from Resident #2's brief. Resident #2 laughed and pulled the sheets back up covering herself. The residents were immediately separated without incident. CNA B asked Resident #2 if she was ok and Resident #2 responded, .we are fine . and laughed. Resident #1 and Resident #2 did not exhibit any mental or physical distress at the time.</p> <p>Review of a Psychiatric Evaluation for Resident #1 dated [DATE] revealed .Have been asked by facility staff to evaluation this patient for management of his psychiatric conditions .following an incident .wherein this resident was engaged in sexual behaviors with another resident .patient was found in female .room facility staff saw female resident laying supine on the bed with her legs spread, the covers pulled down and her pants partially removed. One side of her brief had been opened and [Resident #1] hand was noted to be inside the .brief .When staff entered the room [Resident #1] stated, ' .here they come .' At that time the female resident attempted to pull the sheets over herself .Facility staff state .both seemed to be enjoying themselves .No evidence of physical aggression, distress or nonconsensual activity was noted .[Resident #1] is alert makes good eye contact .affect is appropriate .patient is unable to recall/volunteer the events described above .when the scenario is described to him, patient states he ' .faintly .' recalls this situation .He does not remember which resident he was involved with in the above situation .Patient [Resident #1] was recently in romantic relationship with another resident who became his girlfriend. Unfortunately the girlfriend recently passed away .[Resident #2] .was residing in the room of his deceased girlfriend .Patient would frequently enter that room to visit his girlfriend to visit with her .Overall the patient has very poor recall and is unable to provide meaningful context or further details regarding the situation .it is felt possible that he was confused and thought he was with his previous girlfriend .Some of his responses to questions are inappropriate and disorganized .When asked if he would ever touch another person in a sexual manner without their consent he replies .I would never do that . While the patient has been involved in a romantic relationship previously, he had not exhibited sexually inappropriate behavior or any sexual disinhibition toward facility staff or other residents . There was no indication the situation above occurred in a non-consensual manner based on the disposition of each resident when they were found by staff and the lack of any behavior or expressions that would indicate any distress on behalf of either party .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a telemedicine Psychiatric Evaluation Note dated [DATE] for Resident #2 revealed, .I have been consulted to evaluate this patient for the management of her psychiatric conditions .following an incident where .this patient was involved in a sexual encounter with another resident .facility staff saw [Resident #2] laying supine on the bed with her legs spread, the covers pulled down, her pants partially removed .One side of her brief had been opened and the male resident's hand was inside the brief .The patient is alert, makes good eye contact, speaks clearly and discernably .She appears cheerful, jovial and makes small jokes throughout the interview .Affect is appropriate .She is an unreliable source of historical information .she denies any acute distress, anxiety, or other complaints .is unable to provide simple social information such as her age or whether she has been married in the past .She is oriented only to person .Currently tells me she is traveling with her father .She states ' .I did not even know I was at a nursing home . ' .When questioned about the events above and whether or not she was recently involved in a sexual encounter, the patient states ' .no, I wish I had been though . ' .Patient has a good laugh about this .Patient is unable to recall any of the events above .She is noted to have very poor recall .was asked how she would respond if ever someone attempted to touch her in a sexual manner without her consent .She replies ' . I would probably slap the shit out of them . ' in report from family members .patient is described as a very social person who is flirtatious and enjoys male attention .</p> <p>During interview on [DATE] at 1:15 PM, Licensed Practical Nurse (LPN) A stated she was the nurse on duty at the time of the incident on [DATE] between Resident #1 and Resident #2. LPN A stated the incident occurred a few minutes prior to the evening shift change around 7:00 PM on [DATE]. LPN A stated CNAs B and C found the residents in Resident #2's room and Resident #1 had his hand in Resident #2's brief. LPN A stated the residents were separated without incident. LPN A stated when she interviewed the CNAs who found the residents, they reported Resident #2 was heard giggling as they approached the room and stated . here they come or they're coming . as staff entered the room and it appeared to them the residents were involved in a consensual act. LPN A stated Resident #2 was a new admission and was noted to be very sociable and at times flirtatious with males, but to that point had not exhibited any negative behaviors. LPN A stated Resident #2 occupied the bed previously occupied by a female resident who had passed away a few days prior, with whom Resident #1 had a consensual relationship for over 4 months with consent of both responsible parties. LPN A stated she believed Resident #1 in his confused state may have mistaken Resident #2 for the deceased resident. LPN A reported both residents had no recall of the incident a few hours afterwards and at that point still had no recall of it.