



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

To: Assistant Inspector General for Healthcare Inspections
From: Bay Pines Regional Director for Healthcare Inspections
Subject: Quality of Care Issues at the Knoxville VA Outpatient Clinic,
Knoxville, Tennessee, MCI# 2012-00027-HI-0301

The Office of Inspector General Office of Healthcare Inspections (OHI) received allegations regarding the care of a patient at the William C. Tallent VA Outpatient Clinic Knoxville, Tennessee.

The complainant alleged that:

- The facility failed to provide timely evaluations, appropriate treatment, and follow up care after knee surgery.
- Clinicians failed to diagnose and treat the patient's knee infection in a timely manner.
- The patient's repeated complaints of pain and distress were ignored.
- The patient lost his leg due to physician negligence.
- A clinician broke privacy laws when he discussed the patient's medical condition in front of other patients.

We contacted the CBOC's parent facility (James H. Quillen VA Medical Center-Mountain Home, Tennessee) on November 7, 2011 and were told by the Chief of Quality Management that both the patient and his wife have filed tort claims related to the patient's VA care. Therefore, in view of the pending legal action, we will not conduct a formal inspection and recommend that this case be administratively closed

I concur with recommendation for administrative closure of this inspection.

A handwritten signature in dark ink, appearing to read "John D. Daigh, Jr., M.D.", written over the printed name.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

12/27/11