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	09/11/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and review of facility policies titled, DATING AND LABELING POLICY, COMPLETING LOGS POLICY, and DISH WASHING AND POT WASHING, the failed to ensure:1) food items in dry storage and the freezer were dated and labeled,2) a styrofoam cup was not left in the flour bin,3) the freezer temperatures for the evening shift were recorded on 09/04/2025, 09/05/2025, and 09/06/2025 and;4) plates were free of food debris on the tray line.This had the potential to affect 54 of 55 residents who receive meals from the kitchen. Findings Include: 1) Review of an undated policy titled, DATING AND LABELING POLICY revealed: Policy: All foods are to be labeled and dated appropriately to ensure food safety regulations are followed. Procedure: 1. Upon receiving and storing all items must be labeled with the name of food and receive date. On 09/07/2025 at 2:46 PM, the surveyor toured the dry storage area and the freezer with [NAME] #1. The surveyor observed a ten-pound bag of spaghetti, enriched macaroni and raisin bran cereals with no open and no use by date in dry storage. The surveyor observed in the freezer two bags of peppers and onions opened with no open and use by date. On 09/10/2025 at 8:44 AM, an interview was conducted with [NAME] #1. [NAME] #1 stated that there were several items in dry storage and in the freezer that did not have an open and use by date. The items include spaghetti, macaroni noodles, raisin bran cereal and peppers and onions in the freezer. [NAME] #1 stated that the items were opened by someone and improperly stored. [NAME] #1 stated that items should be labeled and dated as soon as they are used and before storing them. According to [NAME] #1, the label should contain the name of the items, the open date, the use by date and the person's initial. The [NAME] #1 stated that whoever opened the product was responsible for labeling and dating it. [NAME] #1 stated that the facility's policy on labeling was soon as the product was opened date, label and store it. The cook stated that it was important that food items are dated and labeled because they would need to know the expiration date. On 09/10/2025 at 9:12 AM, an interview was conducted with the Food Service Director (FSD). She stated that it was important that foods are labeled to ensure quality and to make sure no bacteria or hazardous things grow on it. The FDS stated that the facility's policy was to date and labeled everything opened and everyone in the kitchen was responsible for labeling. 2) On 09/07/2025 at 2:46 PM the surveyor along with [NAME] #1 observed a styrofoam cup on top of the flour in the flour bin. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	09/11/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/10/2025 at 8:51 AM an interview was conducted with [NAME] #1. He stated that a white 16 ounces cup was in the flour bin. [NAME] #1 stated that it was used for scoping flour. [NAME] #1 stated that the facility's policy states that nothing should be in the flour bin. [NAME] #1 stated that every cook was responsible for making sure nothing was in the flour bin. According to [NAME] #1, dipping items for the flour should be washed, cleaned, sanitized and stored after use. The [NAME] #1 stated that cups should not be left in the flour bin to prevent cross contamination. On 09/10/2025 at 9:15 AM, an interview was conducted with the FSD. The FSD stated nothing should be in the flour bin but flour. She stated that it was important that cups were not left in the flour bin to ensure no contamination of he flour. 3) Review of an undated policy titled, COMPLETING LOGS POLICY, revealed: Policy: To accurately and effectively track and recording temperatures . Procedure 1. Refrigerator temperatures are to be taken by the opening and closing cooks. All temps should be logged . Review of a facility document titled, FREEZER TEMPERATURE RECORD . dated Sept (September) 2025. There were no dates logged for 09/04/2025, 09/05/2025 and 09/06/2025. On 09/07/2025 at 2:46 PM, the surveyor observed no recorded temperatures for the evening shift on 9/04/2025, 09/05/2025 and 09/06/2025. On 09/10/2025 at 9:08 AM, an interview was conducted with [NAME] #1. [NAME] #1 stated there was no recorded temperature for 09/04/2025, 09/05/2025 and 09/06/2025. Cook #1 stated that the morning temperature was recorded and not the evening. [NAME] #1 was asked what the facility policy was on documenting on the temperature log. He stated that all temperatures must be recorded twice daily in the morning and evening before going home. The [NAME] stated that the temperatures should be documented to prevent food from spoiling, and to let them (kitchen staff) know the equipment was cooling properly. On 09/10/2025 at 9:24 AM an interview was conducted with the FSD. She stated that temperatures should be recorded on the freezer log