STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445098	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Knoxville	809 East Emerald Ave Knoxville, TN 37917

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30647 Based on review of facility policy, medical record review, review of facility investigations, observations and interviews, the facility failed to ensure 4 residents (Residents #1, #7, #9, and #3) were free from physical abuse during 4 separate resident versus resident altercations of 23 sampled residents. The findings include: Review of the Administrative Procedures Manual, Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, dated [DATE], revealed .Abuse: the willful infliction of injury .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Physical Abuse: includes hitting, slapping, pinching and kicking . 1. Review of the medical records and facility investigation documentation revealed a resident-versus-resident altercation occurred between Resident #1 and Resident #2 on [DATE]. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Hypertensive Disease, Cellulitis of Left Lower Limb, Adult Failure to Thrive, Chronic Pain Syndrome, Anxiety and Delusional Disorders. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident was cognitively intact. Review of the Nursing Progress Notes for Resident #1 dated [DATE] at 5:05 PM, revealed .Resident [#1] yelling let go of my hair staff [Certified Nursing Assistant-CNA R] witnessed another resident [Resident #2] pulling her [Resident #1's] hair, and immediately separated residents [Resident #1 and Resident #2]. NP [Nurse Practitioner], Psych [psychiatric] provider, Administration [Director of Nursing-DON], SS [Social Services], and family [of Resident #1] made aware. Resident [#1] assessed with no injuries noted. Resident [#1] stated 'my head hurts.' Tylenol offered per order and accepted. Resident [#1] provided a safe calm environment . (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Progress Notes for Resident #1 dated [DATE] at 5:49 PM, revealed .Resident [#1] alert and verbal. Denies pain or discomfort at this time, resident [#1] states 'I'm fine, its [it's] not a big deal, she [Resident #2] dont [don't] know what shes [she's] [Resident #2] doing.' Resident [#1] has no changes in range of motion to head neck or upper body at this time. Will continue to observe for changes and provide a safe calm environment . Review of the Nursing Progress Notes for Resident #1 dated [DATE] at 1:41 AM, revealed .Resident [#1] resting on bed .No signs of injuries noted from recent incident. No complaints of pain . Review of the Nursing Progress Notes for Resident #1 dated [DATE] at 9:30 AM, revealed .moves extremities per usual with minimal discomfort noted to left side of neck. Resident cheerful and pleasant . Review of the Social Services Progress Note for Resident #1 dated [DATE] at 10:24 AM, revealed the resident reported she was okay. Resident #1 verbalized she was not afraid of Resident #2. Review of the Physician Progress Notes for Resident #1 dated [DATE] at 11:27 AM, revealed .regulatory visit today, and also to follow-up on a patient incident that happened yesterday evening .Yesterday evening another patient [Resident #2] with known Dementia became agitated and pulled her [Resident #1's] hair . A cervical spine x-ray was ordered and revealed .Degenerative changes are identified. Postsurgical .hardware seen .cervical spine. No fracture dislocation or bony destructive lesions [abnormality in bone tissue] are identified . Review of the Nursing Progress Notes for Resident #1 dated [DATE] at 3:04 PM, revealed .Resident sitting up in dining room participating in activities. No c/o pain or discomfort .pleasant and interacting with other resident . Review of the Nursing Progress Notes for Resident #1 dated [DATE] at 8:15 PM, revealed the resident denied pain and discomfort . Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Severe Dementia with Anxiety, Senile Degeneration of Brain and Delusional Disorder. The resident expired on [DATE]. Review of a quarterly MDS assessment dated [DATE], revealed Resident #2 scored 99 on the BIMS assessment, indicating severe cognitive impairment. The resident experienced hallucinations and exhibited behaviors not directed toward others (hitting or scratching self or verbal/vocal symptoms like screaming, disruptive) during the assessment period. Review of the Nursing Progress Notes for Resident #2 dated [DATE] at 4:57 PM, revealed .Resident [#2] noted to have pulled another resident's [#1] hair as seen by staff [CNA R], and hearing the other resident [Resident #1] say 'let go of my hair.' Residents [Resident #1 and Resident #2] immediately separated. Administration [DON], SS, Psych provider, and NP made aware. [Resident #1's] Family and hospice also made aware. Resident [#1] will be moved to 3rd floor . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a comprehensive care plan for Resident #2 dated [DATE], revealed .Behaviors .false beliefs . yelling .worry about babies .pulling other resident's hair .room change to third floor .Provide patient with calm environment and remove from high traffic areas during periods of anxiety and agitation. Provide one on one care as needed .provide 1:1 as needed when resident may have aggressive episodes towards others . Review of the witness statement by CNA R dated [DATE], revealed .[Resident #1] yelling for help [on 200 hall] [Resident #2] had her hands in [Resident #1's] hair. Had to physically open [Resident #2's] hands to remove [Resident #1's] hair. Brought [Resident #2] back to her room. [Resident #2] Been one on one since . Review of the Physician Progress Notes for Resident #2 dated [DATE] at 11:08 AM, revealed .Patient [Resident #2] seen today due to an incident that happened yesterday evening. Evidently, she became agitated while being weighed and then reached out and grabbed another resident's [Resident #1] hair and pulled it .Today I find her [Resident #2] in bed relaxed with her eyes closed . During an observation and interview on [DATE] at 8:55 AM, Resident #1 stated Resident #2 had pulled her hair during activities 7 or 8 months ago. The resident did not voice concerns of pain or discomfort following the incident with Resident #2. Resident #1 stated the facility investigated the incident, she felt safe, and was not afraid of anyone in the facility. 2. Review of a facility investigation dated [DATE], revealed a resident versus resident altercation occurred between Resident #7 and Resident #8. Review of a facility investigation dated [DATE], revealed Resident #8 was seated in her wheelchair and was observed patting Resident #7's hand, also seated in a wheelchair. Resident #7 moved Resident #8's hand at which time Resident #8 hit Resident #7 in the face. The residents were immediately separated. The MD/NP (Medical Doctor/Nurse Practitioner), families, Ombudsman, police, and state agency were notified. The residents were assessed for injury with none noted. Residents with a BIMS score greater than 8 were interviewed for abuse, residents with a BIMS score less than 8 received skin assessments. Staff who provided care for the residents were also interviewed to determine if the residents had exhibited behaviors prior to the altercation, no concerns were identified. Resident #7 expired in the facility on [DATE], Resident #8 expired in the facility on [DATE]. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease and Dementia with Anxiety. Review of the annual MDS assessment dated [DATE], revealed Resident #7 scored 1 on the BIMS assessment, which indicated the resident had severe cognitive impairment. Review of the comprehensive care plan revealed the facility identified Resident #7 was at risk for behaviors with interventions and monitoring implemented. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus Type 2, Chronic Kidney Disease and Vascular Dementia with Anxiety. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS dated [DATE] revealed Resident #8 scored 6 on the BIMS assessment, indicating the resident had significant cognitive impairment. Continued review revealed the resident had delusions (beliefs that are firmly held, contrary to reality) and verbal behavior symptoms directed toward others. Review of the comprehensive care plan revealed the facility had identified Resident #8 was at risk for behaviors .hitting others . During an interview on [DATE] at 12:50 PM, with Licensed Practical Nurse (LPN C) she confirmed she had assessed Resident #7 and #8 for injuries with none noted, and Resident #8 was immediately relocated to a different room. During a telephone interview on [DATE] at 9:00 AM, CNA L confirmed he witnessed the altercation. The CNA stated .it appeared as if [Resident #8] swiped something off of [Resident #7's] face, it was not a smack . 