STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445524	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brigadier General Wendell H Gilbert TN State Veter	250 Arrowood Drive Clarksville, TN 37042

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility camera footage recording review, police report review, and interview, the facility failed to ensure the residents' right to be free from sexual abuse for 2 of 3 (Resident #1 and Resident #2) sampled residents reviewed for abuse. The findings include: 1. Review of the facility policy titled, Abuse & [and] Neglect of Resident and Misappropriation of Residents' Property, dated 2/20/2013, revealed .In keeping with our facility philosophy to promote the total well-being of our residents through the provision of the highest quality of care with the goal of maintaining or enhancing each resident's functional level and quality of life, [Named facility] takes a firm stand on the issues of mistreatment, neglect, or abuse of residents and the misappropriation of resident's property. Each resident is to be treated at all times with courtesy and respect, and full recognition of the individual's dignity and individuality.Each resident has the right to be free from.sexual.abuse.Residents must not be subjected to abuse by anyone.'Sexual Abuse' includes but is not limited to sexual harassment, sexual coercion or sexual assault.Training will include .Prohibition and preventing all forms of abuse .Identifying what constitutes abuse .Recognizing signs of abuse . Residents that may be at increased risk: Confused residents .Behaviorally disturbed residents-aggressive, agitated .The facility will strive to identify, correct and intervene in situations in which abuse .is more likely to occur .In cases of resident-to-resident abuse, steps will be taken to prevent further interaction between the parties involved . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Traumatic Brain Injury (TBI), Depression, Hypertension, Phonological Disorder (a type of speech sound disorder where a person has difficulty organizing sound patterns in their brain), and Paranoid Schizophrenia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 99, which indicated Resident #1 was unable to complete the interview to assess his cognitive status and was severely cognitive impaired. Review of the Nurse's Note dated 11/23/2023, revealed .This nurse [Licensed Practical Nurse (LPN) C] was called to [named room number] where RDT [resident (Resident #1)] was found in .[Resident #2's] room having an inappropriate interaction with female resident in her room. This nurse had RDT [Resident #1] leave room & return to his assigned room. 3. Review of medical records revealed Resident #2 was admitted to the facility on [DATE], with diagnoses including Traumatic Brain Injury, Major Depressive Disorder and Dementia. Review of significant change MDS assessment dated [DATE], revealed a BIMS score of 12, which indicated Resident #2 was moderately cognitively impaired. Review of the Social Service Director (SSD) Progress Notes date 9/15/2023, revealed a BIMS score of 12, which indicated Resident #2 was moderately cognitively impaired. Review of the Care Plan dated 9/28/2023, revealed an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] impaired cognition r/t Traumatic Brain Injury [TBI] in 2017.at risk for potential unwanted side effects from daily use os [of] psychotropic medication for diagnosis of anxiety disorder.have mild cognitive deficits as related to my diagnosis of dementia. I have short term memory loss and may need help at times with decision making. Review of the Nurses' Notes dated 11/23/2023, revealed .This nurse was called to [Numbered room for Resident #1] where RDT [Resident #2] was found in a female resident's [Resident #1] room having an inappropriate interaction with female resident in her room. This nurse had RDT leave room & return to his assigned room where he stayed the remainder of this shift. House Supervisor on duty in facility notified. RDT placed on immediate 1:1 observation. Review of the Nurses' Notes dated 11/24/2023, revealed .IDT [interdisciplinary team] recommends 1:1 [one on one] close observation [of Resident #2], room change, and psych referral. Review of the Nurses' Notes dated 11/24/2023, revealed .Report received of inappropriate contact with another resident [#1]. Resident [#2] had been placed on close contact 1:1 [one on one] observation, immediately. Both residents have been monitored in separate locations. SSD, DON [Director of Nursing] and Administrator have been informed. Review of the Nurses' Notes dated 11/24/2023, revealed .Social Services.Resident [#2] was sitting in his room alongside a CNA [certified nursing assistant], prior to SSD speaking to the resident about recent behaviors. Attempt was made to gather information about what transpired, but resident [#2] appeared to not comprehend what was being said/asked. SSD utilized whiteboard near resident [#2]'s bed to communicate message, but this too appeared ineffective as resident [#2] did not respond appropriately to questions asked. SSD spoke to the other resident [Resident #1] , and she stated feel safe, adding, He came in my room, but the CNA came in fast. He doesn't know what he's doing. Asked if she was harmed, she