STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445410	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knollwood Manor	405 Times Ave Lafayette, TN 37083

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (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 0553 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 facility policy review, medical record review, and interview, the facility failed to ensure Care Plan conference meetings were held on admission and quarterly for 2 of 12 (Resident #5 and #19) sampled residents reviewed for Care Plan meetings. Based on facility policy review, medical record review, and interview, the facility failed to ensure Care Plan conference meetings were held on admission and quarterly for 2 of 12 (Resident #5 and #19) sampled residents reviewed for Care Plan meetings. The findings include: 1. Review of the undated facility policy titled, Care Plan Meeting Policy, revealed .To ensure each resident receives a person-centered, up-to-date plan of care developed by an interdisciplinary team, with resident/family participation, per federal and state standards.A care plan meeting will be held within 7 days following a new comprehensive assessment. Care plan meetings will be reviewed and updated at least quarterly.The resident, and/or the resident's family or legal representative, should be invited and encouraged to participate. A written summary of the meeting must be entered into the resident's record.including participant names and roles.If the resident or representative chooses not to participate, that decision.must be documented. Residents have the right to be involved in decisions about their care.The facility administrator or designated quality manager will periodically audit care plan meetings and documentation for compliance. 2. Review of the medical record revealed Resident #5 was readmitted to the facility on [DATE], with diagnoses including Traumatic Subarachnoid Hemorrhage, Convulsions, Cerebral Infarction, and Pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #5 scored a 13 on the Brief Interview of Mental Status (BIMS) assessment, which indicated Resident #5 was cognitively intact. The facility was unable to provide documentation that Resident #5 and/or her representative was invited to the Care Plan meeting after the completion of the 12/17/2024 quarterly MDS assessment. Review of the annual MDS assessment dated [DATE], revealed Resident #5 scored a 1 on the BIMS assessment, which indicated Resident #5 was severely cognitively impaired. The facility was unable to provide documentation that Resident #5 and/or her representative was invited to the Care Plan meeting after the completion of the 3/1/2025annual MDS assessment. Review of the quarterly MDS assessment dated [DATE], revealed Resident #5 scored a 12 on the BIMS assessment, which indicated Resident #5 was moderately cognitively impaired. The facility was unable to provide documentation that Resident #5 and/or her representative was invited to the Care Plan meeting after the completion of the 8/26/2025 quarterly MDS assessment. Review of the medical record revealed Resident #5 Care Plan was last reviewed and revised on 9/15/2025 3. Review of the medical record revealed Resident #19 was admitted to the facility on [DATE], with diagnoses including Fracture of Right Femur, Fracture of Left Femur, and Seizures. Review of admission MDS assessment dated [DATE], revealed Resident #19 scored a 12 on the BIMS assessment, which indicated Resident #19 was moderately cognitively impaired. Review of the medical record revealed Resident #19's Care Plan was reviewed and revised on 9/15/2025. The facility was unable to provide documentation that Resident #19 and/or his representative was invited to the admission Care Plan meeting after the completion of the 8/21/2025 admission MDS assessment. During an interview on 9/30/2025 at 4:55 PM, the Interim Director of Nursing (DON) was asked, can you provide any documents to show that a care plan meeting was held with Resident #5 and/or her representative following the assessments on 8/26/2025, 3/1/2025, and 12/17/2024. The Interim DON searched her computer for each date given and verified she was unable to provide any documentation that the care plan meetings were completed. The Interim DON was asked how soon should a care plan meeting be scheduled with the resident and/or their representative after admission. The Interim DON stated, .2-3 weeks. The Interim DON was asked if a care plan meeting had been scheduled or completed for Resident #19. The DON stated, .It had not.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview, the facility failed to report an injury of unknown origin for 6 of 6 (Resident #8, #16, #20, #23, #25, and #35) sampled residents reviewed. The findings include: 1. Review of the undated facility policy titled, ABUSE, revealed .Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents shall not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.if an incident is determined to have unknown origin or is suspicious in nature.then that incident shall be reported to the State of Tennessee within 2 hours of the occurrence, even if the patient has osteoporosis for a diagnosis. Review of the undated facility policy titled, ACCIDENT/INCIDENT REPORTS (RESIDENTS), revealed . When an accident or incident involving a resident occurs, any witnessing staff will offer immediate assistance. An accident/incident report and the appropriate documentation will be completed by the end of the shift. Questions about what constitutes an accident/incident should be immediately directed to the Director of Nursing or the Administrator.the incident will be reported to the TDH [Tennessee Department of Health] as per the department's guidelines. 2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Anxiety, and Insomnia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) was not completed due to resident is rarely/never understood, which indicated Resident #8 was severely cognitively impaired. Resident #8 had no behaviors and required staff assistance for Activities of Daily Living (ADLs), bed mobility, and transfers. Review of a Progress Note dated 6/15/2025, revealed .RESIDENT [Resident #8] NOTED WITH SKIN TEAR TO RIGHT FOREARM. AREA CLEANSED WITH NS [Normal Saline], STERI-STRIPS APPLIED. ROUTINE ORDERS IN PLACE TO MONITOR STERI [sterile]-STRIPS Q [every] SHIFT, FOR S/SX [signs/symptoms] INFECTION, UNTIL HEALED. RP/MD [Responsible Party/Medical Doctor] NOTIFIED . Review of the incident report dated 6/15/2025, revealed . notified by CNA [Certified Nursing Assistant] that resident [Resident #8] had superficial skin tear to R [right] forearm; unknown cause . Review of the facility Investigation dated 6/15/2025 revealed the facility failed to report the injury of unknown origin for Resident #8 to the state agency. 3. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Osteoarthritis, Osteoporosis, Depression, and Anemia. Review of the quarterly MDS dated [DATE], revealed a BIMS score of 6, which indicated Resident #16 was severely cognitively impaired. Resident #16 required staff's assistance with ADLs, bed mobility, and transfers. Review of a Progress Note dated 8/10/2025, revealed .RESIDENT [Resident #16] SITTING IN RECLINER CHAIR AWAITING LUNCH. 6 [inch] HEMATOMA [closed wound where blood pools under the skin] NOTED TO LEFT FOREARM. RESIDENT UNABLE TO TELL US WHAT HAPPENED. LEFT ARM WRAPPED IN AN ACE BANDAGE, ICE APPLIED AND ARM ELEVATED ON A PILLOW. SON NOTIFIED. Review of the incident report dated 8/10/2025, revealed .Resident [Resident #16] was found to have a 6 hematoma to left forearm when lunch tray taken into Room. Resident sitting up in a recliner . Review of the facility investigation revealed the facility failed to report the injury of unknown origin for Resident #16 to the state agency. 4. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE], with diagnoses including Bronchitis, Alzheimer's Disease, and Transient Cerebral Ischemic Attacks. Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 6, which indicated Resident #20 was severely cognitively impaired, required staff's assistance with ADLs, bed mobility, and was dependent of staff for transfers. Review of a Progress Note dated 7/19/2025, revealed .9:30 AM NOTED DURING AM [morning] CARE A1 [a 1] CM [centimeter] S/T [skin tear] TO RIGHT ELBOW, UNKNOWN CAUSE. AREA CLEANED WITH N/S, APPROXAMATED [approximated meaning to bring the edges of a wound together] AND STERI [sterile] STRIPS APPIED [applied] AND MONITOR Q [every] SHIFT . Review of the incident report dated 7/19/2025, revealed .During AM care, noted a 1 cm s/t to R [right] elbow. Unknown cause, area cleaned with NS pat dry. Wound approxamated [approximated] and steri strips applied will monitor q shift until healed . Review of the facility investigation revealed the facility failed to report the injury of unknown origin for Resident #20 to the state agency. 5. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE], with diagnoses including Spinal Stenosis, Chronic Kidney Disease, Diabetes, and

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:6Number of residents cited:6Based on policy review, medical record review, and interview, the facility failed to perform a complete and thorough investigation for injuries of unknown origin for 6 of 8 (Resident #8, #16, #20, #23, #25, and #35) sampled residents reviewed for abuse. The findings include: 1. Review of the undated facility policy titled, ABUSE, revealed .Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents shall not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.Incident reports shall be completed by charge nurses for all incidents to residents. These reports shall be completed for falls, bruising, skin tears .that occur or appear on each shift. Investigation of each incident shall be sufficient to determine just cause of the accident/incident with comments to prevent further injury noted on the incident report. 2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Anxiety, and Insomnia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score was not completed due to resident is rarely/never understood, which indicated Resident #8 was severely cognitively impaired. Review of the incident report dated 6/15/2025, revealed .notified by CNA [Certified Nursing Assistant] that resident [Resident #8] had superficial skin tear to R [right] forearm; unknown cause. treated per facility protocol . The facility was unable to provide an investigation with the incident report. 3. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Osteoarthritis, Osteoporosis, Depression and Anemia. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 6, which indicated Resident #16 was severely cognitively impaired. Review of the incident report dated 8/10/2025, revealed . Resident [Resident #16] was found to have a 6 [inch] hematoma to left forearm when lunch tray taken into Room. Resident sitting up in a recliner . The facility was unable to provide an investigation with the incident report. 4. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease and Transient Cerebral Ischemic Attacks. Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 6, which indicated Resident #20 was severely cognitively impaired. Review of the incident report dated 7/19/2025, revealed .During AM [morning] care, noted a 1 cm [centimeter] s/t [skin tear] to R [right] elbow. Unknown cause, area cleaned with NS [normal saline] pat dry. Wound approxamated [approximated-to bring the edges of a wound together] and steri [sterile] strips applied will monitor q [every] shift until healed . The facility was unable to provide an investigation with the incident report. 5. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE], with diagnoses including Spinal Stenosis, Chronic Kidney Disease, Diabetes, and Peripheral Vascular Disease. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 12, which indicated Resident #23 was moderately cognitively impaired. Review of the incident report dated 7/26/2025, revealed .abrasion to L [left] shin. unknown origin . The facility was unable to provide an investigation with the incident report. 6. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including Dementia, Anxiety, and Chronic Kidney Disease. Review of the .BIMS Evaluation assessment dated [DATE], revealed a BIMS score of 0, which indicated Resident #25 was severely cognitively impaired. Review of the incident report dated 9/22/2025, revealed .Pt [patient-Resident #25] up into chair sitting in hallway, notice skin tear to left forearm . The facility was unable to provide an investigation with the incident report. 7. Review of the medical record revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including Depression, Cerebral Infarction, and Anxiety. Review of the significant change MDS assessment dated [DATE], revealed a BIMS score of 7, which indicated Resident #35 was severely cognitively impaired. Review of the incident report dated 8/28/2025, revealed .noted c [with] Purple Discoloration on R [right] outer, upper Arm . The facility was unable to provide an investigation with the incident report. 8. During an interview on 9/30/2025 at 11:28 AM, the Director of Nursing (DON) was asked if the facility completes investigations on skin incidents. The DON stated, On the skin we just ask the nurses. The DON was asked if the discussion with staff regarding skin incidents are documented. The DON stated, Yes, usually, and I put that with the incident report. During an interview on 10/1/2025 at 2:55 PM, the DON was asked if there were investigations to go with Resident #8

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on policy review, record review, and interview, the facility failed to ensure food was stored, handled, prepared, and served under sanitary conditions, when temperatures for the refrigerator, freezer and cooler, were not recorded daily. 38 residents received food trays from the kitchen. The findings include: 1. Review of the undated facility policy titled, Sanitation / Food Storage, revealed .The following rules of safe food storage have two purposes.to prevent contamination of foods.to prevent growth of bacteria that may already be in foods.Temperature control is an important part of food storage.Temperature of each freezer shall be recorded daily.Temperature of each refrigerator shall be checked and recorded each day. 2. Review of the Record of Refrigeration Temperatures, dated September 2025, revealed the facility failed to document the refrigerator temperature on the following dates: a. 9/5/2025 b. 9/18/2025 c. 9/19/2025 d. 9/20/2025 e. 9/22/2025 f. 9/23/2025 g. 9/24/2025 h. 9/25/2025 i. 9/26/2025 j. 9/27/2025 k. 9/28/2025 l. 9/29/2025 3. Review of the Record of Refrigeration Temperatures, dated September 2025, revealed the facility failed to document the freezer temperature on the following dates: a. 9/5/2025 b. 9/18/2025 c. 9/19/2025 d. 9/20/2025 e. 9/22/2025 f. 9/23/2025 g. 9/24/2025 h. 9/25/2025 i. 9/26/2025 j. 9/27/2025 k. 9/28/2025 l. 9/29/2025 4. Review of the Record of Refrigeration Temperatures, dated September 2025, revealed the facility failed to document the cooler temperature on the following dates: a. 9/4/2025 b. 9/5/2025 c. 9/18/2025 d. 9/19/2025 e. 9/20/2025 f. 9/22/2025 g. 9/23/2025 h. 9/24/2025 i. 9/25/2025 j. 9/26/2025 k. 9/27/2025 l. 9/28/2025 m. 9/29/2025 During an interview on 9/30/2025 at 2:15 PM, the Dietary Manager was asked if the temperature of the refrigerator, freezer, and cooler in the kitchen should be checked and recorded on the Record of Refrigeration Temperatures daily. The Dietary Manager stated, Yes .