Theresa Hawkins

3/19/24

chg 03.28.2024

Knollwood Pointe Assisted Living Facility

Provider ID: D4943

ADPH Survey Dated 1/16/2024

Kathetheia Pringle — **02/21/2024**

Executive Director — Date

Revisions completed and submitted by Shandra Davis, Regional Director on 3/19/2024 on behalf of the facility.

Deficiency 608

The facility's Abuse policy is defined as the willful infliction of injury, confinement, intimidation or punishment with resulting physical abuse, and mental anguish. The facility physically restrained a resident in a wheelchair.

- Staff will receive re-education and re-training on the Abuse Policy and Procedure by 02/29/24. Mandatory Abuse re-training will be scheduled with the Ombudsman and after with ALD or designee for make up re-training all to be completed by 3/15/24.
- The facility has identified that all 17 residents could be affected by the deficient practice without corrective measures and education being implemented.
- Staff will receive ongoing monthly abuse re-training provided by ALD or designee for 3 months, then quarterly for 6 months, then annually, upon hire and with any identified deficits.
- Monitoring compliance will be performed monthly, then quarterly by ALD or designee. Training monitoring will be kept in the Administrators office. Continued noncompliance will result in re- education, systems review and/or corrective disciplinary action up to and including termination.

Deficiency 601

Medication policy & Procedure the RN/LPN is responsible for administering medications to the residents in this community. He/she may administer medication to residents only in accordance with physician orders and the Nurse Practice Act. New resident procedure RN/LPN must verify all prescriptions, meds with the doctor. RN/LPN will initiate the resident's MAR. The facility did not ensure physicians orders were followed.

- RN/LPN will receive education on verifying all prescriptions and following physician's order.
- The facility has identified that all 17 residents have the potential to be affected by the same deficient practice.
- Weekly monitoring by the ALD or designee until 6/30/2024 on internal monitoring documentation. This monitoring documentation will be kept in the ALD's office. Staff will aid with the self-administration of medication per Physician's order.
- The Executive Director will review the monitoring documentation in weekly clinical meetings to ensure that all corrective actions remain in place and are being followed. The monitoring documentation will be kept in the ALD office.

Deficiency 611

The facility's policy titled "Resident assessment and service planning (care plan) policy and procedure is to maximize the physical, functional, social and emotional well-being of the resident. It is the policy of this facility to have a comprehensive service plan for all residents. The facility did not develop care plans to address the special needs of residents.

- All current resident records will be audited for care plans. Plans of care will be discussed with sponsors by ALD/LPN. Care staff will receive education on care plans 3/1/2024 RN or designee.
- The facility has identified that all 17 residents have the potential to be affected by the same deficient practice.
- Weekly monitoring by ALD or designee until 8/16/2024 on internal monitoring documentation. This documentation will be kept in the ALD's office.
- The Executive Director will review the monitoring documentation in weekly clinical meetings to ensure that all corrective actions remain in place and are being followed. This documentation will be kept in the ALD's office.

Deficiency 604

The facility's assessment policy. Policy aims to ensure thorough assessments, timely identification of changes, and appropriate interventions to maintain the well- being of our residents. The facility did not accurately assess residents.

- All care staff will receive education on assessments on 2/29/2024. All current resident records will be audited by the ALD or designee for any incident dealing with assessments.
- The facility has identified that all 17 residents have the potential to be affected by the same deficient practice.
- Weekly monitoring by ALD or designee until 8/16/2024 to ensure that all assessment protocols are being followed on internal monitoring documentation which will be kept in the ALD office.
- The Executive Director will review the monitoring documentation in weekly clinical meetings to ensure that all corrective actions remain in place and are being followed. This documentation will be kept in the ALD's office.

Deficiency 702

The facility's Protection of food from contamination policy & procedure. To ensure that food stored, prepared and served in this facility is protected from contamination and potentially hazardous foods are handled appropriately to protect against contamination and food borne illnesses. The facility did not store food properly.

- Staff were re-educated on food storage and handling to prevent contamination.
- The facility has identified that all 17 residents have the potential to be impacted by this deficient practice.
- Daily monitoring by Dietary Manager or designee until 5/16/2024 to ensure that all food items are properly stored, labeled and dated, weekly monitoring will continue through 8/16/2024 on internal monitoring documentation of the same items.
- All monitoring documents will be kept in the Dining Manager's office and will be reviewed weekly by the Executive Director to ensure compliance in addition to random spot checks in the kitchen.

Deficiency 1101

The facility's policy is titled fire drills, fire alarm, sprinkler & fire extinguisher checks policy & procedures. To ensure the safety of the residents, employees and visitors is always maintained. The facility did not ensure the fire alarm system was inspected semiannually as required.

- Met with International Fire Protection, effective 3/1/2024, new agreement in place for semi- annual inspections.
- The facility has identified that all 17 residents have the potential to be impacted by this deficient practice.
- Inspections will be verified by the Maintenance Director and logged on internal monitoring documentation. All inspections will be kept on file in the Maintenance Director's office.
- The Executive Director will monitor and inspect the semi-annual logs by keeping them tracked on calendar invitations to ensure that they are in compliance.