in the morning and evening. The cook should record the temperatures on the freezer log to ensure the temperature was in range to keep the food safe. 4) Review of an undated policy titled, DISH WASHING AND POT WASHING . revealed: .v Dishwasher Operation: . Inspecting items. Check items as they come out of the machine and put through again if not clean. On 09/09/2025 at 10:32 AM, the surveyor observed [NAME] #2 pull four dirty plates off the food line and served food in three of those four dirty plates. The surveyor observed black spots in three plates. On 09/10/2025 at 9:05 AM, an interview was conducted with [NAME] #2. She was asked what was in the plates that was pulled from the tray line, and she stated something was on them, they were not clean. She stated she had no idea why food debris was in the plates. According to [NAME] #2, whoever washed the dishes was responsible for clean plates at the tray line. [NAME] #2 stated that the facility policy on dirty plates was to remove them from the tray line and [NAME] # 2 said she put (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	09/11/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	food of 2 dirty plates that were removed from the tray line. On 09/10/2025 at 9:21 AM, an interview was conducted with the FSD. She was asked what she saw in plates pulled from the tray line. She stated stains and food debris. According to the FSD, the plates were not inspected properly after cleaning. She stated that it was important that plates were clean at the tray line to ensure no contamination or bacteria was transferred to the residents.

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	09/11/2025

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interviews and a review of a facility policy titled GARBAGE AND TRASH DISPOSAL POLICY, the facility failed to ensure the door of the trash dumpster on the front side was closed. This had the potential to affect 55 of 55 residents who reside at the facility. Findings Include: Review of an undated facility policy titled GARBABE AND TRASH DISPOSAL POLICY revealed: PURPOSE: To educate all new hires and current employees on the proper procedures for garbage and trash disposal. PROPER GARBAGE AND TRASH DISPOSAL: . Dumpsters should be properly maintained: Dumpster door . must be closed at all times when not in use. On 09/07/2025 at 3:01 PM, the surveyor and the evening [NAME] #1 toured the dumpster area. The dumpster door was opened on the front side. On 09/10/2025 at 8:57 AM, an interview was conducted with [NAME] #1. [NAME] #1 stated that the dumpster door was opened. He stated that someone did not close the dumpster. According to [NAME] #1, everyone was responsible for keeping the dumpster door closed. [NAME] #1 stated that the dumpster door should be closed because of rodents and odors. [NAME] #1 stated that the facility's policy states that the dumpster should be closed at all times. According to [NAME] #1, everyone in the facility could be affected by the dumpster doors being left open because of food and trash. On 9/10/2025 at 9:18 AM, an interview was conducted with the FSD. The FSD stated that the dumpster should be closed at all times unless it was in use. She stated the person who was using the dumpster was responsible for keeping it closed. According to the FSD, the dumpster doors should be closed to ensure animals do not enter and for safety reasons.

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	09/11/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, medical record review and facility policies titled, Oxygen Administration and Oxygen Tubing and (&) Humidification Change Policy, the facility failed to ensure Resident Identifier (RI) #'s 9, #15, #42 and #54 Oxygen (O2) tubing was labeled/dated. The facility further failed to ensure RI #42 and RI #54's O2 concentrator water bottle was not empty during the administration of oxygen on 09/07/2025.This deficient practice affected RI #9, RI #15, RI #42 and RI #54 four of four residents sampled for respiratory care. Findings Include: Review of a facility policy titled, Oxygen Administration with a revision date of 2010, revealed: Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration . Steps in the Procedure 12. Check the mask . humidifying jar, . to be sure they are in good working order . Be sure there is water in the humidifier . and the water level is high enough that the water bubbles as oxygen flows through. Review of a facility undated policy titled, Oxygen Tubing (And) & Humidification Change Policy, revealed: Purpose: To ensure the health, safety, and comfort of resident by maintaining clean and functioning respiratory equipment. Policy Details: 1. Tube Change: weekly -All respiratory tubing (including oxygen tubing, .) must be changed at least once a week . 