STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015463	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knollwood Healthcare	3151-A Knollwood Drive Mobile, AL 36693

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29671 Based on observations, interviews, record review and a facility policy titled Answering the Call light, the facility failed to accommodate the needs of Resident Identifier (RI) #'s 21, 26, 31 and 34 by failing to ensure the call light was accessible on three of six days of the survey. This affected RI #'s, 21, 26, 31 and 34, four of 34 sampled residents. This deficient practice was cited as a result of investigation of complaint/report number AL00046050. Findings Include: Review of a policy titled Answering the Call Light, revised September 2022, documented: . The purpose of this procedure is to ensure timely responses to the resident's requests and needs . 5. Ensure that the call light is accessible to the resident . RI #21 was readmitted to the facility on [DATE] with diagnoses to include Weakness and Dysphagia. On 04/02/2024 at 7:05 PM during the initial tour of the facility the surveyor observed RI #21's call light out of reach. The call light cord was behind the bed on the wall and was not in reach. On 04/03/2024 at 4:49 PM the Surveyor and Maintenance Director (MTD) observed RI #21's call light cord by the wall out of RI #21's reach. The Maintenance Director was asked what he saw and said the call light was out of reach and further said the resident should have access to the call cord in case of an emergency. RI #26 was readmitted to the facility 09/19/2022 with diagnoses to include a history of falling. On 04/02/2024 at 7:39 PM during the initial tour of the facility the surveyor observed RI #26 sitting in his/her recliner. The call light cord was behind the resident and out of his/her reach. On 04/03/2024 at 4:59 PM the surveyor and Maintenance Director observed RI #26's call light cord behind his/her recliner. The Maintenance Director was asked if the call light would be accessible from the recliner or the bed. The MTD said the call light cord was not long enough to reach if the resident was in bed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RI #31 was readmitted to the facility on [DATE] with diagnoses to include contracture of left hip. On 04/02/2024 at 7:38 PM the surveyor observed RI #31 lying in the bed. The resident's call light cord was behind the bed out of RI #31's reach. On 04/03/2024 at 12:08 PM the surveyor observed RI #31 lying in the bed. The resident's call light cord was behind the bed out of RI #31's reach. On 04/03/2024 at 4:55 PM, the surveyor and Maintenance Director observed RI #31's call light cord hanging on the wall out of reach. The Maintenance Director was asked what he saw, and he said the call light was out of reach and the risk of this would be something could happen to the resident. RI #34 was admitted to the facility on [DATE] with a diagnosis to include Muscle Weakness. On 04/04/2024 at 9:00 AM, The surveyor observed RI #34 lying in bed. The call light cord was not near the head of the bed. The call light was not in reach. An interview was conducted with the Director of Nursing (DON) on 04/04/2024 at 12:51 PM. During the interview, the DON was asked about the residents' ability to get assistance when their call light was out of reach. In response, the DON stated that if the call light was not within reach, the residents would be unable to call for help. Furthermore, the DON said that this would be a risk as the residents may have an emergency and not be able to use the call light. The DON said residents should have access to a working call light at all times. An interview was conducted with the Director of Nursing (DON) on 04/06/2024, at 11:10 AM. During the interview, the DON was asked if RI #34's call light should be within reach. The DON said that it should be, in order to ensure that the resident's needs are met. Additionally, the DON said that call lights should be accessible for all residents to meet their needs and guarantee they are receiving adequate care. The DON said that the potential negative consequence of call lights not being within reach would be the possibility of the resident's needs not being met.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on observations, interviews, and facility policies titled, Homelike Environment and Resident Rights the facility failed to ensure: 1) Baseboards on the 400 hall were not missing leaving white sheet rock with peeled paint exposed; 2) Ceiling tiles were not missing in the Physical Therapy (PT) room; 3) Scuffs and holes were not on the wall outside of the PT room; 4) Handrails around the 400 hall were not missing pieces on the corners and easily removable; 5) RI #19 and #27's room did not have electrical box hanging from the ceiling with excessive wire hanging out; 6) The linen room on the 400 unit was not missing a ceiling tile exposing the main drain line; 7) RI #21's room did not have a ceiling tile with brown color stain; 8) RI #26's room did not have cable wire loosely hanging from the ceiling. This deficient practice was cited as a result of investigation of complaint/report number AL00045036 Findings include: A review of the facility policy titled, Homelike Environment revealed: . Policy Interpretation and Implementation . 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. a. clean, sanitary and orderly environment; . On 04/03/2024 at 5:30 observations of the facility with the Maintenance Director (MTD) and simultaneous interviews were conducted with the MTD. 1) An observation was made on 04/03/2024 at 5:30 PM of the baseboards on the 400 unit with the MTD. The baseboards were missing, leaving white sheet rock and peeled paint. The MTD stated that the baseboards were not on the bottom of the walls because he had been fixing the floors and ran out of baseboards a couple of months ago. The MTD stated he was the only working on the baseboards at the time. The MTD stated the missing baseboards did not look good. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 04/03/2024 at 5:32 PM an observation of the physical therapy (PT) room was conducted with the MTD. The PT room was missing two ceiling tiles. The MTD stated the ceiling tiles probably fell back into the ceiling. The MTD stated that there should not be any missing ceiling tiles. The MTD stated it should not have been missing ceiling tiles because it looked terrible. 3) On 04/03/2024 at 5:35 PM an observation of the wall outside of the PT room was made was with the MTD. The wall had black scuff marks, and an open area in the corner by the vent. The MTD stated that the marks and the hole was from the food carts hitting the doors. The MTD stated the wall should not have had the scuff marks. 4) On 04/03/2034 at 5:39 PM, an observation was made with the MTD of the handrails around the 400 hall. The ends of the railing at the corners were pulled off and set on the railing leaving the ends uncovered. The MTD stated that the corners of the handrails pulled off. The MTD stated that a resident came by and pulled off the ends or corners of the hand railing. The MTD stated he had not had the time to fix the handrails. He stated that there was a risk for a resident getting hurt due to the missing ends of the handrails. 5) RI #19 was readmitted on [DATE]. RI #27 was admitted on [DATE]. An observation was made on 04/03/2024 at 11:50 AM of RI #19 and RI #27's room. A cable wire and electrical box was hanging from the ceiling unsecured and away from the wall and the wire went behind the television. An interview was conducted with the MTD on 04/03/2024 at 4:41 PM. The MTD stated the electrical box was hanging down from the ceiling by the cable wire because that was how they ran the cable. The MTD stated he did not know how long it had been like that. The MTD stated that he could add an adapter box to secure the electrical box in RI #19 and RI #27's room. 6) An observation was made on 04/03/2024 at 12:18 PM of the 400 unit linen room. The observation of the linen room revealed a missing a large ceiling tile with exposed white pipes, large brown stains and black irregular spots on what appeared to be damaged drywall. An observation of the 400 unit linen room and interview with the MTD was conducted on 04/03/2024 at 4:45 PM. The MTD stated the missing ceiling tile that was seen was the main drain line that he had removed a few months ago due to a clogged drain. The MTD stated it was not fixed because he had forgotten about that area. The MTD stated that the area should have been fixed. 7) RI #21 was admitted to the facility on [DATE]. An observation on 04/02/2024 at 7:05 PM was made of RI #21's room. A cable wire was observed coming from the ceiling to the floor and then back up to the television. A ceiling tile above the closet cabinet, had a brown stain. An observation of RI #21's room and interview with the MTD was conducted on 04/03/2024 at 4:49 PM. The MTD stated the wire that was hanging down from the ceiling to the television did not look appealing and was not secured. The MTD stated it should not be left in that way. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8) RI #26 was readmitted to the facility on [DATE]. An observation was made on 04/02/2024 at 7:40 PM of RI #26's room with the cable wire hanging freely from the ceiling and had extra length that was curled up behind the television on the dresser. An interview was conducted with the MTD on 04/03/2024 at 5:00 PM. The MTD stated that the wire that was hanging down from the ceiling in RI #26's room should have been secured and the excess removed.