Deficiency 604

The facility's retention policy. Our commitment is to provide a safe, supportive, and comfortable environment that promotes the well-being of our residents. The facility retained a resident whose care exceeded the capabilities and licensure of the facility.

- All current residents' service plans were audited for any incidents dealing with unmanaged needs. All Plans of care calls have been completed. Resident has been moved to a Memory Care unit.
- The facility has immediately determined that all 17 residents have the potential to be impacted by the same deficient practice.
- The Resident Care Coordinators and Facility RN will ensure that the assessment guidelines are being followed as required by state regulation and company policies. Any residents requiring level of care needs/changes will be identified through discussion at daily clinical stand and/or shift change report up to ensure prompt interventions are in place.
- The Executive Director will review the monitoring documentation in weekly clinical meetings to ensure that all corrective actions remain in place and are being followed. This documentation will be kept in the ALD's office.

Deficiency 302

Based on observations, interviews and records reviews, the facility failed to follow its own internal policies.

- The Executive Director has set up mandatory in-services and training in response to all identified internal policies that are currently not being followed.
- The facility has immediately determined that all 17 residents have the potential to be impacted by the same deficient practice.
- Employee orientation procedures have been reviewed to ensure that every hired employee has had the required, documented training on all internal policies. Additionally, internal policy binders have been created to ensure easy access to policies for all staff when needed and kept in accessible areas for all staff.
- The Executive Director will review every new hire orientation checklist within 14 days of hire to ensure that all required training have been completed and will address any deficiencies immediately with the appropriate hiring manager. The Regional Director will audit the same minimally at quarterly visits or more often as needed. This documentation will be kept in the Executive Director's office.

Deficiency 303

Based on interview and record review, the Administrator, Employee Identifier (E1) #1, failed to ensure Resident Identifier (R1) #1 was not retained at the facility when R1#1's care needs required a higher level of care.

- EI#1, met with LPN and sponsor to communicate the plan for R #1 transitioning to Memory Care unit. EI#1 transferred to RI #1 to Memory Care unit on 1/25/2024.
- The facility has immediately determined that all 17 residents have the potential to be impacted by the same deficient practice.
- All assessment protocols will be followed as directed by state and company policies. As soon as a resident is found to need a different level of care to meet heir needs, that transition will be immediately facilitated
- The Executive Director will review change of condition assessments in weekly clinical meetings to ensure that all corrective actions remain in place and are being followed. Additionally, Regional Clinical Director will audit monthly via a combination of remote and onsite visits as warranted. This documentation will be kept in the ALD's office.

Deficiency 403

The facility failed to maintain a personnel file for EI #5 a former C N A.

- The facility has audited all employee files with verification of employee files maintained at facility completed 2/12/2024. The Executive Director has been retrained by the Regional Director on file retention policies.
- The facility has immediately determined that all 17 residents have the potential to be impacted by the same deficient practice.
- The Executive Director will ensure that all personnel files are retained as required by state and company policies. All files will be kept secured in the Executive Director's office to prevent loss of records. In the event this secured storage is compromised, the Executive Director will report immediately to the Regional Director.

- The Executive Director will audit retained files monthly and an audit log will be kept in a folder in the Executive Director's office. The Regional Director will audit these logs quarterly via a combination of on and offsite visits.

Deficiency 504 (Part 1)

Based on record reviews and interviews, the facility failed to honor resident's rights to have the previous survey findings posted and to provide a safe environment where a resident was not restrained.

- E1 #1 had its last survey and Plan of correction readily accessible to be viewed on January 9, 2024, 9:23am.
- The facility has immediately determined that all 17 residents have the potential to be impacted by the same deficient practice.
- The Executive Director will ensure that this is accessible to be viewed at all times by any resident.
- The Executive Director will visually inspect this required posting when entering/exiting the facility and will also ensure that the concierge is aware that this posting must be made available. The Regional Director will audit these logs quarterly via a combination of on and offsite visits. This documentation will be kept in the Executive Director's office.

Deficiency 504 (Part 2)

Based on record reviews and interviews, the facility failed to honor resident's rights to have the previous survey findings posted and to provide a safe environment where a resident was not restrained.

- Staff will receive re-education and re-training on the Abuse Policy and Procedure by 02/29/24. Mandatory Abuse re-training will be scheduled with the Ombudsman and after with ALD or designee for make-up re-training all to be completed by 3/15/24.
- The facility has immediately determined that all 17 residents have the potential to be impacted by the same deficient practice.
- Staff will receive ongoing monthly abuse re-training provided by ALD or designee for 3 months, then quarterly for 6 months, the annually, upon hire and with any identified deficits.

- Monitoring compliance will be performed monthly, then quarterly by ALD or designee. Training monitoring will be kept in the Administrators office. Continued noncompliance will result in re- education, systems review and/or corrective disciplinary action up to and including termination. Monitoring documents will be maintained in the Executive Director's office.

Deficiency 508

Based on record reviews and interviews the facility failed to report incidents to the Online Incident Reporting System in a timely manner.