2. Humidifier Change: -Humidifier water chambers and reservoirs must be emptied, cleaned, and refilled with sterile or distilled water at least once a week. 3. Procedure: - Staff must follow . instructions for cleaning and replacing tubing and humidifiers. RI #54 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with a diagnosis of Acute Respiratory Failure with Hypoxia. RI #54's Physician Orders for September 2025 revealed: Oxygen (O2) at @2L (liters)/NC (nasal cannula) AS NEEDED TO KEEP O2 SAT >90% as needed . Change O2 supplies included O2 tubing and humified water bottle. Label tubing and water bottle with date . On 09/07/2025 at 4:54 PM, the surveyor observed RI #54 lying in bed. RI #54's O2 machine was on but RI #54 was not wearing his/her oxygen mask. The surveyor observed no label/date on RI #54's oxygen tubing and no water in the humidifier. (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	09/11/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/07/2025 at 5:40 PM an interview was conducted with the Assistant Director of Nurses (ADON). The ADON said RI #54's oxygen tubing was not labeled/dated but should have been labeled and dated. She said the night nurse was responsible for ensuring the oxygen tubing was labeled/dated. The ADON said the nurse should place her initials and date on the tubing, so the nursing staff would know when the oxygen tubing was changed. The ADON further said the humidifier bottle should be changed when ran out. RI #42 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease, and Chronic Respiratory Failure with Hypoxia. RI #42's Physician Orders for September 2025 revealed: Oxygen @2L PER N/C continuous for Shortness of Breath (SOB) and to keep sat>90% every shift, change O2 supplies including O2 tubing and humidified water bottle. Label tubing and water bottle with date . every night shift every Sunday (Sun) . On 09/07/2025 at 5:12 PM, the Surveyor observed resident with O2 on infusing per nasal cannula, there was no date on the oxygen tubing and no water in the humidifier/water bottle. On 09/07/2025 at 5:48 PM an interview was conducted with the ADON. The ADON stated RI # 42's oxygen tubing was not labeled/dated and there was no water was in the humidifier/water bottle. When asked what was the importance of ensuring the oxygen tubing was labeled and dated, she said the oxygen tubing expires every 7 days. The ADON further stated it was important to ensure the humidifier/water bottle was filled, because it keeps the nasal cavity moist; when there was no water in the humidifier it would dry the resident's nose. RI #9 was admitted to the facility on [DATE] with diagnosis of Chronic Respiratory Failure with Hypercapnia. Resident was readmitted to the facility on [DATE] with diagnoses to include Acute and Chronic Respiratory Failure with Hypoxia and Obstructive Sleep Apnea. A review of RI #9's Physician Order Report dated 07/21/2025, revealed an order to Clean O2 concentrator filter every night shift every Sun . Change oxygen tubing and canister every night shift every Sun. Change oxygen tubing and canister as needed. Oxygen at 2 Liters/minute Via: NC every shift. A review of RI #9's Physician Order Report dated 07/21/2025 revealed: BIPap with pressure settings12/6 as needed for during the day while napping. BIPap with pressure settings 12/6 at bedtime related to CHRONIC RESPIRATORY FAILURE WITH HYPERCAPNIA, OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC). A review of RI #9's Significant Change Minimum Data Set (MDS) with Assessment Reference Date (ARD) 08/27/2025 Section O indicated oxygen therapy and Noninvasive mechanical ventilator (BIPAP). (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	09/11/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/07/202 at 4:00 PM, the surveyor observed RI #9 lying in bed. RI #9's oxygen was infusing via nasal cannula. There was no label nor date on the oxygen tubing nor humidified water bottle. The BIPAP mask was not labeled nor dated. On 09/07/2025 at 5:54 PM an interview was conducted with Licensed Practical Nurse (LPN) #12. LPN #12 escorted the surveyor to RI #9's room. The surveyor asked LPN #12 what she observed with RI #9's oxygen tubing and she stated it was not dated. Surveyor asked LPN #12 should the CPAP mask be covered and she stated yes it should be. LPN #12 stated that oxygen/nebulizer tubing and masks should be changed weekly. When asked the concern of the tubing not being changed and dated LPN #12 stated staff would not know when the tubing was changed and its a risk for infection. RI #15 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia and Sleep Deprivation. Resident was readmitted to the facility on [DATE]. A review of RI #15's Physician Order Summary Report dated 03/18/2025, revealed Continuous oxygen @2 L per NC A review of RI #15's Physician Order Summary Report dated 03/21/2025, revealed an order to Clean O2 concentrator and filters every night shift every Sun .Change O2 supplies including 02 tubing and humidified water bottle .Label tubing and water bottle with date. Apply