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F 0600 Level of Harm - 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** 47408 Based on interviews, record review, review of a facility policy titled GHC Abuse Policy, review of the Facility Reported Incident(FRI) received by the Alabama State Survey Agency, and review of the facility's investigative file, the facility failed to protect the Resident Identifier (RI) #3's right to be free from verbal abuse by Certified Nursing Assistant (CNA) #16 and CNA #17. On 10/11/2023, at approximately 4:27 PM, RI #3's daughter was visiting and requested assistance from staff. RI #3's daughter left her cellphone on record in the room as CNA #16 and CNA #17 entered the room to provide care. After CNA #16 and CNA #17 finished providing care, the daughter returned to the room and stopped the recording. RI #3's daughter listened to the recording and heard both CNA's making multiple derogatory statements and threats of punishment toward RI #3. The daughter heard swearing and noises that sounded like the resident was being hit. RI #3's daughter stated she was so upset that she left the facility without reporting it to anyone. At approximately 5:40 PM RI #3's daughter returned to the facility and reported the incident to the Infection Control Nurse (ICN), Licensed Practical Nurse (LPN) #8. These deficient practices affected RI #3. This deficiency was cited as a result of the investigation of complaint/report number AL00045846 The survey team applied the Reasonable Person Concept in determining the psychosocial outcome related to the deficient practice. Findings include: The facility's policy titled GHC Abuse Policy dated 08/2022 revealed: Our residents have the right to be free from abuse . Policy Interpretation and Implementation Definitions To help with recognition of abuse, the following definitions of abuse are provided: 1. Abuse is defined as the willful infliction of injury . intimidation or punishment with resulting physical harm, pain or mental anguish . 2. Verbal Abuse is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. 5. Mental abuse is defined as, but not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Prevention . 11. Monitoring staff on all shifts to identify inappropriate behavior towards residents (e.g. using derogatory language, rough handling of residents .) . Response . 1. Our facility does not condone resident abuse by anyone including staff members . RI #3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Hemiplegia following Cerebral Infarction, Acute Respiratory Failure, and Vascular Dementia. RI #3's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/09/2023, indicated RI #3's Brief Interview Mental Status (BIMS) was 00, which indicated the resident was cognitively impaired. Section E of the MDS indicated RI #3 did not have any behaviors directed toward others. The Alabama Department of Public Health Online Incident Reporting System form, dated 10/11/2023, documented that CNA #16 and CNA #17 were in RI #3's room to provide care. RI #3's daughter recorded the conversation of the CNA's after she left the room. Both CNA's could be heard verbally abusing the resident. RI #3's daughter provided a copy of the recording on 04/25/2024 at 3:00 PM from RI #3's daughter, and the playback of the recording revealed: Voice one asking someone to step out so they could perform care on resident. Voice one said, .You got everything (CNA #17's name)? Voice two said, I was coming in here to change (his/her) shirt. Voice one said, (He/She) wants to show out. Voice two said, I don't want to do this shit. Voice one said, You know you don't want to do that, so don't even play like that. Voice two said, (He/She) done wet the bed .like what the fuck. Voice one said, He/She already know, he/she already know. Voice one screamed, Put your leg back in the bed! Voice one said, Can you put your leg back in the bed? .uh huh, now you want somebody to help . play with me, play with me, play with me, play with me, play with me. I want you to do it. I'm gonna call the police. You want me to call the police? . You want this brief off or not? . You done soaked this fucking bed up . play with me . crazy ass . crazy ass . you crazy . I'm crazy too . you can't even help yourself! . I don't play with (his/her) ass . I don't care . I don't play with (his/her) ass . they better give (him/her) (his/her) medicine or something . lay back so I can put this on you bruh. You can't do nothing for yourself and come up here act a fucking fool. Don't grab me, bruh don't grab me, grab me one more time, do it again! (laughter) . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Voice two said, Just flip (his/her) ass over . come here motherfucker .bitch . motherfucker . Voice one said, Can't do nothing for yourself, come on, uh huh, uh huh, uh huh, what you do, uh huh try it . police gonna kick (his/her) ass . that's why they gonna beat (his/her) ass in jail. Resident's voice said, It's all wrong. Voice one said, It's all wrong. Voice two said, Look at this shit . it's the last time I'm coming in here today. Voice two said, Turn (his/her) ass over . fuck you . Voice two said, Let's just sell him/her to sex traffickers . crazy ass. Voice one said, I'm gonna call the police . done scratched my motherfucking hand up, I'm fixing to report your ass. Voice two said, Your the lying king, lying. Voice one said, Fuck (him/her), (he/she) don't mean shit . (he/she) scratched the fuck out of me . (he/she) don't want the shirt on fuck it . The facility's Investigative Summary dated 10/13/2023 and signed by Former Administrator (FA) #2, documented, . (RI #3) . who resides in (named room) at (name of facility) is A&O x2, has limited speech and has a BIMS of 0 . is being seen by . hospice . (RI #3's daughter) requested assistance from (CNA #17) to provide care to . (RI #3). (RI #3's daughter's) cellphone was left in the room and on record while (CNA #17) and another CNA (CNA #16) were in the room providing care to the resident. When (CNA #17) and (CNA #16) were finished with providing care, (RI #3's daughter) returned to the room and turned on the recording . heard both (CNA #17) and (CNA #16) making derogatory comments toward resident. Threatening comments were made and . noises that sounded like resident being hit. (RI #3's daughter) played the recording to this writer (FA #2). Most of the recording was audible and based on what was said by (CNA #16) and (CNA #17) it was substantiated that the resident was verbally and mentally abused by both (CNA #16 and CNA #17). This writer heard what sounded like slaps; someone hitting another person and heard one of the CNAs say, Don't hit him bitch . turn over after this it sounded as though someone was hit. The resident could be heard telling the CNA(s) . get away from me, to which one of the CNA's responded, Fuck you, I'm going to call the police and have you arrested. (He/She) done scratched my damn hand. Fuck it. Today (10/13/2023) the resident was found to have swelling in his right hand . This writer cannot say if the swelling was due to the incident with the CNA's though the swelling was not noted before the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Other comments made to the resident included the CNA's yelling at resident telling (him/her) to put his/her leg back in the bed. Don't play with me. (He/She) already know. (He/She) just wants to show out. I'm going to call the police. Where you tryin' to go? Want me to call the police? Ain't nobody going to play with you, Acting a fucking fool. I'm about to punch the fuck out of (him/her). I'll kill your ass; bitch mother fucker . (CNA #16) and (CNA #17) were interviewed . They denied the allegations. (CNA #16) admitted hearing (CNA #17 curse the resident . (CNA #17) denied the allegation, but state the resident called her a bitch, so she said called (him/her) a bitch back. During an interview on 04/04/2024 at 9:22 AM, Infection Control Nurse, Licensed Practical Nurse (LPN) #8 stated she was working a double shift on 10/11/2023, and a family member brought a recording that was on her phone of CNA #16 and CNA #17 providing care for their family member and being verbally abusive. LPN #8 stated that she listened to about thirty seconds of the recording, and it was so bad she stopped listening to the recording. She stated that she immediately reported the abuse to the Administrator (Former Administrator #2). On 04/04/2024 at 1:40 PM and interview was conducted with FA #2. The FA #2 said the family member recorded the CNAs changing RI #3. The FA #2 said CNA #17 was cursing and inappropriate. FA #2 said the other CNA was being aggressive. She said she substantiated the allegation by listening to the recording. On 04/25/2024 at 9:22 AM an interview was conducted with RI #3's daughter. RI #3's daughter stated it would have made RI #3 very upset and angry if he/she had not did not have decreased cognition because it was very disrespectful. An interview was conducted on 04/25/2024 at 11:20 AM with the Administrator. The Administrator said it could cause psychological or emotional distress to a reasonable person in a similar situation as the incident on 10/11/2023 involving RI #3 and CNA #16 and CNA #17. The Administrator said if there was cursing at resident it would be considered verbal abuse. An interview was conducted on 04/25/2024 at 11:35 AM with Social Services Director (SSD) in reference to 10/11/2023 incident. The SSD said a reasonable person in a similar would probably be afraid of any CNA that would take care of them. The SSD said that situation was verbal abuse. A follow-up interview was conducted with RI #3's daughter on 04/25/2024 at 3:00 PM. RI #3's daughter stated she heard the recording and that they talked very mean and ugly to him/her. RI #3's daughter stated she visited RI #3 one day prior to the incident and RI #3 told her that staff did not treat him/her right so she left her phone on record while staff provided care on 10/11/2023. On 04/24/2024 at 3:15 PM CNA #17 was called via telephone. The number was no longer in-service. On 04/24/2024 at 3:20 PM CNA #16 was contacted via telephone. A male answered and hung up when the surveyor requested to speak with CNA #16.