- Staff will receive re-education and re-training on the Abuse Policy and Procedure by 02/29/24. Mandatory Abuse re-training will be scheduled with the Ombudsman and after with ALD or designee for make-up re-training all to be completed by 3/15/24. All care staff will include re- education on reporting to the Departments Online reporting system within 24 hours all incidents. Re-education and training on reporting to the ADPH online reporting system completed on 2/16/2024 to direct care staff.
- The facility has immediately determined that all 17 residents have the potential to be impacted by the same deficient practice.
- Staff will receive ongoing monthly abuse re-training provided by ALD or designee for 3 months, then quarterly for 6 months, the annually, upon hire and with any identified deficits.
- Monitoring compliance will be performed monthly, then quarterly by ALD or designee. Training monitoring will be kept in the Administrators office. Continued noncompliance will result in re- education, systems review and/or corrective disciplinary action up to and including termination. Monitoring documents will be kept in the Executive Director's office.

Deficiency 605

Based on observation, record review and interview, the facility failed to provide health supervision to arrange for RI#1 to be transferred to a higher level of care that RI#1 required for health and safety.

- All current residents' service plans were audited for any incidents dealing with unmanaged needs. All Plans of care calls have been completed. Resident has been moved to a Memory Care unit. EI#1, met with LPN and sponsor to communicate the plan

for R #1 transitioning to Memory Care unit. EI#1 transferred to RI #1 to Memory Care unit on 1/25/2024.

- The facility has immediately determined that all 17 residents have the potential to be impacted by the same deficient practice.
- The Resident Care Coordinators and Facility RN will ensure that the assessment guidelines are being followed as required by state regulation and company policies. Any residents requiring level of care needs/changes will be identified through discussion at daily clinical stand and/or shift change report up to ensure prompt interventions are in place.
- The Executive Director will review the monitoring documentation in weekly clinical meetings to ensure that all corrective actions remain in place and are being followed. This documentation will be kept in the ALD's office.

Deficiency 606

Based on observations, interviews and record reviews the facility failed to ensure that residents with health and/or safety needs beyond the capability of the facility were safely transferred or discharged to an appropriate level of care and failed to ensure that RI#1 was observed for changes in health and physical abilities including medication awareness.

- All current residents' service plans were audited for any incidents dealing with unmanaged needs. All Plans of care calls have been completed. Resident has been moved to a Memory Care unit.
- The facility has immediately determined that all 17 residents have the potential to be impacted by the same deficient practice.
- The Resident Care Coordinators and Facility RN will ensure that the assessment guidelines are being followed as required by state regulation and company policies. Any residents requiring level of care needs/changes will be identified through discussion at daily clinical stand and/or shift change report up to ensure prompt interventions are in place.
- The Executive Director will review the monitoring documentation in weekly clinical meetings to ensure that all corrective actions remain in place and are being followed. This documentation will be kept in the ALD's office.

Deficiency 613

Based on observation and interview the facility failed to ensure RI#1 was able to pass a medication awareness screening. This failure indicated RI#1 was unable to protect themselves from a medical error.

- All care staff will receive education on assessments on 2/29/2024. Records will be audited for any incident dealing with assessments. All care staff will receive re-education on medication awareness test.
- The facility has immediately determined that all 17 residents have the potential to be impacted by the same deficient practice.
- Weekly monitoring by ALD or designee until 8/16/2024 on internal monitoring documentation to ensure that all medication awareness screenings are completed as required.
- The Executive Director will review the monitoring documentation in weekly clinical meetings to ensure that all corrective actions remain in place and are being followed. This documentation will be kept in the ALD's office.

Deficiency 615

Based on record reviews and interviews the facility failed to ensure EI#2, the Licensed Practical Nurse (LPN) charted contemporaneously when administering medications.

- All RNs/LPNs will receive education on verifying all prescriptions and following physician's order by 1/18/24.
- The facility has identified that all 17 residents have the potential to be affected by the same deficient practice.
- Weekly monitoring by the ALD or designee until 6/30/2024 on internal monitoring documentation to ensure that all medications are documented as given when given as required.. This monitoring documentation will be kept in the ALD's office.
- The Executive Director will review the monitoring documentation in weekly clinical meetings to ensure that all corrective actions remain in place and are being followed. The monitoring documentation will be kept in the ALD office.

Deficiency 1002

On January 9, 2024, a surveyor observed carpeting in hallways of the facility stained and worn down. App. 18 inches long and 24 inches wide at the intersection of the entrance hall and the main hallway was noted 5 rows of buckling carpet.

- The company has been made aware of carpeting issues and has received quotes and bids on carpet removal and installation. Completion date of floors to be removed/replaced is no later than 4/15/24.
- The facility has identified that all 17 residents have the potential to be affected by the same deficient practice.

- The Executive Director will discuss weekly the progress of the carpet repairs/replacement to ensure that everything is on track. If any unforeseen delays are present, this will be immediately communicated.
- The Regional Director will coordinate all activities included in this scope of work to ensure proper and timely resolve and will keep the Executive Director informed of all progress weekly. Monitoring will be kept by the Regional Director via email.