STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095026	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knollwood Hsc	6200 Oregon Ave NW Washington, DC 20015

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, for one (1) of eight (8) sampled residents, the facility staff failed to implement its written policies and procedures for investigating incidents of abuse. Resident #4 The findings included:A review of the facility's policy titled Investigation of Incidents Abuse, Falls, Wounds, Reportable Events(effective date 09/2024), documented the following: 5. Procedure .C. Category Specific Guidance 1. Abuse Allegations: Remove alleged abuser from resident care pending investigation, Report to DC DOH per regulation, File with Adult Protective Services, if applicable, Submit findings to DOH .A review of a facility reported incident (FRI) (DC~12149) submitted to the State Agency on 07/31/23 at 4:31 PM documented the following: At 1:45 PM today (7.31.23), resident said to me that she has [had] a CNA (Certified Nurse Aide on evening shift (3-11 PM) this past Saturday (7/29) and Sunday (7/30) that was mean to her. I asked her, 'What made her mean?' She said she put the phone on the dresser hard for no reason and went on to say she was rough in the way she handled her. I asked her how. She said 'Everything she did and said - It's not a nurse. Normally, people say turn on the left side or the right side. This one is verbally rough, like she is taking care of a truck driver, not the patient.' I asked her about physical interaction. She said, 'She was ok, but she made me feel like I did something wrong and that I am against her. I thought maybe it was the age .when the younger age does not know how to take care of the elderly. A review of Resident #4's medical record revealed: Resident #4 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Chronic Diastolic Congestive Heart Failure, Schizophrenia, Unspecified Dementia, Major Depressive Disorder, and Tobacco Use. An admission MDS assessment dated [DATE],3,which documented that Resident #4 had a Brief Interview for Mental Status summary score of 13, indicating that the Resident had intact cognition and required extensive assistance by one staff member for bed mobility, transfers, and personal hygiene. A review of the facility's investigation documents for the alleged incident showed the following: 1. A written statement dated 07/31/23 from Employee #6, (Certified Nurse Assistant/ CNA), assigned to Resident #4 and alleged perpetrator in the incident that documented: [Name of Resident #4] was assigned to me on Saturday, 3:00 to 11:00, and Sunday 3:00 to 7:00 AM, Monday, 7/31/23. After Sunday evening, Resident #4] was my first resident to take care of. She was in bed while I was doing [her] care after washing her up. I wanted to put the wet diaper in the trash can. At the time, I noticed that the telephone cord and the oxygen cord was [were] wrapped under one of my feet, in the process of putting the wet diaper in the trash can. That's what caused her telephone to drop on the floor. I, [Name of Employee #6], was not verbally rough with the resident. [Name of Resident #4] asked me, 'What is that noise?' and I replied to her saying, 'It is the telephone which dropped on the floor.' Right away I took off my dirty gloves and put [the phone] back. where it was. I make [made] sure everything is cleared off [out of] my way before finishing care with her. Before leaving her room, I made sure I put everything by her reach.2. A typed statement dated 08/02/23, from Employee #7 (Former Director of Nursing/ DON) that documented: Conclusion to the investigation regarding report of staff caring for her being verbally rough [Name of Resident #4] reported 7/31/23 at 1:45 PM that the CNA who took care of her Saturday evening, 7/29/23 and Saturday night shift was verbally rough. [The] Resident was asked what happened on Saturday. She stated that the care was fine physically, and the CNA didn't say anything that was not kind, nor was she disrespectful. I asked her again if the CNA yelled at her, or if she was physically rough with her. She stated,' No.' She stated, that the CNA [placed] the phone hard on the dresser. Social Services also interviewed several residents on CNA's assignment, and there were no concerns about inappropriate interactions. Staff were reminded to be extra patient with her {Resident #4], and use please and thank you with requests. The allegation of being fairly rough could not be substantiated. A follow-up report was sent to the State Agency dated 08/02/23, which documented: Follow up to the Incident report sent 7/31/23 regarding resident [Name of Resident #4] report of staff being verbally rough and staff putting the phone hard on the dresser. The resident was interviewed by the social worker and DON (Director of Nursing), and she stated that the staff was not rude to her and didn't yell at her; she just didn't use please and thank you when communicating with her. The resident was also informed that the phone had fallen to the floor, which might be the noise that she heard. The staff that was mentioned in the concern was interviewed and stated that her interaction with the Resident didn't reflect the report. Several residents who were part of the C.N.A assignment were interviewed, as well, and they report[ed] just great interactions with staff. This allegation could not be substantiated A review of the Nursing assignment sheets