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on interviews, record reviews, facility policy GHC Abuse Policy and review of an ADPH Online reporting form, the facility failed to ensure allegation of abuse was reported to the Alabama Department of Public Health (ADPH) within two hours on 10/11/2023 for Resident Identifier (RI) #3. On 10/11/2023 at 5:40 PM facility staff reported an allegation of verbal abuse for RI #3. The facility reported the allegation of verbal abuse at 8:24 PM on 10/11/2024 to ADPH. This failure affected one (RI #3) of fifteen sampled residents reviewed for abuse. This deficient practice was cited as a result of the investigation of complaint/report number AL00045846 and AL00047519. Cross-Reference F600 Findings included: A review of a facility's policy titled, GHC Abuse Policy, Updated 8-2022, revealed, . Reporting Serious Crimes- Elder Justice Act . 2. Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion . RI #3 was readmitted to the facility on [DATE] and readmitted on [DATE]. A review of the Alabama Department of Public Health Online Incident Reporting System revealed a Confirmation of Receipt of Online Incident Report, dated 10/11/2023, that indicated the facility submitted a report of alleged physical abuse to the state survey agency on 10/11/2023 at 8:24 PM. The report indicated the allegation was reported to the Administrator on 10/11/2023 at 5:50 PM. Licensed Practical Nurse (LPN) #8 indicated that on 10/11/2023 she listened to a recording that the family had made of Certified Nursing Assistant (CNA) #16 and CNA #17 verbally abusing resident. The report identified RI #3 as the affected resident. During an interview on 04/04/2024 at 9:22 AM, Infection Control Nurse, Licensed Practical Nurse (LPN) #8 stated she was working a double shift on 10/11/2023, and a family member brought a recording that was on her phone of CNA #16 and CNA #17 providing care for their family member and being verbally abusive. LPN #8 stated that she listened to about thirty seconds of the recording, and it was so bad she stopped listening to the recording. She stated that she immediately reported the abuse to the Administrator (Former Administrator #2). During a phone interview on 04/04/2024 at 1:40 PM with the previous the Former Administrator #2, former Abuse Coordinator, she stated that the abuse allegation should have been reported ADPH within two hours of the abuse allegation being reported.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41928 Based on interviews, medical record review, review of the facility's policies titled Wandering and Elopements, and Elopement Guideline and review of a facility document summarizing the facility's investigation into Resident Identifier (RI) #1's elopement, facility failed: 1) to supervise RI #1 after he/she stated he/she had a desire to leave and was given a one-time dose of Ativan, 2) to ensure all doors in the building were secure and closed properly to prevent residents leaving the facility without staff's knowledge, and 3) to ensure RI #1 was not left by a staff member in an unsafe environment. On 02/05/2023, RI #1 told the staff he/she wanted to leave the facility around 1:10 PM. RI #1 was given Ativan, a psychotropic medication, at 2:21 PM, then was not supervised nor observed. RI #1 left the facility through an unsecured door. RI #1 was seen by an off-duty staff member at approximately 3:30 PM on a busy two-lane road near the facility. The staff member did not stay with the resident to provide supervision and left RI #1 in an unsafe environment. RI #1 was not returned to the facility until another off-duty staff member returned him/her to the facility at approximately 4:10 PM. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (d) Free of Accident Hazards/Supervision/Devises at a scope and severity of J. On 04/06/2024 at 12:44 PM, the Director of Nursing (DON), Owner, and Regional Consultant (via phone) were provided a copy of the Immediate Jeopardy Template and notified of the findings of substandard quality of care at the Immediate Jeopardy level in the area of Quality of Care, at F689-Free of Accident Hazards/Supervision/Devices. The IJ began on 02/05/2023 and continued until 04/08/2024 when survey team verified onsite that corrective actions had been implemented. On 04/08/2024 the immediate jeopardy was removed, F689 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00043280. Findings include: A facility policy titled, Wandering and Elopements with an updated date of 07/06/2021, documented, Policy Statement (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knollwood Healthcare	3151-A Knollwood Drive Mobile, AL 36693

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Policy Interpretation and Implementation . 2. If an employee observes a resident leaving the premises, he/she should: . C. Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident is attempting to leave or has left the premises. A facility policy titled, Elopement Guideline dated of 07/06/2021, documented, Purpose Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. The facility's initial report titled Alabama Department of Public Health Online Incident Reporting System dated of 02/05/2023, documented, . Narrative summary of incident: (Certified Nursing Assistant (CNA) #11) alerted staff that (RI #1) eloped around 3:20 PM. An off duty nurse was driving to the facility and saw (RI #1) on the side of the road . She asked him/her to get in her car and he/she complied. She drove him/her to the facility. He/she told the staff that he/she saw someone go out the side door . and followed her out. He/she said he/she .was going to buy beer . Actions taken by the facility in response to the incident . Facility will be notifying the hospital in report that (RI #1) should stay at the hospital for an assessment to see if there is a medical reason for his/her agitation and some confusion noted . The facility's investigation documentation titled 5 Day Investigation Report dated 02/10/2023, documented, . It was reported on February 5, 2023, that (RI #1) had eloped from the facility . and was found . walking . (CNA #11) saw him/her when she was leaving the facility . She pulled over in an attempt to get him/her to go back to the facility with her but he/she kept refusing. She drove back to the facility and had front desk person call a code . An agency employee who was on her way to the facility . picked him/her up and brought him/her back to the facility. (RI #1) told the staff that he/she was watching staff go out the side door when he/she saw someone go out and noticed that the door wasn't shut so he/she pushed on the door and was able to get out. He/she told them he/she got his/her money ($30) Friday and was walking to get a beer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prior to this incident, (RI #1) had been exhibiting agitation and was wanting to get out of the facility. This behavior was noted around 1:15 PM the day of the incident. The DON and Medical Director were notified and orders to give him/her a one-time dose of 1 mg Lorazepam for the agitation stemming from Altered Mental Status was obtained along with an order to send out to hospital if the symptoms continued to worsen. Before they had a chance to discharge (him/her), the resident had already eloped. RI #1 has a BIMS (Brief Interview Mental Status) score of 12 . The agitation and insistence on leaving the facility by walking has not been (his/her) norm . RI #1 was admitted to the facility on [DATE] with diagnoses to include Cerebral Infraction and Altered Mental Status. RI #1's Minimum Data Set with an Assessment