3. Review of a facility investigation dated [DATE], revealed a resident versus resident altercation occurred between Resident #9 and Resident #10. Resident #10 entered Resident #9's room and confronted him about his (Resident #9) behavior of cursing facility employees. A CNA heard Resident #9 and Resident #10 exchange words and alerted the nurse. The residents were immediately separated and assessed for injury, with none noted. Resident #9 reported Resident #10 hit him on the leg. The Administrator, DON, MD/NP, families, state agency, police, and Ombudsman were notified. Residents with a BIMS score 8 or greater were interviewed for abuse. Residents with a BIMS score less than 8 received skin assessments. Staff who provided care for the residents, were also interviewed to determine if the residents had exhibited behaviors prior to the altercation, with no concerns identified. Resident #9 and Resident #10 remained in the facility at the time of the complaint survey conducted on [DATE]-[DATE]. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE], with diagnoses including Unspecified Mood Disorder, Chronic Obstructive Pulmonary Disease, Congestive Heart Disease and Unspecified Hearing Loss. Review of the annual MDS dated [DATE], revealed Resident #9 scored 15 on the BIMS assessment, which indicated the resident was cognitively intact. Review of the comprehensive care plan revealed Resident #9 had a history of verbal/manipulative behaviors with interventions and monitoring implemented. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE], with diagnoses including Bipolar Disorder, Diabetes Mellitus, Acquired Absence of Right Leg Below Knee, Acquired Absence of Left Leg Below Knee, Low Vision to Right Eye and Blindness to Left Eye. Review of the annual MDS assessment dated [DATE], revealed Resident #10 scored 15 on the BIMs assessment, which indicated the resident was cognitively intact. Review of the comprehensive care plan revealed the facility identified Resident #10 was at risk for verbal and physical behaviors with interventions and monitoring implemented. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:50 AM, Resident #9 stated Resident #10 entered his room ([DATE]) and . just started in on me . and hit his leg. During an interview on [DATE] at 9:20 AM, Resident #10 confirmed he had confronted Resident #9 about his recent cursing at the staff. Continued interview revealed Resident #10 reported Resident #9 became angry when confronted. Resident #10 reported Resident #9 then reached for his grabber (a assistive device to extend reach) that was lying on the bed beside his leg. Resident #10 stated he then hit Resident #9 on his leg with an open hand. 4. Review of the medical records and facility investigation documentation dated [DATE], revealed a resident versus-resident altercation occurred between Resident #3 and Resident #4. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses including Anemia, Chronic Obstructive Pulmonary Disease and Dementia with Mood Disturbance. Review of an annual MDS assessment dated [DATE], revealed Resident #3 scored 6 on the BIMS assessment, indicating severe cognitive impairment. Review of the Social Services Progress Notes for Resident #3 dated [DATE] at 3:36 PM, revealed .[Resident #3] understands that the other patient [Resident #4] was confused. She [Resident #3] denies feeling scared and states she's not injured or hurt .Trauma Screen completed and [Resident #3] denies trauma from interaction. [Resident #3] states she is fine . Review of the Nursing Progress Notes for Resident #3 dated [DATE] and [DATE], revealed no signs of bruising or injury. The resident denied pain or discomfort. Review of the Psychiatric Diagnostic Evaluation Notes for Resident #3 dated [DATE], revealed .[Resident #3] was recently involved in an altercation with another resident [Resident #4]. [Resident #3] says she is doing 'just fine . She denies any pain, distress, or fear. She says understands .'people get confused around here' . Staff reports no specific concerns regarding behaviors or issues .Recommendations: Continue to monitor and offer supportive care. Continue current treatment plan and medications. No adverse effects or distress/fear from recent patient altercation noted or reported . Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including Atrial Fibrillation, Anxiety, Depression and Severe Dementia with Mood Disturbance. Review of a quarterly MDS assessment dated [DATE], revealed Resident #4 scored 3 on the BIMS assessment, indicating severe cognitive impairment. The resident had not exhibited behaviors or aggression toward others during the assessment period. Review of the Nursing Progress Notes for Resident #4 dated [DATE] at 3:01 PM, revealed .resident [#4] was removed from activities today because she continued to yell. she then removed a wheelchair from behind another resident [#3] when she stood up almost causing her [Resident #3] to fall. then, she begin to hit another resident [#3] .activity staff removed her [Resident #4] from the activity and brought her back to west station where she continues to yell, verbally abuse staff, and ask for us to let her leave this place . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Progress Notes for Resident #4 dated [DATE] at 3:10 PM, revealed the resident was moved to the 3rd floor. Review of the Social Services Progress Notes for Resident #4 dated [DATE] at 3:53 PM, revealed .Social worker spoke with [Resident #4] regarding patient interaction. [Resident #4] stated she would never hit anyone and does not remember doing so . Review of a comprehensive care plan for Resident #4 dated [DATE], revealed .Psychosocial Well-Being .at risk for complication related to psychosocial well being related to patient to patient interaction .Encourage choices and allow control over daily routine .Encourage to express feelings of .anger . Review of the Psychiatric Follow Up Notes for Resident #4 dated [DATE], revealed .[Resident #4] recently had a physical altercation with another resident [Resident #3]. [Resident #4] is very confused and unable to tell me anything about it. She tells me that she needs to go home. She denies any pain or injuries. No distress noted or reported . Review of the facility's investigation dated [DATE], revealed .During a cornhole activity a patient [Resident #4] hit .[Resident #3] when she [Resident #3] sat down in her rolling walker . Resident #3 and Resident #4 were separated and placed on different floors to avoid contact. A skin assessment was performed for Resident #3 with no injuries noted. Resident #4 was interviewed and denied feeling scared and stated she was not injured. Resident #3 was interviewed and stated she would never hurt anyone and did not remember hitting Resident #4. Continued review revealed Resident #4 had been a resident at the facility since [DATE], and had no indication of aggressive behaviors toward other residents. Further review revealed .The incident was verified through interviews and witnesses. No indication of harm to victim [Resident #3] physically or psychologically . Continued review of the facility investigaiton revealed The MD/NP (Medical Doctor/Nurse Practitioner), families, Ombudsman, police, and state agency were notified of the altercation. Review of Resident #3's statement dated [DATE], revealed .Social worker spoke with [Resident #3] regarding her patient-to-patient altercation. [Resident #3] stated she was finishing her turn at cornhole, and the other patient [Resident #4] grabbed her rollator [walker equipped with a seat] from her. [Resident #3] said when she got her rollator back, she sat down, and [Resident #4] softly hit her on her head. [Resident #3] states she tried to remove herself from the situation. [Resident #3] states she knows [Resident #4] gets confused sometimes .[Resident #3] denies injury, states she is not fearful and reports being okay . Review of Resident #4's statement dated [DATE], revealed .Social worker spoke with [Resident #4] regarding patient-to-patient altercation in activities. [Resident #4] denies any altercation. [Resident #4] stated she would never hit anyone. [Resident #4] Denies any distress, and fully denies any event. Reports that she [Resident #4] doesn't even remember going to activities today . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:51 PM, the Activities Director stated Resident #4 was sitting behind Resident #3 during a cornhole activity. The Activities Director stated Resident #4 pulled Resident #3's rollator walker as she (Resident #3) went to sit down on the walker. Resident #4 started striking Resident #3 in the back of her head. Further interview revealed Resident #4 struck Resident #3 with her forearm. The residents were immediately separated. The Activities Director reported she took Resident #4 back to her room and reported the incident to the resident's nurse. The Activities Director stated Resident #3 thought it was minor and continued with activities. The Activities Director stated Resident #4 was relocated to the 3rd floor. During an interview on [DATE] at 9:47 AM, the DON acknowledged when physical contact was made during resident versus resident altercations, the facility was required to report the altercations as allegations of abuse.