ear protectors as resident will allow every night shift every Sun related to CHRONIC RESPIRATORY FAILURE WITH HYPOXIA (J96.11). On 09/07/2025 at 6:05 PM, surveyor observed RI #15 lying in bed. RI #15's oxygen was infusing via nasal cannula. There was no label nor date on the oxygen tubing nor humidified water bottle. On 09/09/2025 at 11:40 AM surveyor made an observation in RI #15's room and noted the oxygen tubing lying on the bedside table uncovered. On 09/09/2025 at 11:45 AM an interview was conducted with LPN #13 after escorting to RI #15's room. The Surveyor showed LPN #13 the oxygen tubing on the bedside table disconnected from the water bottle. When asked if the tubing should be disconnected, LPN #13 stated the tubing should not be disconnected from the water bottle or on this bedside table. She stated that the tubing should be in a plastic bag to protect from germs and bacteria. On 09/09/2025 at 3:56 PM Certified Nursing Assistant (CNA #14) was asked if a resident on oxygen or nebulizer with the mask not in use, where should the tubing be placed, and she stated it should be in a plastic bag with the date on it. On 09/11/2025 at 4:00 PM an interview was conducted with the Director of Nursing (DON). She was given the facility policy to review and was asked according to the oxygen tubing and Humidification Change Policy how often tubing was to be changed. She stated weekly and as needed should it appear damaged. The DON stated humidifier bottles and nebulizer masks should be changed weekly, labeled with name of resident with date and initials of person who changed it. The DON stated the RN or LPN changes the oxygen /nebulizer tubing/masks every Sunday on night shift and the change should be documented on the Medication Administration Record (MAR). The DON was asked why RI #9 and RI #15's oxygen tubing was not labeled on 09/07/2025 during the initial tour. The DON stated a staff nurse did not follow policy to label the tubing on 08/31/2025 even though it was documented on (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	09/11/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the MAR. The DON stated that oxygen tubing/nebulizer masks should be stored in a zip lock or plastic bag to help prevent infection and contamination. The DON stated it was important to date oxygen tubing/ humidifier bottles/masks to verify that it has been changed and to prevent risk of infection.

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	09/11/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on interviews, resident record review, review of a Facility Reported Incident (FRI), review of the facility investigative file, and review of a facility policy titled Accidents and Incidents, the facility failed to ensure Certified Nursing Assistant (CNA) #5 immediately reported an incident/accident to licensed nurses on 09/05/2025 when Resident Identifier (RI) #20 voiced discomfort during care and told CNA #5 someone ran over his/her foot with a wheelchair. CNA #5 failed to report to anyone RI #20's voiced discomfort and observed swelling to RI #20's foot. The incident/accident was not reported or investigated until 09/09/2025 when RI #20 was observed with bruising and swelling to the right knee and leg and x-ray results revealed an acute proximal tibia fracture. This deficient practice affected RI #20 one of two residents sampled for accidents and had the potential to result in delayed assessment and treatment. Findings Include: On 09/09/2025 the State Agency received a FRI from the facility alleging an injury of unknown origin was identified on 09/09/2025 at 8:33 AM when CNAs were bathing RI #20 and noticed bruising and swelling to the right knee and leg and called for the Director of Nursing (DON) and Assistant DON to come to the shower to observe the swollen knee and leg; upon x-ray a fractured proximal tibia was revealed; the doctor was notified and RI #20 was sent to the hospital. A facility policy titled Accidents and Incidents-Investigating and Reporting with a revision date of 2017 documented:Policy StatementAll accidents or incidents involving residents . shall be investigated and reported to the administrator. Policy Interpretation and Implementation 1. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the report of incident/accident form:a. The date and time the accident or incident took place;b. The nature of the injury/illness . c. The circumstances surrounding the accident or incident;d. Where the accident or incident took place; . RI #20 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Heart Failure, and a History of Pain in the Right Knee. RI #20's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/28/2025 documented a Brief Interview for Mental Status (BIMS) score one which indicated severe cognitive impairment. The facility investigative file for the FRI included RI #20's mobile imaging x-ray results with a date of service of 09/09/2025 and a conclusion of an acute proximal tibia fracture. The facility investigative file for the FRI included an undated summary of the incident signed by the Administrator which documented: . On 09/09/2025 a CNA bathing (RI #20) noticed bruising and swelling to (RI #20's) right knee and leg. x-rays were ordered . results confirmed a fracture to the . tibia. (RI #20) told 2 different sets of events. The first event . stated (he/she) fell, . The second event was when someone ran over (his/her) foot with the wheelchair. We interviewed staff, and on 09/05/25 a CNA reported some swelling but no bruising. She did not report this to the nurse . we are substantiating an injury of unknown origin.The investigative file contained a handwritten witness statement for CNA #5 on a facility document titled Staff Interview Questions dated 09/10/2025 signed by the DON as the interviewer. The statement documented the following: . 1. Have you noticed swelling or bruising to (RI #20's) leg? (RI #20) had a little swelling on Friday (9/5/2025) . 4. Has (RI #20) ever said Ouch or given any indication of pain . in the last 2 weeks? Yes. On Friday (he/she) said someone rolled over (his/her) foot with a wheelchair.On 9/11/2025 at 10:22 AM CNA #5 was asked to review her witness statement and she agreed that was her statement regarding RI #20. CNA #5 said, the last time she worked with RI #20 was on 09/05/2025 when RI #20 told her someone had ran over his/her foot with a wheelchair. CNA #5 said, she was putting a sock on RI #20 when RI #20 said, ouch, and that someone had ran over his/her foot with a wheelchair. CNA #5 said, she observed minimal swelling on RI #20's foot with no bruising. CNA #5 stated, she did not report this incident to anyone because RI (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	09/11/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#20 did not identify who had run over his/her foot, or when it occurred, and RI #20 described it as an accident. When asked if this incident should have been reported, CNA #5 said, it should have been reported due to RI #20's claim that his/her foot had been run over and reported pain when his/her foot was touched. CNA #5 said, the importance of reporting the incident was to ensure everyone was informed and RI #20 received appropriate care.Review of RI #20's medical record revealed a Weekly Body Audit form dated 09/03/2025, electronically signed by the DON, indicating no new skin alteration was identified. On 09/11/2025 at 12:05 Licensed Practical Nurse (LPN) #6 who worked on 09/05/2025 from 2:00 PM to 10:00 PM indicated that throughout her shift there were no reports of anyone having run over RI #20's foot with a wheelchair. LPN #6 said, if RI #20 had informed a CNA it should have been communicated to either herself or the supervisor. LPN #6 said, had this been reported to her she would have notified the supervisor and assessed the resident. LPN #6 said, it was important to ensure the resident received appropriate care. On 09/11/2025 at 12:39 PM LPN #7 was asked about the incident involving RI #20. LPN #7 stated she became aware of the injury of unknown origin on 09/09/25 when RI #20 was being transported to the shower room. LPN #7 said she observed swelling and discoloration on RI #20's leg. LPN #7 said that no CNA had reported to her that RI #20's foot had been run over by a wheelchair or that he/she had fallen. LPN #7 said, if a resident told a CNA someone ran over their foot with a wheelchair or they saw swelling, it should have been reported it to the nurse or supervisor. LPN #7 said this was important to ensure no delay in care.On 09/11/2025 at 12:49 PM Registered Nurse Supervisor (RNS) #8 was questioned regarding the incident involving RI #20. RNS #8 indicated she worked on 09/05/2025 from 2:00 PM to 10:00 PM, on 9/6/2025 from 2:00 PM to 10:00 PM, and from 10:00 PM to 6:00 AM on 9/7/2025. RNS #8 reported that during her shifts she saw RI #20 in his/her wheelchair. RNS #8 said, no staff members informed her of any pain experienced by RI #20 on either 09/05/2025 or 09/06/2025. The RNS stated that if staff had reported an incident concerning RI #20, she would have assessed the resident, checked for pain, and notified the Doctor and Director of Nursing (DON). RNS #8 stated, if an incident was not reported, it could result in a more serious issue and a delay in treatment.On 09/11/2025 at 1:17 PM the RN Unit Manager (RNUM) #9 was questioned regarding an incident involving RI #20. The RNUM confirmed she worked on 09/05/2025 from 9:00 AM to 2:00 PM. RNUM #9 stated, no staff members reported to her that RI #20 said someone had run over his/her foot with a wheelchair which resulted in swelling and had such a report been made she would have assessed the resident, prepared an incident report, notified the administrator and DON, and contacted the Medical Director (MD). RNUM #9 said the significance of reporting this incident would be to determine