Reference date of 01/02/2023, documented RI #1 had a Brief Interview Mental Status (BIMS) score of 12 of 15, which means RI #1 was moderately cognitive impaired. Section G of the MDS indicated RI #1's walking ability with or without assistive device was not steady and he/she was only able to stabilize himself/herself with staff's assistance. RI #1's Progress Notes included a Behavior Note dated of 02/05/2024 at 1:15 PM that documented, . Resident is walking around the second floor yelling and screaming (he/she) is about to leave here, and (he/she) is calling the police and will jump out the window if (he/she) has to. The note further indicated the DON and MD were contacted and an order was received for one-time dose of Ativan (lorazepam). The note indicated to contact his/her family and also if his/her behavior continued to send him/her to hospital for evaluation. The note was electronically signed by Licensed Practical Nurse (LPN) #18. A review RI #1's Medication Administration Record for February 2023 indicated lorazepam 1 (one) milligram oral tablet was administered on 02/05/2023 at 2:21 PM. A telephone interview was conducted with CNA #11 on 04/03/2024 at 12:32 PM. CNA #11 stated on 02/05/2023, around 3:30 PM, after leaving the building she saw RI #1 walking on the side of the road. CNA #11 said RI #1 was kind of stumbling which made her think he/she was getting tired. She stated she turned her car around and tried to pick up RI #1, but RI #1 refused. She stated after RI #1 refused, she went to the facility to let them know RI #1 was up the street and they needed to call a code. CNA #11 said that she should have stayed with RI #1, called the facility to let them know a resident had gotten out of the facility and waited for someone to come to assist her. CNA #11 said RI #1 had gotten hysterical, and she panicked. CNA #11 said it was a poor decision on her part. She stated RI #1 started getting loud, yelling, and cursing. An interview was conducted with CNA #13 on 04/04/2024 at 4:09 PM. CNA #13 stated after RI #1 was returned to the facility, she asked RI #1 why did he/she leave the facility. She stated, RI #1 told her the football game was on and he/she wanted some beer. CNA #13 stated that RI #1 said that he/she watched girl go out the door, and then he/she just kicked it with his/her feet and went out the door. CNA #13 said the RI #1 exited through the door used by staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with CNA #14 at 4:34 PM. CNA #14 stated on 02/05/2023, she saw RI #1 on the second floor. RI #1 told her that he/she was going to get himself/herself some cigarettes and some beer. CNA #14 said that she told RI #1 to not leave the facility. She stated she was not assigned to RI #1 on that day; however, she informed the nurse about his/her behavior. CNA #14 stated after she informed the nurse of RI #1's behavior she did not see RI #1 anymore, she assumed he/she went back upstairs. A telephone interview was conducted with CNA #15 on 04/04/2024 at 5:00 PM. CNA #15 stated RI #1 left out the facility through a side door. She stated staff had to make sure it was closed all the way or it would not be closed. CNA #15 said the door had been that way as long as she could recall and had worked at the facility two years. An interview was conducted with the Maintenance Director (MTD) on 04/04/2024 at 5:20 PM. The MTD stated the side door was not broken. He stated the CNAs would leave the door open when they took the trash out. He said the staff would make it look like the door was closed and just rest it on the latch, so they would not have to go all the way around to the front door to reenter. A telephone interview was conducted with the Former Administrator #1 on 04/03/2024 at 7:36 PM. The FA #1 said she was unsure of what interventions were put in place after RI #1 stated earlier in the day that he/she wanted to leave the building. She stated RI #1 exited the facility through the side door which was used by staff. She stated the facility had issues with that door closing. The FA #1 stated RI #1 was found a half mile from the facility. The FA #1 said the resident usually used a rolling walker and it was found at the top of the hill near the entrance to the facility. The FA #1 stated per protocol, the staff should have tried to get the resident to come back to the facility when the staff saw a resident off the premises. The FA #1 continued to say, if the resident would not return with that staff, the staff should stay with the resident and call the facility for help. The FA #1 said CNA #11 did not follow the facility's protocol. An interview was conducted with the Physical Therapy Director (PTD) on 04/24/2024 at 3:50 PM. The PTD said RI #1 was unable to walk without the use of his/her rolling walker. A follow-up interview was conducted with the FA #1 on 04/05/2024 at 3:02 PM. The FA #1 stated she was unsure why staff did not keep an eye on RI #1 when he/she told staff he/she wanted to leave the building and had been given lorazepam on 02/05/2023. She was asked what interventions were in place to prevent RI #1 from leaving the facility without staff's knowledge. The FA #1 said when she was there all of the exit doors required a code to exit. She stated the concern with staff leaving doors unsecured was residents would be able to elope from the building without anyone knowing and it was a general safety risk. She said the facility did not allowing doors to be propped open. An interview was conducted with the facility's Owner (FO) #2 on 04/05/2024 at 11:00 AM. The FO #2 stated the concern with the unsecure door was when employees taking out the garbage or taking a break, they were leaving the door ajar. They were putting something on top of the door so the door would not close when they left, because they did not want to walk around to the front door. On 04/02/2024 at 6:00 PM, surveyor observed front door to facility propped opened with a brick. ********** (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/08/2024 at 4:44 PM, the facility submitted an acceptable Removal Plan for F689 which documented: 1. R#1 expressed desire to leave the facility. The facility received orders to administer Ativan but failed to provide supervision of RI #1 and to ensure all exits were secure. Therefore, R#1 was able to elope from the facility. 2. On April 6th, 2024, the F689 Removal Plan was written by Regional Consultant. 3. On April 7th, 2024, the Governing Body and QAPI committee (Director of Nursing, Medical Director via phone, Facility Owner, Dietary Manager, Social Services, Activities Director, Environmental Services/Maintenance Director, Rehabilitation Director, MDS Coordinator, Staff Development/Infection Control via phone, Unit Manager 2nd Floor, Unit Manager, 3rd Floor, Business Office Manager, Staffing Coordinator, Human Resources Director, Wound Care Coordinator, Housekeeping Supervisor) reviewed the current Elopement Policy and were educated on the following new policies by the Regional Consultant: i. The Door Safety Assessment and Review Policy, ii. The Elopement Response iii. The Elopement Response and Prevention Policy During the Governing Body and QAPI meeting, the facility discussed the elopement incident and identified a root cause of what failed to ensure the residents' safety. Upon review of the facility's current policies, the above policies were developed and implemented based on the root cause and debriefing of the incident and investigation. It was discovered the facility did not have a policy and procedure on what staff should do if a resident would voice and/or express desire to leave the facility. Further, the facility did not have a policy and procedure on what staff should do if a resident is found off campus. During the meeting, The Governing Body and QAPI committee made recommendations on doing monthly elopement drills, weekly door checks on ensuring doors are secure by the Maintenance Director, as well as daily routine checks by IDT. The facility failed to ensure the door was secure when a staff member exited the facility, thus, training on ensuring doors are secure upon exiting the facility was completed. In February 2023, following this incident, an alarm was placed on this door to alert staff when the door is not fully secure. 4. On April 7th, 2024, the Governing Body (Owner, Regional Director via phone, and Regional Consultant via phone) met and discussed the policies being implemented. 5. On June 15th, 2023, RI #1 was discharged from the facility. 