</p> <p>During interview on [DATE] at 1:30 PM Resident #2 was pleasantly confused but cooperative. Resident #2 had a bright affect and was neatly groomed and showed no signs of neglect. Resident #2 had no recall of the incident. Resident #2 stated she felt safe in the facility. Resident #2 was asked if anyone touched her against her will in a private area and stated .if anybody did that and I didn't want it, I'd knock the shit right out of them . then began to laugh. Resident #2 stated she .liked it here [at the facility] . Resident #2 smiled throughout the interview and showed no signs of psychological distress.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview with Resident #1 on [DATE] at 1:45 PM, Resident #1 reported he .was just passing through . Resident #1 had no recall of the incident, stated he was widower and did not recall his prior relationship with another resident, (the previous occupant of Resident #2's bed where she was located at the time of incident and with whom Resident #1 had intimate relations). Resident #1 stated he would never touch anyone without consent. Resident #1 denied any complaints or concerns, stated he felt safe in the facility, and hoped to go home in a few days. Resident #1 showed no signs of anxiety or other psychological distress and was clean, neatly groomed and appeared free of signs of neglect.</p> <p>During interview on [DATE] at 2:50 PM, CNA B stated she entered Resident #2's room with CNA C behind her on the evening of [DATE] and observed Resident #1 with his hand inside Resident #2's brief as reported in the facility investigation. CNA B stated both residents pulled the sheets up to cover Resident #2's groin as she entered the room and Resident #1 withdrew his hand from her brief. CNA B stated Resident #2 did not appear uncomfortable or in any distress and appeared to be engaged in a consensual act and was smiling and giggling as she pulled the bed sheet up to cover herself. CNA B reported the residents held hands briefly before she separated them while CNA C went to get LPN A. CNA B stated she remained in the room with the residents separated until evaluated by LPN A. CNA B stated she remained with Resident #1 and provided 1 to 1 supervision as directed by LPN A and noted Resident #1 did not exhibit any further behaviors.</p> <p>During interview on [DATE] at 3:05 PM, CNA C stated she entered the room behind CNA B and did not see Resident #1's hands clearly. CNA C confirmed she did see both residents as they pulled up the bed sheet and Resident #2 was laughing as she did so. CNA C stated she heard Resident #2 state . here they come . as the CNAs initially entered the room. CNA C stated it appeared Resident #2 had no distress during the occurrence. CNA C reported Resident #2 laughed at her when she asked Resident #2 if she was okay. CNA C reported Resident #2 stated .I am fine . as she laughed. CNA C reported Resident #1 was very confused at baseline and noted Resident #1's former paramour previously occupied the bed where Resident #2 was situated at the time of the incident. CNA C reported Resident #1's former paramour had died a few days earlier and she and Resident #2 looked very similar in terms of physical appearance and stated she thought it possible that Resident #1 may have mistaken Resident #2 for her.</p> <p>During interview on [DATE] at 3:15 PM, the Director of Nursing (DON) reported the facility investigation concluded the act between the residents was likely consensual. The DON acknowledged both residents involved in the incident were cognitively impaired and had no recall of the incident hours afterwards. The DON acknowledged the act was willful. The DON was unable to confirm or deny if the act was consensual based solely on the BIMS scores.</p> <p>The facility implemented multiple interventions in response to the incident which were validated onsite by the surveyor on [DATE] which are outlined as follows:</p> <p>On [DATE] at the time of the incident, Residents #1 and #2 were immediately separated. Resident #1 was placed on 1 to 1 supervision for monitoring as the incident was reported to Administration and an investigation was launched. Ad Hoc Quality Assurance (QA) of the incident by the DON and Administrator was performed as the investigation was initiated.</p> <p>On [DATE] the facility reported the incident to all authorities within 2 hours of occurrence as required by state and federal law.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] Care Plans for both residents were updated with orders to monitor proximity of both residents.</p> <p>On [DATE] the facility assessed all residents on the unit to ensure no impacts of the incident on others with no negative findings. No other residents were touched by Resident #1.</p> <p>On [DATE] Resident #2 was relocated to a different bed in a different room with family consent to move her from the bed previously occupied by Resident #1's paramour was recently deceased .</p> <p>On [DATE] the Psychiatric Provider performed an initial telehealth assessment of both residents with no new orders for Resident #2 and ordered Resident #1 maintained on 1 to 1 supervision until onsite evaluation could be performed the following day.</p> <p>On [DATE] the mental health provider and medical staff evaluated both residents in person. Neither resident recalled the incident. Neither resident exhibited negative impacts to physical or psychosocial health as a result of the incident. The mental health clinician determined there was no evidence of coercion or opposition to the acts reported as observed by staff by either resident and it was likely the acts were consensual. 