the extent of the injury, understand what transpired, and provide treatment as necessary to avoid any delays in care. The RNUM noted that during her shift on 09/05/2025 RI #20 did not report any pain. On 09/11/2025 at 4:51 the Certified Registered Nurse Practitioner (CRNP) was questioned regarding the incident involving RI #20. The CRNP indicated she first became aware of the incident concerning RI #20 on 09/09/2025 when she received a call reporting bruising, swelling, and an x-ray revealed a fracture. The CRNP said she wrote an order for RI #20 to be sent out for an evaluation. The CRNP stated she had not been informed on 09/05/2025 about any swelling or pain related to RI #20. The CRNP said, if a resident had reported on 09/05/2025 that someone had run over their foot with a wheelchair and swelling was observed she would expect the facility to conduct an x-ray and inform her of the results. On 09/11/2025 at 10:00 AM the DON was asked when she became aware of RI #20's injury. The DON said, the morning of 09/09/2025, the x-ray was done at the facility at 10:00 until 10:40 AM; the results were reported at 1:30 showing a broken tibia; and she informed the doctor. The DON said, RI #20 told them someone ran over his/her foot with a wheelchair. The DON said, during the facility investigation CNA #5 reported RI #20's leg was swollen on 09/05/2025.This citation was written as a result of Incident #2612850.

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	09/11/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record review, and facility policies titled Pain Assessment and Management and Administering Pain Medications, the facility failed to ensure Licensed Practical Nurse (LPN) #6 conducted a pain assessment to include the location of pain or other pain characteristics prior to administering as needed (PRN) pain medication to Resident Identifier (RI) #20 on 09/03/2025. This deficient practice had the potential to result in inadequate evaluation of the resident's pain and inappropriate treatment and affected RI #20 one of two resident sampled for pain. Findings Include:A facility policy titled Pain Assessment and Management with revision date of October 2022 documented: PurposeThe purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. General Guidelines 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management.3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of pain;e. Developing and implementing approaches to pain management;f. Identifying and using specific strategies for different levels and sources of pain;g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary.Assessing Pain4. Assess pain using a consistent approach .5. During the pain assessment gather the following information .c. Characteristics of pain:(1) Location of pain;(2) Intensity of pain .(3) Characteristics of pain (. aching, burning, crushing, numbness, burning .);(4) Pattern of pain (. constant or intermittent);(5) Frequency, timing, and duration of pain; . A policy titled Administering Pain Medications with a revision date of October 2022 documented: PurposeThe purpose of this procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication.Steps in the Procedure1. Provide for resident privacy.2. Explain the purpose of the assessment to the resident.3. Conduct a pain assessment as indicated.4. Conduct an abbreviated pain assessment if there has been no change of condition . The assessment shall consist of at least the following components:a. Whether pain has improved or worsened since the last assessment;b. The general condition of the resident;c. Verbal and non-verbal signs of pain;d. Level of consciousness; ande. Evidence or reports of adverse consequences related to medications.9. Re-evaluate the resident's level of pain 30-60 minutes after administering.DocumentationDocument the following in the resident's medical record: 1. Results of the pain assessment; 2. Medication; 3. Dose; 4. Route of administration; and 5. Results of the medication (adverse or desired). RI #20 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease, Heart Failure and Essential Hypertension. RI #20's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/28/2025 documented a Brief Interview for Mental Status (BIMS) score of one which indicated severe cognitive impairment. A review of RI #20's care plan documented a potential for pain. Interventions included to administer medication as ordered and assess for effectiveness of medication and document. RI #20's Medication Administration Record (MAR) dated September 2025 documented RI #20 received 500 milligrams (MG) of PRN acetaminophen on 09/03/2025. The MAR indicated the PRN pain medication was effective.On 09/11/2025 at 6:01 PM an interview was conducted with Licensed Practical Nurse (LPN) #6. During this interview LPN #6 was questioned regarding the administration of PRN pain medication given to RI #20 on 09/03/2025. LPN #6 said RI #20 had expressed