6. The facility does not have anyone expressing the desire to leave the facility currently based on review of the 24-hour report along with Q-shift nurse report check offs. An assessment scoring report, consisting of residents' wander risk scores, was checked to ensure an elopement binder and appropriate interventions are in place. The facility also places residents that are identified as High Risk to Wander as well as an Elopement Risk on the 3rd floor, as room availability permits, as a preventative measure for elopement. Elopement book assessed and checked on April 6th, 2024. No discrepancies were identified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	SYSTEMIC CHANGES 7. On April 6th, 2024, the following policies Door Safety Assessment and Review, the Elopement Response and Resident Elopement Prevention and Response were developed and implemented. 8. A review of door security was conducted on April 6th, 2024, by the maintenance director). The maintenance director conducted a thorough assessment of all doors in the facility to ensure they were properly secured and functioning. This included checking for any breaches or issues with door securing, as well as ensuring that no doors were propped open. No other doors during the audit were identified to be a concern. 9. On April 7th, 2024, the Door Safety Assessment and Review policy was revised to include no propping of doors. 10. On April 6th, 2024, signage was placed at all exits alerting staff and guests to use certain doors for use and to not prop open doors. One sign states Do not prop door. The other sign states Attention all staff, this is an emergency exit only. Please keep this door closed. Thank you, Knollwood Healthcare. 11. On April 7th, 2024, the Door Assessment and Review policy update includes that staff are to only use the front door for entering and exiting the facility and all other exits (doors) are for emergency use only. Signage has been placed on doors/exit that are not to be used. The Elopement Prevention and Response policy advises staff on what actions to take when a resident voices that they are going to elope. Actions to include assessment, supervision if necessary, determining the appropriate plan of care/intervention, consulting with interdisciplinary team and reviewing/updating care plan. TRAINING: 12. Education was provided to the Maintenance Director by the Regional Consultant on April 6th, 2024, regarding Door Safety Assessment and Review Policy. 13. Education was provided to the Director of Nursing regarding The Elopement Response Policy by Regional Consultant on April 6th, 2024. This policy addresses what staff should do if a resident is found off campus. 14. On April 6th, 2024, the DON trained the Designee and together they began training the IDT team and all full-time staff including, CNA's, LPN's, RN's, Therapy Dept., Housekeeping, Maintenance, and Kitchen Personnel on Door Safety Assessment and Review, Resident Elopement Prevention and Response, the Elopement Response policies. Training included resident behavior management, including the identification of at-risk residents, appropriate interventions, and the updated policies and procedures related to elopement prevention. Training was completed April 6th, 2024, through April 8th, 2024. As of April 8th, 2024, ninety of 102 employees have been educated. Staff that have not yet been educated in the above policies and procedures will not be permitted to return to work prior to education being completed. All part-time, PRN staff, and contract staff will not be permitted to work prior to education being completed. ********** (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 04/08/2024.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 33739 Based on record review, interviews and review of facility policies Antipsychotic Medication Use, and Administering Medications, the facility failed to ensure Resident Identifier (RI) #1 was assessed and monitored by licensed staff after receiving a onetime dose of Lorazepam (Ativan), when RI #1 became agitated and expressed he/she was going to leave the facility. This occurred on 02/05/2023 and affected RI #1. This deficient practice was cited as a result of investigation of complaint/report number AL00043280. Findings Include: Review of a facility policy Antipsychotic Medication Use with a revised date of July 2022 documented . Policy Interpretation and Implementation . 2. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. 17. The staff will observe, document, .information regarding the effectiveness of any interventions, including the antipsychotic medications. 18. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications . Review of a facility policy Administering Medications with a revised date of April 2019 documented . Policy Interpretation and Implementation . 23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: . f. any results achieved and when the results were observed, . RI #1 was admitted to the facility 09/19/2022, with diagnoses of Alcohol Abuse and Anxiety Disorder. A review of RI #1's Quarterly Minimum Data Set with an Assessment Reference date of 01/02/2023 indicated RI #1 with a Brief Interview for Mental Status score of 12 of 15 which indicated moderate cognitive impairment. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of RI #1's Progress Notes dated 02/05/2023 at 1:15 PM documented RI #1 walking around yelling, and screaming that (he/she) is about to leave here, and (he/she) is calling the police and will jump out the window if (he/she) has to. The MD was contacted, and an order given for a one time dose of Ativan. The next entry was at 16:10 (4:10 PM) RI #1 was found away from the facility walking on the road. RI #1 stated was going to get a beer and coming back. Further review of RI #1's record did not indicate documentation from licensed staff after the Ativan was administered to indicate effectiveness or not. A review RI #1's Medication Administration Record for February 2023 indicated Ativan was administered on 02/05/2023 at 2:21 PM. On 04/05/2024 at 3:00 PM during an interview with the Medical Director, he said he was called due to RI #1 being agitated saying he/she was leaving. The MD said he gave an order for one dose of Ativan for agitation. The MD said RI #1 did not have behaviors prior to this event. The MD said he was not sure why the staff did not keep closer watch on RI #1, and he/she was then found having left the facility. The MD said RI #1 should have been assessed after the Ativan was given within about 30 minutes. He said the assessment should be documented in the medical record by the nurses. The MD said RI #1 should have been monitored for effectiveness and side effects such as over sedation, more agitation, an unusual change in mood or behavior. The MD said he was unsure if RI #1 was monitored once the Ativan was given. The MD was asked what interventions were done prior to administering the Ativan; he said it was standard practice to redirect and try to calm the resident. If that was unsuccessful call the physician and if necessary, send out to the hospital for evaluation. He was not sure if that was done. On 04/06/2024 at 10:00 AM, during an interview with the Director of Nursing, she said the policy for administering medication was right resident, right medication, time given, document given, and the monitoring of any adverse effects. The DON said Ativan was an antianxiety medication. She said when staff gives a resident new medication of Ativan one time dose, they should chart it was given then follow up in 15 to 30 minutes for effectiveness or adverse effects. When asked how the nurse monitored RI #1 once she gave him/her the Ativan; she said according to the record they did not monitor him. The DON said RI #1 should have been monitored for respiratory changes and changes in mental status. The nurse should have made some documentation after she administered the Ativan. The DON said the concern with the nurse not monitoring RI #1 when she gave him/her the Ativan one time dose was she did not monitor for effectiveness or any side effects.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 29671 Based on interviews and review of the Administrator job description, the facility's Administrator, responsible for the day-to-day operation of the facility failed to ensure the QAPI (Quality Assurance and Performance Improvement) committee met to identify all concerns using root cause analysis to ensure corrective actions needed with plans to prevent further occurrence including ongoing monitoring after Resident Identifier (RI) #1 eloped from the facility on 02/05/2023. This failure placed all 53 residents residing in the facility at risk for immediate jeopardy, as it was likely to result in serious injury, serious harm, serious impairment, or death, due to the ongoing risk of elopement. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, S483.70 Administration at a scope and severity of L. On 04/06/2024 at 12:44 PM, the Director of Nursing (DON), Owner, and Regional Consultant (via phone) were provided a copy of the Immediate Jeopardy Template and notified of the findings at the immediate jeopardy level in the area of F 835 - Administration. The IJ began on 02/05/2023 and continued until 04/08/2024 when survey team verified onsite that corrective actions had been implemented. On 04/08/2024 the immediate jeopardy was removed, F835 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00043280 and AL00046465. Findings include: Cross-Reference F689, F867, and F837. A review of the Administrator job description documented: . Lead and direct the overall operation of the facility in accordance with resident needs, government regulations and Company policies so as to maintain care for the residents while achieving the facility's business objectives . The facility policy titled Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership revised date of March 2020 documented: Policy Statement The quality assurance and performance improvement program is overseen and implemented by the QAPI committee, which reports its findings, actions and results to the administrator and governing body. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Policy Interpretation and Implementation 1. The administrator, whether a member of the QAPI committee of not, is ultimately responsible for the QAPI program, and for interpreting its results and findings to the governing body. 4. The responsibilities of the QAPI committee are to: . c. identify and help resolve negative outcomes . d. utilize root cause analysis to help identify where identified problems point to underlying systematic problems; . An interview was conducted on 04/03/2024 at 7:36 PM with the Former Administrator #1, who said that she started as the administrator in January of 2022, and held the position for over a year. She said that she served as the Abuse Coordinator and was available round the clock to address any allegations, which were reported to Alabama Department of Public Health (ADPH) and the ombudsman. When asked about RI #1 leaving the premises on 02/05/2023, she stated that she did not recall the specific incident but remembered that he/she was discovered on a nearby street and brought back to the facility. Regarding the protocol for staff encountering a resident off-site, she stated that they should remain with the resident and contact the facility for assistance. When asked if the staff member followed the protocol when RI #1 was found off-site, she said that the CNA received one on one re-education. After RI #1 arrived back to the facility a body audit was conducted, and he/she was sent to the hospital. Additionally, the incident was reported to ADPH. In response to the question about how far RI #1 had gotten off-site, she replied approximately 0.5 miles. The Former Administrator said RI #1 had exited the building through a side door that had a closing issue. When asked about the measures taken to prevent RI #1 or other residents from leaving the building, she stated that the door had been changed out. She explained that when RI #1 managed to leave the building, the door became stuck when a staff member took the trash to the dumpster. Finally, when asked if this incident was taken to Quality Assurance (QA), she said that typically all reportable incidents are presented to QAPI. She was uncertain if an emergency QAPI was conducted after the incident. On 04/05/2024 at 3:02 PM, a follow-up interview was conducted with the Former Administrator #1. During the interview, she was asked about the education provided to the staff after RI #1 eloped. She said that one on one training was conducted with CNA #11, and typically elopement training would have been conducted as well, although she was uncertain if it had taken place. According to her, the training records were usually stored in the staff members' personnel files. The FA #1 was also asked about the concern regarding leaving doors unsecured when a resident expressed a desire to leave the building. She stated that it posed a general safety risk. When questioned about why QAPI did not create an action plan after RI #1 eloped from the facility, she explained that all QAPI records were maintained on the medical records computer and no formal plan was implemented. An interview was conducted with the Director of Nursing (DON) on 04/06/2024 at 11:41 AM. During the interview, the DON was questioned regarding the documentation of the incident when RI #1 eloped from the facility. She stated that there was no documentation available. The DON said that the QAPI program was overseen by the Administrator, with monthly meetings scheduled. When asked about evidence of a QAPI meeting following RI #1's elopement, she said there was no evidence. Finally, when questioned about the facility's compliance with effective administration, the DON said they were not in compliance. (continued on next page)

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	015463	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knollwood Healthcare	3151-A Knollwood Drive Mobile, AL 36693

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	********** On 04/08/2024 at 4:44 PM, the facility submitted an acceptable Removal Plan for F835 which documented: ********** 1. After RI #1 eloped from the facility on February 5th, 2023, the Administrator failed to ensure the QAPI committee met to identify all concerns using root cause analysis to ensure corrective actions needed with plans to prevent further occurrence including ongoing monitoring. 2. Removal plan written on April 6th, 2024, by Regional Consultant 3. The new Administrator started on April 8th, 2024, and was trained by the Regional Consultant on the QAPI Policy, Quality Assurance and Performance Improvement (QAPI) Program-Governance Leadership and their responsibility of ensuring QAPI compliance and resident safety. The NHA was also trained on the new Door Safety Assessment and Review Policy, Elopement Prevention and Response, the Elopement Response Policy. The new administrator was trained on the Administrator's job responsibilities. 4. The facility has a policy and procedure on QAPI as well as the NHA's responsibility to ensure QAPI. Policy is from med pass and is titled Quality Assurance and Performance Improvement (QAPI) Program-Governance Leadership. Administrator Training completed on April 8th, 2024. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 04/08/2024 and the scope and severity was lowered to no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to further address and monitor the deficient practice in order to achieve compliance.

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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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 49218 Based on record review, interviews and the facility policy Governing Body Duties and Responsibilities, the governing body failed to provide oversight to the QAPI committee. The Governing Body failed to provide guidance to the QAPI committee to use root cause analysis to determine all concerns and to make a determination of corrective actions needed with plans to prevent further occurrence after Resident Identifier (RI) #1 eloped from the facility on 02/05/2023. On 02/05/2023, RI #1 told the staff he/she wanted to leave the facility around 1:10 PM. RI #1 was given a psychotropic medication at 2:21 PM, then was not supervised. RI #1 left the facility through an unsecured door. RI #1 was seen by an off-duty staff member at approximately 3:30 PM on a busy two-lane road near the facility, but the staff member did not stay with the resident to provide supervision, and left RI #1 in unsafe environment. RI #1 was not returned to the facility until another off-duty staff member returned him/her to the facility at approximately 4:10 PM. This failure affected all 53 residents residing in the facility. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, S483.70 Administration at a scope and severity of L. On 04/06/2024 at 12:44 PM, The Owner of the company, the Corporate Consultant, and the Director of Nursing, were provided a copy of the immediate jeopardy template and notified of the immediate jeopardy finding in the area of Governing Body, F837. The IJ began on 02/05/2023 and continued until 04/08/2024 when survey team verified onsite that corrective actions had been implemented. On 04/08/2024 the immediate jeopardy was removed, F837 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. Further the Governing Body failed to ensure the facility had an acting Administrator from 03/29/2024 through 04/08/2024. This deficiency was cited as a result of the investigation of complaint/report number AL00043280. Cross-Reference F689, F835, and F867. Findings Include: Review of an undated facility policy titled Governing Body Duties and Responsibilities documented: (continued on next page)

