| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445071 | A. Building<br>B. Wing | 11/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Claiborne Health and Rehabilitation Center | 1850 Old Knoxville Road<br>Tazewell, TN 37879 |

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) |
|---|---|
| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>(continued on next page) |

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 |
|---|---|---|
| | | |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, video surveillance footage review, facility documentation review, and interview, the facility failed to ensure residents were free from physical restraints for 1 resident (Resident #15) of 24 resident reviewed for restraints.The findings include:Review of the facility's policy titled, Restraint Free Environment, revised 1/2020, revealed .Each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience .A physical restraint is defined as any manual method or physical or mechanical device, material .attached or adjacent [next to] the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to .Tucking in a sheet tightly .so that a resident's freedom of movement is restricted .The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms . Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including Reduced Mobility, Adult Failure to Thrive, Dementia, and Anxiety.Review of a comprehensive care plan for Resident #15 dated 4/12/2023, revealed .Alert and confused resident often resists participation in activities .need assistance to be up, dressed, and escorted to and from activities in appropriate chair .Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #15 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Continued review revealed Resident #15 was dependent on staff for personal hygiene and required substantial/maximal assistance with bed mobility and transfers. Further review revealed no documentation the resident had restraints during the 7 day look back period.Review of video surveillance footage dated 3/31/2025 revealed the following:10:19 AM (44 seconds) - Resident #15 was sitting in a geri-chair with her back to nurses' station and facing the day room. Resident #15's legs were loosely covered with a dark colored blanket.10:22 AM (03 seconds) - The alleged perpetrator (AP) Certified Nursing Assistant (CNA) A entered the nurse's station.10:22 AM (46 seconds) - Resident #15's legs remained covered with a dark colored blanket. The resident was restlessly moving her head, hands, and feet.10:27 AM (34 seconds) - CNA A (AP) adjusted the pillow behind the resident's head and obtained vital signs. Resident #15 continued to restlessly move her head, hands, and feet.10:34 AM (35 seconds)-11:00 AM - Resident #15 threw her pillow in the floor multiple times. The resident remained covered with a colored blanket. Resident #15 continued to restlessly move her head, hands, and feet.11:01 AM (37 seconds) - CNA A (AP) approached Resident #15 and secured the pillow behind the resident's head to the geri-chair with a sheet.11:06 AM (52 seconds) - CNA A (AP) approached Resident #15 and removed the dark colored blanket which was covering the resident's legs. CNA A folded a sheet and proceeded to wrap the sheet around Resident #15's lower legs (knees to ankles) twice, then covered the resident's legs and feet with the dark colored blanket. CNA A tucked each side of the blanket under the resident's legs.11:09 AM-11:40 AM - Resident #15's legs remained covered with the dark colored blanket. The resident continued to restlessly move her head, hands, and feet. An unknown CNA placed a second blanket over Resident #15's legs at 11:40 AM.11:47 AM - Resident #15's toes were visible. The resident continued to restlessly move her feet.12:19 PM (04 seconds) - Video ended. Resident #15 remained in the geri-chair with her legs covered with a blanket. The resident continued to restlessly move her feet when the video ended. It was unknown how long the sheet remained wrapped around Resident #15's lower legs.Review of an Order Summary Report for 1/1/2025-11/30/2025 for Resident #15 revealed no orders for use of restraints.Review of a written witness statement for Registered Nurse (RN) E dated 4/2/2025 revealed .Today we were discussing how a particular resident [Resident #15] was fidgeting/restless. [CNA A] then stated that on either Monday [3/31/2025] or Tuesday [4/1/2025] she took a sheet and tied this resident [Resident #15] legs to her geri-chair and then covered her legs with a sheet . Review of a written witness statement for Licensed Practical Nurse (LPN) D dated 4/2/2025, revealed .On 4/2/25 overheard [CNA A] discussing [Resident #15] about her always being fidgety and about tying her legs down to the chair to prevent her from slinging them out of chair an [and] possible falling out of chair .Review of a written witness statement for CNA B dated 4/2/2025, revealed .We were talking about [Resident #15] moving all the time. [CNA A] said 'well I tied her [Resident #15's] feet down to the chair and covered them up with a sheet. That way she couldn't move around'. Review of facility documentation of an interview with CNA |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility investigation, observation, and interviews, the facility staff failed to ensure an allegation of sexual abuse was reported within 2 hours as required for 1 resident (Resident #83) of 3 residents reviewed for abuse. The findings include: Review of the undated facility policy titled Abuse, Neglect, and Exploitation revealed, .Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes .Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .Review of the medical record revealed Resident #83 was admitted to the facility on [DATE] with diagnoses including Dementia, Heart Failure, and Mixed Receptive Expressive Language Disorder. Review of the discharge Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #83 scored a 6 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment.Review of a Grievance Decision Report dated 11/12/2025, revealed .Reportedly on 11/01/2025-11/02/2025 .Officer [named officer] called [Social Worker-SW] on 11/12/2025 and advised that an allegation had been made to police department concerning [Resident #83]. The allegation was that [Resident #83] was allegedly sexually abused while in our facility by a male .Review of the facility investigation revealed .on 11/12/2025 at 4:15 PM, Social Worker .was notified by the [Local] police department that a report had been filed with APS [Adult Protective Services] by the resident's daughter .The police department relayed that a report had been filed .alleging that [Resident #83] was sexually assaulted prior to her discharge on [DATE] [11/3/2025] .An investigation was immediately initiated . During the investigation a delay in reporting was identified .The review of interviews with facility staff and leadership identified that the facility staff had prior knowledge of the daughter's reported concern with the first identified information being known on 11/3/2025 .The investigation revealed there was a failure to report this timely .Review of a statement dated 11/17/2025, revealed .FNP [Family Nurse Practitioner] stated she was informed on 11/3/2025 that the family wanted to discharge .[Social Worker] told me [FNP], 'The family said the patient told them that someone put something inside her vagina' .They [Family] didn't think that it [sexual assault] happened. 'It was in her mind and real to her' . Continued review of the FNP statement revealed the FNP did not report the allegation of sexual abuse.During an interview on 11/19/2025 at 8:45 AM, Certified Nurse Assistant (CNA) G stated on 11/1/2025 or 11/2/2025, Resident #83's daughter had stopped her while she was finishing up with her shift and stated her mother said she had a vaginal exam and was wondering if that was true. CNA G stopped what she was doing and went and informed her nurse RN H since there was no management in the building to report to. CNA G stated she did not hear anything else about it until a couple weeks later when she was being questioned by management. CNA G further stated she did not notify anyone else of the alleged allegations. During an interview on 11/19/2025 at 9:33 AM, Registered Nurse (RN) H stated on 11/1/2025 or 11/2/2025, CNA G informed her at the nurse's station around end of shift that Resident #83's daughter was asking if her mom had a vaginal exam. RN H went and talked to the daughter who stated she thought her mom had a bad dream and was confused but just wanted to make sure. RN H further stated she thought CNA G notified the Director of Nursing (DON) of the allegation. RN H stated she did not hear anything else about incident until a couple weeks later.During an interview on 11/20/2025 at 8:30 AM, SW stated she became aware of the allegations on 11/3/2025, when Resident #83's daughter came to her office to discuss Resident #83's discharge stating they wanted the resident discharged that day. The SW stated she asked if she could wait until the next day and the resident's daughter stated, .no, because momma thinks someone sexually touched her .momma thinks it real, and we just want to take her home . The SW confirmed she did not notify administration of the allegation because the family blew it off and the resident's daughter stated she did not want to file a complaint. The SW stated she became aware an allegation of sexual assault against Resident #83 had been reported to the local police department. It was at this time the SW notified the Administrator. During an interview on 11/20/2025 at 9:07 AM, the RN MDS Coordinator stated on 11/3/2025, Resident #83's daughters came into the MDS and SW office stating they wanted to take their mother home because she thought someone had touched her inappropriately while she was sleeping. The resident's daughters stated the resident was scared and they want to take her home. RN MDS Coordinator further stated family said she might have been dreaming. RN MDS Coordinator stated at some point the Assistant Director of Nursing (ADON) came into the office and was informed of the dream |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to investigate an allegation of abuse timely for 1 resident (Resident #83) of 3 reviewed for abuse.The findings include:Review of the facility's policy titled, Abuse, Neglect, and Exploitation. Revised 2/2023, revealed .Investigation of Alleged Abuse, Neglect, and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for investigations. 2. Exercising caution in handling evidence that could be used in a criminal investigation. 3. Investigating different types of alleged violations. 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause. 6. Providing complete and thorough documentation of the investigation. Review of the medical record revealed Resident #83 was admitted to the facility on [DATE] with diagnoses including Dementia, Heart Failure, and Mixed Receptive Expressive Language Disorder. Review of the discharge Minimum Data Set assessment dated [DATE], revealed Resident #83 scored a 6 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment.Review of a facility investigation summary revealed on 11/12/2025 the Administrator (ADM) was notified of alleged allegations, and an investigation was initiated. Immediate investigation began including interviews with all relevant staff members and review of available video recordings during the identified time frame. This investigation and the associated interviews included both facility and healthcare system leadership, to ensure a complete and unbiased review. During the investigation a delay in reporting was identified. The review of interviews with facility staff and leadership identified that the facility staff had prior knowledge of the daughters reported concern with the first identified information being known on 11/3/2025. The facility investigation for allegation of sexual abuse did not begin until 11/12/2025. Review of a Grievance Decision Report dated 11/12/2025, revealed .Reportedly on 11/01/2025-11/02/2025 .Officer [named officer] called [Social Worker-SW] on 11/12/2025 and advised that an allegation had been made to police department concerning [Resident #83]. 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