discomfort due to knee and back pain. When asked whether she had recorded RI #20's pain level before giving the pain medication LPN #6 indicated that she could not remember if such documentation had been made prior to the medication's administration. LPN #6 said, she believed that the pain level was no greater than three otherwise she would have contacted the (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	09/11/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical doctor. LPN #6 said, she could have documented in a progress note but if it was not in the record, she did not document an assessment. LPN #6 said, she did not see the need to document the assessment because she thought RI #20 was fine after receiving the acetaminophen. On 09/11/2025 at 4:51 PM the Certified Registered Nurse Practitioner (CRNP) was questioned regarding RI #20 receiving PRN pain medication. The CRNP stated, when PRN pain medication was administered the nurse should evaluate the pain level using a scale from 1 to 10, and then reassess the pain after 30 minutes of medication administration. The CRNP indicated she would expect the nurse to record the pain level. The CRNP said it would be important to determine the pain level to see if the medication was working and if further assessment was needed.On 09/11/2025 at 5:20 PM an interview was conducted with the Director of Nursing (DON). During the interview the DON was asked whether the nurse had performed a pain assessment before administering RI #20 pain medication on 09/03/2025. The DON stated there was not any documentation in the medical record confirming that a pain assessment had been conducted. Furthermore, the DON stated the LPN should have been aware of the necessity to carry out the pain assessment prior to administering the pain medication. The DON said the significance of performing a pain assessment before the administration of pain medication was to evaluate its effectiveness and to ascertain whether the pain was a new occurrence or a chronic issue. Additionally, the DON said, RI #20 was prescribed pain medication due to a history of surgeries on the right knee, right ankle, and right hip. When questioned about how nurses would assess pain in residents with dementia, she explained that the assessment would encompass observations of breathing patterns, negative vocalizations, facial expressions, body language, and the ability to be consoled. This citation was written as a result of Incident #2612850.

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	09/11/2025

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Number of residents sampled:Number of residents cited Based on observations and interviews the facility failed to ensure the most recent Survey Results were readily accessible and visible for residents and visitors to review. Further, on 09/09/2025 during resident council, 10 out of 10 residents were not aware of how to access the Survey Results. The surveyor observed no Survey Results book in the front lobby area, or on the units on four out of the five days of survey. This deficient practice had the potential to affect 55 out of 55 residents residing in the facility and any visitor. Findings Include: Upon entering the facility on 09/07/2025 at 2:00 PM, the surveyor observed there were not any Survey Results posted, visible, or accessible in the lobby area for residents and visitors. On 09/07/2025 at 3:00 PM, the surveyor observed the bulletin board on the main hallway with postings of Resident Rights information, Grievance Forms and instructions, Ombudsman contact name and number, and a sign above the Grievance Forms that documented: Most recent results are available for your review and can be found in the front lobby . On 09/08/2025 at 8:27 AM and at 6:33 PM, the surveyor observed there were not any Survey Results posted in a visible area in the lobby area for residents and visitors. On 09/09/2025 at 2:00 PM a Resident Council meeting was held, and 10 out of 10 residents were unaware of where to access the Survey Results book. On 09/09/2025 at 9:04 AM and at 3:30 PM the surveyor observed both halls of the facility and there were no Survey Results posted or visible on either hall. On 09/10/2025 8:38 AM, the surveyor observed there were not any Survey Results posted in a visible area in the lobby area for residents and visitors. On 09/10/2025 at 9:05 AM an interview was conducted with the Social Services Director (SSD) about Survey Results postings. The SSD said the Survey Results were posted for families and residents to view and were kept in the front lobby. The surveyor and SSD walked to the front lobby for observation of the Survey book, and the SSD said it was supposed to be in the lobby. When asked why the book was not in the lobby, the SSD said, it should be and it must have been moved. The SSD said, it was important to have the Survey Results book accessible for residents and families to view.