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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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Policy Statement/Purpose: The Company must have a Governing Body that assumes full legal responsibility for establishing and implementing policies regarding the management and operation of the facility. Policy Interpretation and Implementation: 1. GOVERNING BODY DUTIES AND RESPONSIBILITIES A. Policies and Procedures: The Governing Body is legally responsible for establishing and implementing policies regarding the management and operation of the facility. The Governing Body, in conjunction with regular reporting by the Administrator, should assess on a regular basis that services are being provided in accordance with facility policies, that policies are current and reflect an acceptable standard of care, that care is coordinated among professional staff, and that there is effective use of resources. C. Appointment of Administrator: The Governing Body is responsible for appointing an Administrator who shall: . c. Report to and be accountable to the Governing Body. i. Facility will determine a means and schedule for regular reporting to the Governing Body and how the Governing Body will respond to the Administrator. The facility policy titled Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership revised date of March 2020 documented: Policy Statement The quality assurance and performance improvement program is overseen and implemented by the QAPI committee, which reports its findings, actions and results to the administrator and governing body. Policy Interpretation and Implementation 1. The administrator, whether a member of the QAPI committee of not, is ultimately responsible for the QAPI program, and for interpreting its results and findings to the governing body. 2. The governing body is responsible for ensuring the QAPI program: a. is implemented . b. is sustained through transitions of leadership and staffing . (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 04/05/2024 an interview was conducted with the Facility Owner #2. FO #2 said he only remembered that RI #1 had left the building either through the front or side door. FO #2 said when the staff were taking out the garbage or taking a break, they were leaving the door ajar. FO #2 said the staff were putting on top of the door so the door would not close when they left because they did not want to walk around to the front door. FO #2 did not recall if the incident was reviewed by the Quality Assurance, also called QAPI, team. FO #2 did not know how often the QAPI committee meet and said the Director of Nursing was currently responsible for the QAPI program. On 04/05/2024 at 5:33 PM an interview was conducted with the Facility Owner (FO) #1. He said that Facility Owner #2 and himself were the Governing Body. FO #1 said he did not remember the oversight he gave to Former Administrator #1 during the incident involving RI #1. He said he would have instructed to do a full investigation of what occurred, how it occurred, at the time, interview any staff and resident, that might have been around the area around that time. The facility would have reported it to the authorities. FO #1 said he did not remember all the details of the incident. He directed them to check all exit doors, do a head count, they evaluated any other concerns, changed the codes of doors, educated all staff on proper protocol and the necessity for ensuring all doors are properly closed and secured at all times. When he was asked where this information was documented he said that was a good question. He said he could not answer if there was a formal plan done; he said the facility had a nurse consultant that would have done one and there should have been a sign-in sheet. When asked what oversight was the governing body providing now since the facility did not have an Administrator. FO #1 said the duties of the governing body were to oversee the facility and the Administrator and to be involved in QAPI and administration. On 04/24/2024 at 4:22 PM an interview was conducted with the Regional Nurse Consultant (RNC). The RNC said it was important for the facility to have an Administrator so that they could oversee what was going on in the facility, oversee regulatory issues, develop monitor any care approaches with the deptartment heads, and to supervise the home and department heads. The RNC said from 03/29/2024 to 04/08/2024 the facility did not have an acting Administrator. ********** On 04/08/2024 at 4:44 PM, the facility submitted an acceptable Removal Plan for F 837 which documented: 1. RI #1 eloped from the facility on 2/5/2023, the Governing Body failed to provide oversight to the Administrator and QAPI committee and guide the committee to identify all concerns using root cause analysis to ensure corrective actions needed were in place with plans to prevent further occurrence including ongoing monitoring. 2. On April 6th, 2024, the F867 Removal Plan was written by Regional Consultant. 3. On April 7th, 2024, the Regional Consultant completed education with The Governing Body (Owner, Regional Director via phone, and Regional Consultant via phone) on their responsibility to provide oversight over the Administrator and ensuring the QAPI Program meets to identify all concerns using root cause analysis and developing corrective actions needed with plans to prevent further occurrence including ongoing monitoring. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	4. On April 7th, 2024, the Governing Body met with the Director of Nursing to discuss ensuring an effective QAPI committee (Director of Nursing, Medical Director via phone, Facility Owner, Dietary Manager, Social Services, Activities Director, Environmental Services/Maintenance Director, Rehabilitation Director, MDS Coordinator, Staff Development/Infection Control via phone, Unit Manager 2nd Floor, Unit Manager, 3rd Floor, Business Office Manager, Staffing Coordinator, Human Resources Director, Wound Care Coordinator, Housekeeping Supervisor) takes place in the facility, that can function to identify all concerns with incidents, perform root cause analysis and determine corrective actions needed to prevent further incidents. 5. On April 7th, 2024, an emergency QAPI meeting was then held by the Governing Body. The Governing Body guided the QAPI committee in identifying root causes and corrective actions needing to take place for elopement prevention. 6. Root causes identified, on April 7th, 2024, were lack of staff education regarding elopement, staff failure to supervise the resident at risk, staff not ensuring all doors and exits were secure, and further, staff not ensuring resident safety if observed in an unsafe environment. 7. On April 7th, 2024, at 0900, The Governing Body met with the QAPI committee to review the new and updated policies and procedures Door Safety Assessment and Review Policy, Elopement Prevention and Response, and the Elopement Response Policy that will ensure staff is able to respond appropriately to residents at risk for elopement as well as to residents observed in an unsafe environment. 8. The facility has a policy and procedure on QAPI as well as the NHA's responsibility to ensure QAPI. Policy is from med pass and is titled Quality Assurance and Performance Improvement (QAPI) Program-Governance Leadership. Governing Body meetings are scheduled weekly every Thursday via Teams. 9. On April 8th, 2024, the Governing Body met with the new Administrator to ensure an effective QAPI committee takes place in the facility, that can function to identify all concerns with incidents, perform root cause analysis and determine corrective actions needed to prevent further incidents. The Governing Body also provided training to the new administrator on Quality Assurance and Performance Improvement (QAPI) Program-Governance Leadership and that the Governing Body meetings are scheduled weekly every Thursday via Teams. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 04/08/2024 and the scope and severity was lowered to an F level, to allow the facility time to further address and monitor the deficient practice in order to achieve compliance.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 39580 Based on staff interview and review of the facility policy titled, Quality Assurance and Process Improvement Committee , the facility failed to maintain minutes of all QAPI meetings to document its ongoing Quality Assurance and Performance Improvement (QAPI) program. This had the potential to affect all 53 residents of the facility. The findings include: A review of a facility policy titled, Quality Assurance and Process Improvement Committee , with an updated date 8/4/22, revealed: .The committee shall maintain minutes of all regular and special meetings that include at least the following information: . b. The names of committee members present and absent; . During an interview with the Administrator on 04/25/24 at 08:16 a.m., the Administrator stated the facility had a QAPI policy. She was asked should the QAPI minutes have been signed by the members. She stated, yes. She was asked what the concern of the QAPI minutes was not being signed by the members in attendance. She stated, can not validate the meeting and who is in attendance.

