

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Knollwood Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055</p> <p>Based on interviews, resident record review, review of a facility policy titled Abuse Policy, review of a Facility Reported Incident (FRI) received by the State Agency, and review of the facility's investigative file, the facility failed to protect Resident Identifier (RI) #1 and RI #2 from physically abusing each other on 07/30/2024.</p> <p>This deficient practice affected RI #1 and RI #2; two residents reviewed for resident-to-resident altercation.</p> <p>Findings Include:</p> <p>Review of a facility policy titled Abuse Policy, updated 08/2022, revealed the following:</p> <p>Our residents have the right to be free from abuse .</p> <p>Policy Interpretation and Implementation</p> <p>Definitions</p> <p>To help with recognition of incidents of abuse, the following definitions of abuse are provided:</p> <p>1. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .</p> <p>RI #1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Unspecified Dementia, Unspecified Severity, with other Behavioral Disturbance, Anxiety Disorder, Disorder of Brain, Pseudobulbar Affect, and Delusional Disorders.</p> <p>RI #1's Annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/15/2024, identified RI #1 to have short-term and long-term memory problems and severely impaired cognitive skills for daily decision making.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RI #2 was admitted to the facility on [DATE], with a diagnosis of Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety.</p> <p>RI #2's Quarterly MDS assessment, with an ARD of 07/19/2024, identified RI #2 to score 0 out of 15 on the Brief Interview for Mental Status, indicating RI #2 had severely impaired cognition.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, submitted on 07/30/2024 at 2:04 PM documented:</p> <p>. Incident Type . Abuse - Physical .</p> <p>Incident Detail .</p> <p>Name(s) of resident(s) involved: (RI #1 VS (verses) RI #2) .</p> <p>Name of alleged perpetrator(s): (RI #1) .</p> <p>Narrative summary of incident:</p> <p>Resident (RI #1) and resident (RI #2) among other residents were in the dining room waiting for lunch to be served. After interviewing residents and staff in the dining room, it was revealed that resident (RI #1) approached resident (RI #2) and slapped (him/her), leading to both residents slapping and hitting one another. Both residents were immediately separated and ensured of safety .</p> <p>What was reported and to whom .</p> <p>Resident to resident, physical altercation. (Name of the LPN [Licensed Practical Nurse]/Unit Manager [UM]), 2nd floor Unit Manager notified DON (Director of Nursing). DON notified the LNHA (Licensed Nursing Home Administrator) .</p> <p>Describe any injury to alleged victims(s) . Skin assessments were completed on both residents involved in the incident. Resident (RI #1) was noted to have bruising/scratches to (his/her) right foreman. Resident (RI #2) did not have any skin issues identified .</p> <p>Action (s) taken by the facility in response to the incident.</p> <p>Both residents were immediately separated and ensured of safety. Resident (RI #1) was sent out for an evaluation. Upon return, resident will be moved to a new room on a different floor. Monitoring has been put in place for any changes from either resident's baseline. MD (Medical Doctor) and Psych NP (Nurse Practitioner) notified and will follow up.</p> <p>A review of the facility's Summary of Investigation, dated 08/05/2024, revealed the following:</p> <p>. Upon completion of the investigation of resident (RI #1) vs (RI #2), resident to resident, physical altercation, the facility has decided to substantiate the incident as physical abuse. The action plan to prevent the recurrence of any resident-to-resident abuse began on 07/30/2024 and was completed on 08/5/2024. The Psych NP plans to follow up with both residents on 8/8/2024 for any adverse effects and ongoing behavior monitoring .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a PSYCHIATRIC PERIODIC EVALUATION report, revealed RI #1 was seen by the NP on 08/06/2024. The report revealed the following:</p> <p>. History of Present Illness:</p> <p>[AGE] year-old (male/female) with a history significant for dementia with behavioral disturbance seen today after (he/she) initiated an altercation with another resident. pt (patient) rolling in hallways calm and cooperative during exam with pleasant demeanor but limited secondary to impaired cognition .</p> <p>Review of a PSYCHIATRIC PERIODIC EVALUATION report, revealed RI #2 was seen by the NP on 08/06/2024. The report revealed the following:</p> <p>. History of Present Illness:</p> <p>[AGE] year-old (male/female) with a history significant for dementia seen today for followup to mood and behaviors after she was the subject of abuse from another resident. pt sitting in chair calm and cooperate with good eye contact and reports I'm doing good .