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews for one (1) of eight (8) sampled residents, facility staff failed to provide a physician discharge summary that included: a recapitulation of the resident's stay that includes, a final summary of the resident's status and reconciliation of all pre-discharge medications for a resident who was discharged home. Residents #4The findings included:Resident #4 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Chronic Diastolic Congestive Heart Failure, Schizophrenia, Unspecified Dementia, Major Depressive Disorder, and Tobacco Use.A review of Resident #4's medical record showed the following:A Nursing admission Note dated 07/28/2023 at 1:04 PM that documented: New admission . Resident, well-kempt, prior stay in assisted living in this facility. Resident is on oxygen 3/liters/minute/min infusing as ordered. [The] Resident was treated at [Name of Local Hospital] for CVA (Cerebral Vascular Accident/stroke) and bilateral hip pain. She has orders for Apixaban 2.5 mg and Tylenol prn (as needed) at 9:00 PM, respectively, for pain. Her diet is soft and bite-sized, with thin liquids, diet slip in place. Resident is DNR (do not resuscitate) .Resident is incontinent of bowel, bladder. Ambulatory with walker with supervision according to report from [Name of Local Hospital] . Some historical diagnoses include Colon ca (cancer), Anemia, PVD, Peripheral Vascular Disease) .A Social Work Progress Note dated 08/03/2023 at 3:56 PM that documented: admission paperwork sent to son for completion - awaiting a response - also LCD (long-term care discharge) will be 8/7/23 - to return to AL (assisted living)/ The Terrace on 8/8/23.A Nursing Progress Note dated 08/08/2023 at 10:58 AM that documented: resident alert, verbally responsive. Review of discharge summary. No questions. Copy provided to [the] Resident. reviewed with [the] Resident that A.L. staff will continue to administer her meds (medications) as before. [The] Resident is currently sitting in a chair in the room. awaiting updates for AL staff as to the time of transfer.A Nursing Progress Note dated 08/08/2023 at 12:35 PM that documented: resident assisted to a.l. (assisted living) In stable condition via w/c (wheelchair)/c on routine oxygen. w/c and other personal belongings brought back to apt. dietary and clinical nurse updated re: discharge.A Social Work Progress Note dated 08/08/2023 at 2:03 PM that documented: Resident returned to her AL Apartment in the Terrace - son aware. Note paperwork has never been returned by the son - 6-108 completed.Of note, there was no documented evidence of a physician discharge summary that included: a recapitulation of the resident's stay that includes a final summary of the resident's status and reconciliation of all pre-discharge medications for Resident #4. The Social Worker and the Nurse who cared for the resident before discharge on [DATE] were no longer employed by the facility and were not available for interview during the survey.During a face-to-face interview on 05/03/25 at 4:00 PM, Employee #2, (/Director of Nursing/DON), acknowledged that there was no physician's discharge summary included in Resident #4's medical record. She then stated that she would speak with the medical team and the Medical Director to ensure that upon a resident's discharge, the physician provided a physician's discharge summary in the resident's medical record that included: a recapitulation of the resident's stay, a final summary of the resident's status and a reconciliation of all pre-discharge medications.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews for one (1) of eight (8) sampled residents, the facility staff failed to update care plan interventions for a resident with a history of aggressive behaviors. Subsequently, the resident had two staff-witnessed incidents of aggressive behavior towards another resident. Residents #1 and #2The findings included1. Incident #1A review of an incident report submitted on 01/29/25 at 4:34 PM to the State Agency, that documented the following: Staff reported that Resident [Resident #1] was hit on shoulder by another resident,[Resident #2] Per staff report, she[staff] was escorting {Resident #2] to hair salon, as [Resident #2] walked past resident [Resident #1], [Resident #2] hit resident [Resident #1] on left shoulder. [Resident #1] responded with pain cues. [The] writer followed up with the resident [Resident #1}, who declined. being hit by another resident, and appeared upset that someone would report that she was hit. Resident [Resident #1] denies pain/discomfort to left shoulder, able to raise left shoulder to 90 as per baseline, no noted redness/discoloration, bruising, or] swelling noted to left arm. [The] Residents' POAs (Power of Attorney) [were] updated re: (regarding) incident .