STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445131	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beverly Park Place Health and Rehab	5321 Beverly Park Circle Knoxville, TN 37918

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** 40606 Based on facility policy review, facility investigation documentation review, observation, and interview the facility failed to protect 1 Resident (Resident #13) from physical abuse of 7 residents reviewed for abuse. The findings include: Review of the facility's policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, revised 9/2021, revealed .It is the policy of the facility to maintain an environment where residents are free from abuse, neglect, exploitation, and misappropriation of resident property .Abuse includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraints not required to treat the residents' medical symptoms .Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation . Medical record review revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including Dementia with Mood Disturbance, and Cognitive Communication Disorder. Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #13 had severe cognitive impairment. No behaviors noted. Review of a comprehensive care plan for Resident #13 dated 9/25/2023, revealed .has outbursts and name-calling directed at staff . Medical record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease, Dementia without Mood Disturbance, and Need for Assistance with Personal Care. Review of an annual MDS assessment dated [DATE], revealed Resident #14 had mild cognitive impairment. No behaviors noted. Review of a comprehensive care plan for Resident 14 dated 1/7/2024, revealed .History of Altercation with another resident, physical contact made, Date Initiated: 12/23/2023 .has the potential to be physically/verbally aggressive with others r/t [related to] cognitive impairments/Poor impulse control . (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 a Sheriff's Office report dated 12/23/2023 at 5:36 PM revealed .Prior to my arrival on scene dispatch advised .suspect [Resident #14] had been transported to [local hospital] for a mental status change and the victim [Resident #13] was still on scene .I spoke with another patient who was near by and she stated [Resident #13 and Resident #14] were in a verbal argument over sharing food .The witness stated the argument continued and [Resident #14] did in fact walk over to [Resident #13] and strike her once in the face causing a loud noise .[Resident #13] did not have any visible injuries .she refused medical treatment . Review of a Telephone Physicians' Order for Resident #14 dated 12/23/2023, revealed .1 on 1 sitter now . send to [local hospital] ER [emergency room] mental status changes . Review of a Nursing Progress Note for Resident #14 dated 12/23/2023, revealed .Allegation of physical aggression initiated, with residents separated, 1:1 sitter placed until resident sent to ER . Review of a Nursing Progress Note for Resident #13 dated 12/23/2023 at 7:24 PM, revealed .Allegation Physical aggression received. Immediate separation of residents, physical exam, notification of family and MD [Medical Doctor], Psych [Psychiatric] NP [Nurse Practitioner], LCSW [Licensed Clinical Social Worker] to increase visits . Review of a Nursing Progress Note for Resident #13 dated 12/23/2023 at 11:58 PM, revealed .Head to toe skin assessment .Denies pain. No redness or bruising to entire body. States she feel safe, and isn't afraid . Review of a Nursing Progress Note for Resident #14 dated 12/24/2023 at 2:56 AM, revealed .Room change . for better placement [upon return] . Review of a Nursing Progress Note for Resident #14 dated 12/24/2023 at 7:25 AM, revealed .Alert Note . Resident returned from the ER, no new orders noted. 1:1 sitter in place . Review of a Psychotherapy Progress Note for Resident #14 dated 12/27/2023, revealed .Pt presented with a stable mood .He discussed how he lashed out at another resident, over the weekend, stating she was cussing me, and I asked her to stop but she didn't and then I tapped her on her shoulder [shoulder], if I hurt her, please tell her I'm sorry. We discussed how it is inappropriate to touch anyone without their consent, especially hitting them for any reason, and how he can better handle his reactions in the future . Review of a Physicians' Progress Note for Resident #14 dated 12/27/2024, revealed .had altercation with another resident and struck her. He doesn't remember striking her but does recall [the] verbal assault . Review of a Nursing Progress Note for Resident #13 dated 1/1/2024, revealed .Alleged incident .Resident does not recall having an altercation with another resident. She reports that she feels safe .She does not appear to be in any acute distress. Residents were separated immediately. Continue current plan of care . (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 facility's investigation titled, Summary of Investigation, dated 1/3/2024, revealed .Brief summary of incident .Both residents in dining room. [Resident #13] was asking [Resident #14] for food. He [Resident #14] stated he did not have food and she continued to ask, he told her to shut up and asked if she wanted him to come over and smack her in the face. [Resident #14] went over to her and used the back of his hand and hit her in the face and returned to his table . Further review revealed .residents immediately separated .1 on 1 sitter placed with [Resident #14] .actions taken .[Resident #14 was sent to [the] ER for [a] mental status change .returned to [a] private room on a different unit with a 1 on 1 sitter .psych NP and medical to eval [evaluate] . During an interview on 7/15/2024 at 11:50 AM, Resident #13 was asked by the surveyor if anyone at the facility had ever done anything mean or hurtful to her, Resident #13 denied abuse and stated, .No .I'm doing ok .I'm fine . During an interview on 7/15/2024 at 11:55 AM, Resident #14 was asked by the surveyor about the allegation of physical abuse that allegedly occurred between himself and Resident #13 on 12/23/2023; Resident #14 stated .I don't think so .no .I don't believe I did [physically abuse Resident #13] . Resident #14's multiple accounts of the incident were inconsistent with investigation and witness statements of Resident #32 and Resident #33. Medical record review revealed Resident #32 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Subsequent Encounter for Closed Fracture with Routine Healing, Hypertensive Chronic Kidney Disease, and Need for Assistance with Personal Care. Review of a quarterly MDS assessment dated [DATE], revealed Resident #32 was cognitively intact. Medical record review revealed Resident #33 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Chronic Obstructive Pulmonary Disease, and Essential Tremor. Review of a quarterly MDS assessment dated [DATE], revealed Resident #33 was cognitively intact. During an interview on 7/15/2024 at 2:50 PM, Resident #32 stated she was present during the altercation on 12/23/2023 and heard both residents (Resident #13 and Resident #14) arguing. Further interview revealed Resident #32 had seen Resident #14 go over to Resident 13's table and hit her in the face with the back of his right hand. During an interview on 7/15/2024 at 3:05 PM, Resident #33 stated she was in the dining room when Resident #14 had struck Resident 13 in the face after a verbal argument. Resident #33 stated .she did not recall if [Resident #13] provoked him [Resident #14] or not, but he hit her . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/15/2024 at 3:10 PM, Licensed Practical Nurse (LPN) A stated she was the weekend supervisor when the allegation of physical abuse occurred on 12/23/2023. LPN A stated she responded to the incident promptly and the residents had already been separated by the staff (LPN A was unable to provide additional names). LPN A stated she interviewed Resident #14 and was told by him Resident #13 had .ran her mouth to where it was annoying .stated he [Resident #14] said to her [Resident #13] .Do you want to see what this [racial expletive] can do .Resident #13 dared him .and he [Resident #14] went over and hit [Resident #13] . LPN A stated there were 2 other residents' present [Resident #32 and Resident #33] who were eyewitnesses the incident. LPN A stated she had conducted interviews with the 2 other residents [Resident #32 and Resident #33] their recollection of the event was collaborated with the altercation. LPN A stated she assessed both residents [Resident #13 and Resident #14] and no injuries were observed to either resident. During an interview on 7/16/2024 at 9:29 AM, the Director of Nursing (DON) confirmed an act of physical abuse occurred on 12/23/2023. A verbal exchange resulted in physical contact when Resident #14 left his table, propelled over to Resident #13, and struck Resident #13 in the face with the back of his hand. The DON stated .he hit her .