</p> <p>The facility's investigative file contained a handwritten Witness Statement, dated 07/30/2024, signed by Certified Nursing Assistant (CNA) #4 which documented:</p> <p>I was in the Dining Room talking to (LPN/UM). When I Looked Around Residents (RI #1) & (and) Resident (RI #2) was hitting One Another. So Me and (LPN/UM) Ran over and Separated them I took (RI #1) to the 3rd floor and stayed with (him/her) until Nurse came and assessed.</p> <p>09/18/2024 at 11:17 AM, the surveyor conducted an interview with CNA #4. CNA #4 said when she first entered the dining room on 07/30/2024, RI #1 was sitting in a Wheelchair (WC) at a table and RI #2 was sitting in his/her WC at a different table. CNA #4 said she was talking to the LPN/UM and someone hollered hey. CNA #4 said it might have been RI #2 because RI #2 will say hey sometimes. CNA #4 said when she turned around, she saw the residents hitting each other with their hands. CNA #4 said she immediately ran over to where the residents were and separated them. CNA #4 said she took RI #1 back to the 3rd floor to his/her room and waited for the nurse to come and assess RI #1. When asked what type of abuse would this incident be considered, CNA #4 said physical, they were both hitting each other. CNA #4 said to ensure an incident like this one would not reoccur RI #1 was moved to the 2nd floor.</p> <p>Contained within the facility's investigative file was a handwritten statement written by the LPN/UM, dated 07/30/2024. The handwritten statement documented the following:</p> <p>I was in the dining room talking with a CNA and saw (RI #1) and (RI #2) in a physical alteration The CNA (and) I separated both residents The CNA took (RI #1) upstairs, and I took (RI #2) into the conference room. I immediately notified the DON. I did not see who started the fight.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/18/2024 at 2:59 PM, the surveyor conducted an interview with the LPN/UM. The LPN/UM said she and another CNA were in the dining room waiting for lunch to be served when all of a sudden, they heard a commotion. The LPN/UM said when she turned towards where the residents were sitting, RI #1 and RI #2 both had their hands up in the air hitting each other. The LPN/UM said she did not see who started the incident. When asked what type of abuse would this incident be considered, the LPN/UM said physical. The LPN/UM said from what she saw, both residents were hitting each other. The LPN/UM said after the incident RI #1 was sent to the ER (emergency room) and came back on antibiotics for a UTI (Urinary Tract Infection). The LPN/UM said to ensure an incident like this would not reoccur between the residents; they were separated immediately, and permanently, by moving RI #1 down to another unit, RI #1 was treated for his/her behavior which was due to a UTI, staff in-services were done, RI #1 was to be observed every two hours, and if no additional behaviors occurred, RI #1 was to be monitor for his/her behaviors every shift which was being done.</p> <p>On 09/18/2024 at 4:06 PM, an interview was conducted with the Social Services Director (SSD). The SSD said she was first made aware of the incident occurring between RI #1 and RI #2 on 07/30/2024. The SSD said she was told by the DON that RI #1 and RI #2 were in the dining room when RI #1 approached RI #2 and slapped RI #2. When asked who witnessed the incident, the SSD said statements came from RI #5, RI #4 and RI #3 which indicated RI #1 was the aggressor. The SSD said this incident would be considered physical abuse; resident-on-resident altercation.</p> <p>RI #5 was admitted to the facility on [DATE].</p> <p>RI #5's Quarterly MDS assessment, with an ARD of 07/12/2024, identified RI #5 scored a 15 of 15 on the BIMS, indicating RI #5 was cognitively intact.</p> <p>The facility's investigative file contained a statement given by RI #5 on 07/30/2024, which documented the following:</p> <p>. I just seen (RI #1) hit this one and next thing I knew they was slapping and hitting one another . (RI #1) started it .</p> <p>On 09/18/2024 at 5:15 PM an interview was conducted with RI #5. When asked what she could tell the surveyor about an incident occurring in the dining room back on 07/30/2024 where two residents were hitting each other, RI #5 said RI #1 passed by the other resident and popped the resident on the hand.</p> <p>RI #4 was admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>RI #4's Quarterly MDS assessment, with an ARD of 06/26/2024, identified RI #4 scored a 15 of 15 on the BIMS, indicating RI #4 was cognitively intact.