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:1Number of residents cited:1 resident #22 Based on policy review, job description review, review of the facility Infection Control Program documents, medical record review, observation, and interview, the facility failed to establish and implement a program to identify, report, investigate, and control infections and communicable diseases when the Infection Preventionist (IP)/Director of Nursing (DON) failed to track organisms being treated in the facility, monitor for outbreaks and cross contamination, and failed to ensure practices to prevent the potential spread of infection were maintained when Enhanced Barrier Precautions (EBP) were not followed for 1 of 1 (Resident #22) sampled residents. This had the potential to affect 38 of 38 residents in the facility. The findings include: 1.Review of the undated facility policy titled, Infection Control Program, revealed .The goals of the infection control program are to.Decrease the risk of infection to patients and personnel.Monitor for occurrence of infection and implement appropriate control measures .Identify and correct problems relating to infection control practices.Insure compliance with state and federal regulations relating to infection control.There is on-going monitoring for infections among patients and personnel and subsequent documentation of infections that occur.Responsibility is delegated to the Infection Control Practitioner (ICP) to carry out the daily functions of the Infection Control Program Those functions are described in the ICP job description. Review of the undated facility policy titled, Infection Control Surveillance, revealed Purpose: To have knowledge of patient and employee infections so appropriate actions/follow-up may be done and to guide prevention activities.The Infection Control Practitioner does surveillance of infections among patients and employees.Nosocomial infections are reported monthly on the .Nosocomial Infection Summary.Line Listing of Patient Infections . Review of the undated facility policy titled, .Enhanced Barrier Precautions, revealed .It is the policy of this facility to implement enhanced barrier precautions.signage will be posted on the door or wall of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves.An order for enhanced barrier precautions will be obtained for residents with any of the following.Wounds.Implementation of Enhanced Barrier Precautions. Gowns and gloves are available near or outside the resident's room.High-Contact Resident Care Activities. Wound Care: any skin opening requiring a dressing. 2. Review of the undated and unsigned facility job description titled Infection Control Practitioner, revealed .Evaluate quality of patient care and patient outcomes as they relate to nosocomial infections; collects, prepares and analyzes nosocomial infection data. Does on-going monitoring of nosocomial infections.Conducts outbreak investigation and initials control measures. 3. Review of the NOSOCOMIAL INFECTION SUMMARY, monitoring documents dated June 2025, July 2025, August 2025, and September 2025, revealed .INFECTION.UTI [urinary tract infection]. RESPIRATORY .WOUNDS DECUBITIS [bed sore].INFECTIONS OF THE EYE/CONJUNCTIVITIS. GASTROENTERITIS [intestinal infection].SEPSIS.OTHER . Review of the LINE LISTING OF PATIENT INFECTIONS, monitoring documents dated 8/2025 and 9/2025, revealed Name/Rm# [Room number] .DX [Diagnosis].TX [Treatment] Date/C&S [Culture and Sensitivity].TREATMENT .ACTION IF NEEDED .NI [Nosocomial Infection] CAI [Community Acquired Infection] . Further review of the facility NOSOCOMIAL INFECTION SUMMARY and LINE LISTING OF PATIENT INFECTIONS revealed there was no documentation that named the organism that was being tracked. Review of the facility Tracking and Trending documentation for July 2025, revealed 1 UTI on the Corner Hall and 5 UTIs on the New Hall. During an interview on 10/1/2025 at 1:00 PM, the IP/DON confirmed that she does not track infections by the organisms in the INFECTION CONTROL PROGRAM. The IP/DON was asked to provide documentation she was tracking infections to rule out cross contamination or outbreak of infection for 5 UTIs occurring on the same hallway in the month of July. The IP/DON stated, Most of ours [UTIs] are from E coli [Escherichia coli]. The IP/DON was unable to provide documentation that the facility monitors for cross contamination between residents. 4. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Deep Tissue Damage of Left Heel, Osteomyelitis, and Malignant Neoplasm of Prostate. Review of the Brief Interview for Mental Status (BIMS) assessment, dated 9/22/2025, revealed a BIMS score of 13, which indicated Resident #22 had intact cognition. Review of the Physician's Order dated 9/17/2025, revealed .ENHANCED BARRIER PRECAUTIONS. Review of the Physician's Order dated 9/25/2025, revealed .CLEANSE LEFT POSTERIOR SHOULDER COVER WITH FOAM DRESSING. Observation of