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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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41928 Based on record review, the facility policy Quality Assurance and Performance Improvement (QAPI) Program, and the facility's policy Quality Assurance and Performance Improvement (QAPI) Program - Analysis and Action the facility's QAPI committee failed to thoroughly review all factors related to Resident Identifier (RI) #1's elopement on 02/05/2023. The facility further failed to develop and implement effective plans and interventions to prevent recurrence and ensure the facility was secured. On 02/05/2023 RI #1 exited the facility through an unsecured side door without staff's knowledge. RI #1 was further left by staff unsupervised in an unsafe area 2,640 feet from the facility. The failure of the QAPI committee to thoroughly review all factors and implement effective interventions following an adverse event had the potential to affect all 53 residents. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, S483.75 Quality Assurance and Performance Improvement at a scope and severity of L. On 04/06/2024 at 12:44 PM, The Facility's Owner, the Corporate Consultant, and the Director of Nursing, were provided a copy of the immediate jeopardy template and notified of the immediate jeopardy finding in the area of Quality Assurance and Performance Improvement (QAPI), F867-QAPI/Quality Assessment and Assurance (QAA). The IJ began on 02/05/2023 and continued until 04/08/2024 when survey team verified onsite that corrective actions had been implemented. On 04/08/2024 the immediate jeopardy was removed, F 867 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00043280. Findings Include: Cross-Reference F689, F835, and F837. A review of a facility policy Quality Assurance and Performance Improvement (QAPI) Program, with a revised date of February 2020 documented Policy Statement This facility shall develop, implement, and maintain an ongoing, facility wide data driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. Authority (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. The owner and/or governing board (body) of our facility is ultimately responsible for the QAPI program A review of the facility policy titled Quality Assurance and Performance Improvement (QAPI) Program - Analysis and Action dated March 2020 documented: .Policy Interpretation and Implementation 1. The QAPI Program, overseen by the QAPI Committee is designed to identify and address quality deficiencies through analysis of the underlying cause and actions targeted at correcting systems at a comprehensive level. 2. The methodology for analysis and action is guided by a written QAPI plan that includes: a. definition of the problem, based on information obtained through data, self-assessments, and feedback systems. b. an analysis of the root cause of the problem from a systems perspective. c. establishing measurable goals and benchmarks for improvement. d. specific interventions aimed at correcting the problem and achieving the stated goals or benchmarks. e. methods and frequency of monitoring performance improvement objectives. 3. The QAPI committee is responsible for analyzing identified problems, establishing corrective actions, measuring progress against the established goals and benchmarks, communicating information to staff, residents, and reporting findings to the administrator and governing board . On 04/06/2024 at 11:41 the Director of Nursing said she could not find QAPI minutes from the incident of elopement that occurred on 02/05/2023. On 04/03/2024 at 7:36 PM during a phone interview with the Former Administrator, she said she did not recall much about the incident of RI #1 leaving the facility he/she was found and returned. She said staff should stay with the resident and call the facility for help if they will not come back with them. She said RI #1 left the building through a side door that had an issue with closing. She said she was not sure what was done when RI #1 expressed wanting to leave the building. The former Administrator said she did not know if there was an emergency QAPI meeting. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 04/06/2024 at 11:41 AM, during an interview with the Director of Nursing, she said there was no evidence of what was done after RI #1 eloped from the facility. She said she had been employed at that facility since January 2024. The DON said the concern of not having evidence of what was done after RI #1 eloped from the facility was the facility could not justify what was done or that staff were provided training and education. The DON said that after RI #1 eloped from the facility, the facility should have conducted proper notification, investigation, in-services, monitoring of the resident, identified the root cause of the incident, and ensured safety measures were implemented after the incident. The DON said the Administrator was over the QA/QAPI program and meetings were supposed to be held monthly. She said the QAPI team was the Administrator, DON, Social Services, MDS, Activities, basically key personal and the Medical Director. ********** On 04/08/2024 at 4:44 PM, the facility submitted an acceptable Removal Plan for F867 which documented: 1. The QAPI committee failed to develop and implement effective interventions including ongoing monitoring to prevent recurrence after the facility failed to prevent RI #1 from leaving the facility on 02/05/2023 unsupervised, through an unsecure side door exiting to the outside of the building. RI #1 was further left by staff unsupervised in an unsafe area 2640 feet from the facility crossing a two-lane road with oncoming traffic. 2. On April 6th, 2024, the F867 Removal plan was written by Regional Consultant. 3. On April 7th, 2024, the Governing Body (Owner, Regional Director, and Regional Consultant) met with the Director of Nursing to discuss ensuring an effective QAPI committee takes place in the facility, that can function to identify all concerns with incidents, perform root cause analysis and determine corrective actions needed to prevent further incidents. An emergency QAPI meeting was then held by the Governing Body. The Governing Body guided the QAPI committee in identifying root causes and corrective actions needing to take place for elopement prevention. 4. On April 7th, 2024, the Regional Consultant provided training to the QAPI committee (Director of Nursing, Medical Director via phone, Facility Owner, Dietary Manager, Social Services, Activities Director, Environmental Services/Maintenance Director, Rehabilitation Director, MDS Coordinator, Staff Development/Infection Control via phone, Unit Manager 2nd Floor, Unit Manager, 3rd Floor, Business Office Manager, Staffing Coordinator, Human Resources Director, Wound Care Coordinator, Housekeeping Supervisor) during an emergency QAPI meeting to ensure an effective QAPI committee takes place in the facility, that can function to identify all concerns with incidents, perform root cause analysis and determine corrective actions needed to prevent further incidents. The QAPI Committee was trained on the facility's QAPI Policy Quality Assurance and Performance Improvement (QAPI) Program-Governance Leadership. 5. On April 7th, 2024, root causes identified were lack of staff education regarding elopement, staff failure to supervise the resident at risk, staff not ensuring all doors and exits were secure, and further, staff not ensuring resident safety if observed in an unsafe environment. (continued on next page)

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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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	6. On April 7th, 2024, the QAPI committee reviewed the new and updated policies and procedures The Door Safety Assessment and Review, Elopement Prevention and Response, and Elopement Response policies to ensure staff are able to respond appropriately to residents at risk for elopement as well as to residents observed in an unsafe environment. 7. On April 7th, 2024, the Door Safety Assessment and Review, Elopement Prevention and Response, and Elopement Response policies were developed and implemented to ensure staff respond appropriately to residents at risk for elopement as well as residents observed in an unsafe environment. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 04/08/2024 and the scope and severity was lowered to an F level, to allow the facility time to further address and monitor the deficient practice in order to achieve compliance. 47408 An interview was conducted on 04-24-2024 at 11:15 AM with former adminstrator. She was asked how often QAPI meetings were held and she stated monthly. When asked who attended the QAPI meetings she stated most department heads, the Administrator, Director of Nursing and maintenance. She stated the Medical Director came periodically but was updated every other week by phone or email .She was asked what was the most recent PIP (program improvement plan) the QAPI committee implemented. She stated she did not remember. She was asked if QAPI Plan included adverse event monitoring; she stated yes and that she was recording anything that was reported to the state including reportables, FRI's and emergency plans that were put in place to prevent episodes from happening and abuse plans. She was asked what direction was provided by the Governing Body regarding the QAPI Program and she stated she did not remember; only had two during the time she she was employed. The facility was unable to locate the records. During an interview conducted on 04-24-2024 at 3:00 PM with former administrator. she was asked how were results of the QAPI meeting communicated to the Governing Body. She stated usually by phone or in person and the local owner was usually present. When asked how the Governing Body provided oversight to the QAPI Program she stated meetings were held quarterly.When asked what actions were taken by the Governing Body to ensure QAPI Program was sustained during changes of leadership/administrators she stated she could not account for the other governing bodies. She was asked why it was important for QAPI to meet at least quarterly she stated so we can look at any trending areas that need addressing and find the root cause such as falls and other incidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015463	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knollwood Healthcare	3151-A Knollwood Drive Mobile, AL 36693

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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 04-24-2024 at 4:22 PM an interview was conducted with the Regional Consultant who stated she has been a consultant since October 2023 and she does all the recruiting and oversees any regulatory issues. She further stated some situations can be taken care of via phone. When asked what her role was as Governing Body of the facility she stated she handles governing calls and any issues that may come up. When asked what actions were taken by the Governing Body to ensure QAPI Program was sustained during changes of leadership/administrators she stated previously they were doing QAPI but they were not scanning the data to shared drive. Going forward during our weekly governing body calls will be shared what is to be discussed in our QAPI meetings. She stated governing body calls are held weekly on Thursdays. During an interview with the adminstator on 04-25-2024 at 12:15 PM she was asked to provide QAPI meeting records for October, November and December 2023 and she replied there is no QAPI papers at all for October 2023, November sign in was blank and the material to be discussed for November 2023 was blank. She furthe stated the December QAPI document and the signature page was blank. When asked where the QAPI documentation that addressed the 10/11/2023 incident involving RI#3 was she stated she could not answer that.