</p> <p>The facility's investigative file contained a statement given by RI #4 on 07/30/2024, which documented the following:</p> <p>. (RI #1) got into (RI #2's) face words were going back and forth</p> <p>(RI #1) hit (RI #2) first,</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident was separated .</p> <p>On 09/18/2024 at 5:34 PM an interview was conducted with RI #4. When asked what she could tell the surveyor about an incident occurring in the dining room back on 07/30/2024 where two residents were hitting each other, RI #4 said she remembered RI #1 kept rolling his/her wheelchair up on RI #2 and RI #2 kept telling RI #1 to leave him/her alone. RI #4 said RI #1 made first contact and hit RI #2 on his/her arm and then they stated hitting each other.</p> <p>RI #3 was admitted to the facility on [DATE].</p> <p>RI #3's Annual MDS assessment, with an ARD of 06/01/2024, identified RI #3 scored a 15 of 15 on the BIMS, indicating RI #3 was cognitively intact.</p> <p>The facility's investigative file contained a statement given by RI #3 on 07/30/2024, which documented the following:</p> <p>. (RI #1) started it all Tried to take another person's Drink. (RI #1) hit the (man/woman) that wears the hat .</p> <p>On 09/19/2024 at 9:23 AM, an interview was conducted with the DON. The DON said on 07/30/2024, approximately around 12:10 PM, the LPN/UM informed her there had been a resident-on-resident altercation in the dining room between RI #1 and RI #2. The DON said the LPN/UM said when she turned around, she saw both residents with their arms/hands in the air hitting at each other. The DON said the LPN/UM said the residents were immediately separated and the CNA who saw it took RI #1 upstairs to the nurse. When asked what type abuse this incident would be considered, the DON said physical; a resident-on-resident altercation. The DON said both RI #1 and RI #2 were cognitively impaired. The surveyor asked the DON how did she think a reasonable person would feel to be hit by someone. The DON said a reasonable person would not feel happy about being hit and may want to lash back out. The DON said to ensure an incident like this one would not reoccur with the residents, they were immediately separated and placed on different halls, RI #1's behaviors were being monitored, and the residents were seen by Psych to see if there was a need for medication adjustments. The DON said it was determined the root cause analysis of RI #1 hitting RI #2 was RI #1 had a UTI; and RI #1 had not exhibited any behaviors of hitting anyone since the incident.</p> <p>Review of a Physicians Order for RI #1, dated 07/30/2024, revealed RI #1 was to receive Keflex Oral Capsule 500 mg (milligrams) one capsule two times a day for UTI until 08/04/2024. One capsule was to be administered every 12 hours for five days.</p> <p>*****</p> <p>The facility took the following immediate corrective actions:</p> <p>07/30/2024 at approximately 12:07 PM</p> <p>- RI #1 and RI #2 were among other residents in the dining room, when LPN/UM, UM for 2nd floor and CNA observed the two residents slapping and hitting each other.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The SSD interviewed residents in the dining room, at the time of the incident, with a BIMS score greater than 12, for possible psychological effects from the incident. No adverse effects were noted.</p> <p>-The LPN, Care Plan Coordinator was assigned to update RI #1's and RI #2's care plans to reflect the incident and to ensure that appropriate interventions were put into place.</p> <p>-Care plans were revised and updated by 07/31/2024 to include increased supervision of RI #1 when in common areas of the facility with RI #2.</p> <p>-Education was given by DON to the IDT/QAPI committee on resident-to-resident abuse and the abuse checklist.</p> <p>-Each department manager was then assigned to educate their staff with the same in-service. This action plan was completed by 08/05/2024.</p> <p>On 7/30/2024 at approximately 6:50 PM and ongoing</p> <p>-RI #1 returned from the hospital, where he/she was found to have a UTI. RI #1 returned to room located on a separate unit from RI #2</p> <p>-RI #1 returned with a new prescription for Keflex 500 mg to be administered 1 capsule by mouth twice daily for 5 days for UTI.</p> <p>-The Infection Preventionist was assigned to in-service nursing staff on UTI prevention to include proper technique of peri-care, hand washing, and increased hydration.</p> <p>-The incident, including the root cause analysis, was reported to the IDT/QAPI committee for further review/monitoring at future QAPI meetings.</p> <p>*****</p> <p>Upon observations, review and verification of the information provided in the facility's corrective action plan, in-service/education records, the facility's investigation, as well as staff interviews, the survey team determined the facility implemented corrective actions from 07/30/2024 to 08/05/2024, with on-going monitoring implemented; thus, past noncompliance was cited.</p>