1 to 1 supervision for Resident #1 was discontinued. Acute mental health referral for Resident #1 was ruled out by the mental health provider as medically unnecessary at that time as there was no evidence Resident #1 presented an imminent danger to self or others and was not in an acute psychiatric crisis. The mental health clinician recommended continued monitoring, redirection, and proximity management of both residents to prevent recurrences. The facility held additional QA of the incident with the Interdisciplinary team (IDT) and reviewed medication changes ordered for Resident #1 which included gradual dose reduction of antidepressant medications and increase in antipsychotic medication (Seroquel increased from 50mg once daily to 75mg administered in divided doses, 25mg in the morning and 50 mg at night). Staff education related to the facility abuse policy which had begun on the unit occupied by both residents, (D Wing) was expanded to include all facility staff.</p> <p>On [DATE] the mental health provider completed follow up assessments of both residents with no new negative findings. The mental health provider assessment was reviewed by administration and members of the IDT.</p> <p>Between [DATE] and [DATE] the facility performed re-education of all staff members on every unit to include non-clinical staff related to the facility abuse policies, definitions of abuse and abuse types and abuse reporting requirements. By [DATE] all staff currently scheduled or actively working were re-educated with 6 additional personnel to be educated identified.</p> <p>On [DATE] the mental health provider performed follow up visits with both residents which showed no evidence of changes in condition or needs for further interventions for either resident. The facility IDT team reviewed the findings during ongoing QA follow up of the incident.</p> <p>On [DATE] with consent of his family, the facility social worker documented that arrangements to transfer Resident #1 to a private room (401D) on the far end of the opposite wing from Resident #2 were arranged with the transfer date set for [DATE] when the room would become available.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] the facility completed education of all current active staff members and provided communications to 4 remaining employees scheduled to work that evening, education was required prior to taking assignments for their next scheduled shift.</p> <p>The surveyor validated facility interventions as follows:</p> <p>On [DATE] during the onsite investigation the surveyor conducted interviews with all personnel involved in the incident, the alleged victim and perpetrator and verified the incident occurred as reported to the SA. No evidence of psychosocial or physical harm to either resident was observed. Neither resident recalled the incident in interviews.</p> <p>On [DATE] the surveyor corroborated Resident #2's prior behavioral history with the responsible party and reported information contained in the FRI relevant to their feelings the act between their loved one and Resident #1 was likely due to confusion but was also likely consensual as reported.</p> <p>On [DATE] the surveyor reviewed care plans and observed both residents on the memory care wing. All interventions added to the care plan were in place and neither resident exhibited problematic behaviors.</p> <p>On [DATE] confirmed Resident #2 was relocated to a different bed on [DATE] as reported.</p> <p>On [DATE] the surveyor reviewed educational materials used to retrain staff, the facility abuse policy, and staff logs which documented staff member education was completed as reported. The surveyor interviewed 3 additional staff members in addition to those involved in the incident and verified all staff were knowledgeable of the facility abuse policy, definitions of abuse, reporting requirements, and the concept of capacity to consent with no negative findings.</p> <p>On [DATE] the surveyor interviewed 3 family representatives with attention to concerns for abuse or neglect, resident rights, resident protection, notification of changes in condition, administration, staffing, nursing services, access to clinical services, or unresolved grievances with no concerns identified. Resident interviews with 2 additional surveyed residents (Residents #4 and #5) showed no concerns.</p> <p>On [DATE] the surveyor reviewed updated staff re-education logs provided to the State Agency electronically, which showed all staff currently active at the facility had been re-educated as reported which included the remaining employees from the [DATE] employee education log. The facility also made communications to those who worked for contract agencies that were not scheduled, employed on an as needed (PRN) basis or were off work on vacation or on FMLA, which advised training would be necessary before resumption of duties had been sent per report of the facility leadership. The surveyor verified the incident had been forwarded to the facility Quality Assurance Committee for additional follow up review in February 2025 and the facility QA committee would make additional recommendations relevant to the incident if any were identified at that time.</p> <p>The facility was cited F-600 as past non-compliance and surveyor verified and validated the corrective actions on site on [DATE] and [DATE]. The facility is not required to submit a Plan of Correction.</p>		