

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 05/22/2025
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** Based on interviews, resident record review, the facility investigative file, and a facility policy titled, Abuse Policy, the facility failed to protect the resident's right to be free from physical abuse on 04/30/2025 when Resident Identifier (RI) #2 hit RI #21. The facility's staff failed to supervise RI #2 and intervene to prevent the incident.</p> <p>RI #2 had a history of verbal and physical behaviors. RI #2 was observed irritable, cursing, and upset as staff were attempting to take RI #2 to his/her bed. The Certified Nursing Assistant (CNA) left RI #2 at his/her doorway and another CNA witnessed RI #2 hit RI #21 on the arm. Staff said someone in that situation being hit would feel shocked.</p> <p>This deficient practice affected RI #21 one of three residents sampled for abuse and was cited as a result of the investigation of complaint/report number AL00051090.</p> <p>Findings include:</p> <p>On 04/30/2025 at 3:58 PM the State Agency received a Facility Reported Incident (FRI) alleging RI #2 hit RI #21 with a closed fist and cursed RI #21. RI #21 had no injury, the residents were separated, RI #2 was sent out to the emergency department, and notifications were made to Resident Representatives and doctor.</p> <p>Review of the facility's abuse 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.</p> <p>Prevention .</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>1. The facility's goal is to achieve and maintain an abuse-free environment.</p> <p>2. Our abuse prevention/intervention program includes, but is not necessarily limited to, the following:</p> <p>3. Training all staff . how to resolve conflicts appropriately; .</p> <p>9. Training staff to understand and manage a resident's verbal or physical aggression; .</p> <p>12. Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect; .</p> <p>13. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues; .</p> <p>The facility's investigative file contained a summary of the incident involving RI #2 and RI #21 signed by the Administrator (ADM) that documented:</p> <p>. Knollwood Healthcare reported an allegation of residents on resident abuse April 30, 2025. Statements gathered from the staff involved reported that they were trying to persuade (RI #2) to go to bed or lay down; (he/she) had said no several times, and they backed away. They brought (him/her) to (his/her) room, as they were rolling up to (his/her) room, (his/her) roommate (RI #21) was leaving (his/her) room. (RI #21) came out of the room trying to get by when (RI #2) hit (him/her). the facility will substantiate resident on resident abuse .</p> <p>RI #2 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Severe Intellectual Disabilities and Anxiety Disorder.</p> <p>RI #2's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/08/2025 documented a Brief Interview for Mental Status (BIMS) score of zero of 15, which indicated severely impaired cognition.</p> <p>RI #2's care plans were reviewed and included a plan of care initiated on 03/03/2020 with a revision date of 02/25/2025 addressing focus areas of verbal and physical behaviors such as: speech was usually unclear garbled unless he/she was cursing, was easily agitated, and history of combative behaviors; and a plan of care initiated on 05/13/2024 addressing focus areas of mood and behaviors including physically and verbally aggressive, verbal outbursts and fist shaking at staff to indicate he/she is upset. RI #2's care plans did not include any direction to staff regarding the level of supervision needed to keep other residents safe until after the incident on 04/30/2025.</p> <p>RI #21 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include: Adjustment Disorder with Depressed Mood, Vascular Dementia, and Major Depressive Disorder.</p> <p>RI #21's annual MDS assessment with an ARD of 03/04/2025 documented a BIMS score of 15 of 15, which indicated no impaired cognition.