[The] MD (Medical Doctor) for both residents was updated. Order for psych consult received for [Resident #2] .A. Resident #1 was admitted to the facility on [DATE] with diagnoses that included: Bilateral Primary Osteoarthritis, Vascular Dementia, Major Depressive Disorder, Difficulty in walking, and Other Abnormalities of Gait and Mobility, and Pain in the Left Shoulder.A review of Resident #1's medical record revealed:An Annual Minimum Data Set (MDS) assessment dated [DATE] which documented that Resident #1, had a Brief Interview for Mental Status summary score of, 13, indicating that the Resident had intact cognition, In addition the Resident had: no display of verbal or physical behaviors towards other, lower extremity impairments on both sides, and used a manual wheelchair for mobility.A care plan initiated on 01/29/25 that documented: Problem: 01/29/25 [Resident #1] was hit by a fellow resident on the left shoulder. Goal: [Resident #1] will not show any signs and symptoms of injuries related to reported interaction. Approach: Administer prescribed pain relief if needed and apply ice to reduce swelling. Assess the injury dash. Check for bruising, swelling, pain or limited movement. Document findings. Monitor for changes dash Watch for increased pain, redness, or other signs of complications. Emotional support -Reassure [Resident #1] offer comfort and assess for emotional distress.SheDuring a face-to-face interview on 05/30/25 at 2:35 PM, Resident #1 stated, 'She [Resident #2] just pulled back and slapped me'. She further commented, 'She [Resident #2] hit me twice, once on the shoulder and another time across her face.' When asked if she felt safe at the facility, she stated, 'Yes, I just stay away from the Resident #2.B. Resident #2 was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease, Peripheral Vascular Disease, Fibromyalgia, Depression, Insomnia, and Chronic Pain Syndrome.A review of Resident #2's medical record showed:A physician's order dated 12/12/24 that directed: Trazadone 50 mg tab; 1/2 tab = 25 mg; orally; Three times a day. Special Instructions: Give 1/2 tab = 25 mg by mouth at 8:00 AM, at 12:00 PM, and at 9:00 PM for Agitated Dementia. (***Hold if resident is drowsy or sleeping).An Annual Minimum Data Set (MDS) assessment dated [DATE], which documented that Resident #2 had severely impaired cognition. In addition, facility staff noted that the Resident showed signs of being short-tempered and easily annoyed, and had received an antidepressant medication within the last seven days of the assessment.A Physician/Psychiatrist Note dated 01/01/2025 at 09:57 PM that documented: For 12-31-2024 patient had just berated another patient who can be at times quite intrusive; however, when I met with her, she was very pleasant and cheerful. Indeed, we joked with one another. Her current dosage of Zoloft is somewhat sedating, and we may well have to consider switching her to a medication which is less sedating.A Physician/Psychiatrist Note dated 01/09/2025 at 10:30 PM that documented: Patient continues to exhibit aggressive behavior. In particular, after lunch. However, she can be distracted and engaged at times in a way that diminishes her anger and excitability.A Physician/Psychiatrist Note dated 02/04/2025 at 5:00 PM that documented: for 02-04-25 patient seen with her usual companion since transfer to unit from assisted living. She was calm and polite but volunteered little information to the questions she was asked. Staff, however, reports she can be very aggressive with aids and at times physically aggressive. She has a very quick temper and, at times has been aggressive with patients. This has been a persistent problem with this patient. She can be calm for extended periods and explosive at the drop of a hat. She gets an angry look in her eyes, and at these times should be left alone and have no further stimulation. She usually calms down. She still has a sense of humor and often responds to a joke about her past. [The] Patient always denies