</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 05/20/2025 at 3:44 PM RI #21 was asked about the incident on 04/30/2025 and RI #21 stated, he/she was trying to go out of the room and RI #2 started swinging at him/her and RI #21 put up his/her hand to block RI #2 from hitting him/her. RI #21 said, RI #2 hit him/her on the wrist. RI #21 stated, he/she was not hurt. RI #21 stated, RI #2 had fits when staff try to put RI #2 in the bed.</p> <p>On 05/21/2025 at 8:20 AM CNA #4, who was working at the time of the incident, was asked about the incident involving RI #2 and RI #21. CNA #4 recalled she pushed RI #2 to his/her room and RI #2 did not want to go to bed. CNA #4 said, she left the resident in front of the door and went to tell the nurse that RI #2 did not want to go to bed. CNA #4 said, when she returned to RI #2's room, CNA #5 told her RI #2 hit RI #21.</p> <p>On 05/21/2025 at 9:55 AM, a phone interview was conducted with CNA #5 who witnessed the incident between RI #2 and RI #21. CNA #5 said she recalled CNA #4 brought RI #2 to her/his room, and RI #2 was crying and did not want to go into the room. CNA #5 said, she saw RI #21 trying to come out of the room and raising his/her hands to block the hit from RI #2.</p> <p>On 05/21/2025 at 8:56 AM Licensed Practical Nurse (LPN) #6 was asked about the incident on 04/30/2025 and she stated RI #2 was in the dayroom, was getting irritable, so she asked CNA #4 to take RI #2 to his/her room to be changed, and about five minutes later CNA #5 came to the nurses station and told her there had been an altercation between RI #2 and RI #21. LPN #6 stated, she immediately went to the room and RI #2 was in the doorway of the room and RI #21 was in activity room. LPN #6 said, a body audit was conducted on both residents, RI #21 did not have any injuries.</p> <p>On 05/21/2025 at 10:05 AM, a follow-up phone interview was conducted with CNA #4. CNA #4 was asked why she left RI #2 at the doorway of her/his room. CNA #4 said, she went to tell LPN #6 that RI #2 would not go to bed. When asked what should she have done when she could not get RI #2 to go to bed, she said she should have brought RI #2 back to the day room.</p> <p>On 05/21/2025 at 3:32 PM, an interview was conducted with the Social Services Director (SSD). The SSD stated, she became aware of the incident between RI #2 and RI #21 during the investigation. The SSD said, she was told RI #2 was trying to go into the room, RI #21 was coming out of the room, RI #2 held his/her hand up and RI #21 blocked RI #2 from hitting him/her. The SSD said, they were separated, and CNA #4 reported the incident to LPN #6. The SSD stated, RI #2 was sent out to the hospital for a psychiatric evaluation. When asked how a reasonable person would feel about being hit, the SSD said, bad and shocked.</p> <p>On 05/21/2025 at 4:50 PM the Director of Nursing (DON) was interviewed about the incident that occurred between RI #2 and RI #21 on 04/30/2025. The DON was asked about RI #2's behaviors and stated RI #2 would curse and had triggers sometimes depending on what was going on at the moment. The DON said no one would like to be hit.</p> <p>The facility took the immediate action to correct the non-compliance; thus, past non-compliance was cited.</p> <p>*****</p> <p>The facility's immediate actions included:</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>04/30/2025 at 1:55 PM- Resident Altercation occurred, residents separated immediately, and nurse informed.</p> <p>04/30/2025 2:05 PM- Administrator (ADM)-informed and investigation began</p> <p>04/30/2025 at 2:07 PM-Mental health notified</p> <p>04/30/2025 at 2:14 PM- Skin assessment completed on both residents</p> <p>04/30/2025 at 2:15 PM SSD and ADM began resident interviews</p> <p>04/30/2025 at 2:17 PM Doctor Notified, orders received to send RI #2 to Providence ER for Evaluation and treatment</p> <p>04/30/2025 at 2:20 PM- Family notified</p> <p>04/30/2025 at 2:50 PM Ambulance picked RI #2, Abuse Inservice started for staff for Resident on Resident abuse</p> <p>04/30/2025 3:58 PM- Care plan updated for supervision of RI #2</p> <p>04/30/2025 Notified ADPH</p> <p>04/30/2025 at 8:07 PM RI #2 returned to facility and room move occurred. Behavior Monitoring Continued</p> <p>05/01/25-3 Day SS Follow up began</p> <p>ADHOC QAPI</p> <p>05/02/2025 PHQA Root Cause Analysis initiated</p> <p>05/05/2025-Mental Health Visit</p> <p>05/06/2025-5 Day Report Sent to ADPH</p>		