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews for one (1) of eight (8) sampled residents, facility staff failed to adequately monitor and supervise a resident with a high fall risk. Subsequently, the Resident had three unwitnessed falls in the same month (02/07/25, 02/22/25, and 02/28/25). The unwitnessed fall on 02/28/25 resulted in a sustained injury. Resident #8The findings included:A review of the facility's policies and procedures approved on 09/06/24, entitled, Fall Prevention Policy documented: Policy Goals: ' .To reduce the risk of falls and related injuries by addressing modifiable factors . Procedure: A fall risk assessment should be completed on admission and quarterly at a minimum. If the total score is 10 or greater, the resident should be considered at risk for falling. The pharmacy consultant should review each resident's medications to uncover potential drug-to-drug interactions and to make suggestions regarding inappropriate drug usage. This should result in written recommendations to the resident's primary care physician that could eliminate or reduce the dosage of medication that could predispose a resident to a fall. After a fall, the resident will be reassessed by the interdisciplinary team. Assessment will include the determination of possible causal factors, considering environmental factors, residents, medical condition, the resident's behavior, manifestation, medical or assistive devices.A review of the facility's policies and procedures approved on 09/06/24, entitled, Resident Monitoring and Rounding Policy, documented: Purpose: To ensure the safety, dignity, and well-being of residents through regular monitoring and timely response to their needs .Scope: This policy applies to all nursing and rehabilitation staff members, including registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), and support personnel 1. Resident Monitoring and Rounding procedures: 1.1 Frequency of Rounds- General Rounds: Nursing staff shall conduct rounds at least every two hours during the night shift to monitor residents who are unable to use signaling devices or who have specific care needs .2. Day and Evening Shifts: Rounds shall be conducted at regular intervals to ensure continuous monitoring and timely response to resident needs. 1.2 Documentation: A written log shall be maintained, recording the date and time of each round, the name of the staff member conducting the round, and any observations or actions taken. Logs shall be retained for a minimum of two years and be available for review buy DOH inspectors .Resident # 8 was admitted to the facility on [DATE] with diagnoses that included: Bilateral Primary Osteoarthritis of first Carpometacarpal Joints, Hypothyroidism, Psychotic disorder with delusions, Prediabetes, Syncope and collapse, Generalized Muscle Weakness, and Unspecified Multiple Injuries.A review of Resident #8's medical record revealed the following:A physician's order dated 10/21/24 that directed, Ambien (Zolpidem) [a hypnotic medication] - Schedule IV tablet; 5 mg (milligram) amt (amount): 1 tab oral. Special instructions: Ambien 5 mg po (by mouth) hs (at bedtime) dx (diagnosis); sleep at bedtime.A physician's order dated 11/05/24 that directed, Eliquis (Apixaban)[an anticoagulant//blood thinning medication] Tablet 5 mg 1 tablet, oral. Special instructions: Eliquis 5 mg po BID (twice) a day for LE (lower extremity), DVT (Deep Vein Thrombosis). Twice a day: 9:00 AM, 5:00 PM.A physician's order dated 1/16/ 24 that directed, Depakote (Divalproex)[an anticonvulsant medication] tablet, delayed release/enteric coated (DR/EC). 125 mg, amt: 1 tab oral; Special instructions: Begin Depakote 125 mg po, give 1 tab BID for Agitation,An annual Minimum Data Set (MDS) assessment dated [DATE] which documented that Resident #8, had a Brief Interview for Mental Status summary score of, 12, indicating that the Resident: had moderately impaired cognition, had displayed verbal behaviors towards others, required substantial/maximal assistance by staff for transfers, had received a hypnotic, an anticoagulant, and an anticonvulsant, within the last seven days of the assessment, and had received physical therapy.A physician's order dated 01/24/25 that directed, Clonazepam - Schedule IV tablet; 0.5 mg; amt: Give 1/2 (one half) tablet (0.25 mg); oral; Special instructions: Begin Depakote 125 mg po give 1 tab BID for Agitation.Fall #1 - Unwitnessed fall on 02/07/25A Nursing Progress Note dated 02/07/25 at 6:00 PM, that documented: At around 6:00 PM, this writer was called by staff to go in[to] [Resident #8's Room Number]. When questioned [asked] what happened, she said she fell. When questioned if she is in pain, she said her left knee, which has a history in the past of having pain and swelling to her left ankle due to decreased mobility, impaired gait balance, and multiple joint pain, with a h/o (history of) falls in the past with injury. ROM (range of motion) done to bilateral UE and LE (upper extremities and lower extremities), and able to move all extremities. With no problem. Neuro checks initiated. No bruises noted at this time. [Name of Physician] [was] notified about the fall with [an] order to continue monitoring [the] Resident and any changes