Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D4943	A. BUILDING: _____ B. WING _____	01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD POINTE ASSISTED LIVING	5601 GIRBY ROAD MOBILE, AL 36695

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On January 16, 2024, an unannounced licensure survey was conducted for this 23 bed Assisted Living Facility with a census of 17. There were three complaints investigated during this survey. LC#20230511005 and LC#20230509010 were substantiated. LC#20230809007 was unsubstantiated. There were deficiencies written as a result of the complaint investigations. Deficiencies were cited during the survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, Assisted Living Facilities. The deficient practices resulted in actual harm for one resident and the potential for significant harm to 17 residents.	A 000		
A 302	420-5-4-.03 (1) (e) Administration. Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the residents. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following:	A 302		

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A 302	Continued From page 1 (i) Facility responsibility to protect all residents from abuse, neglect, and exploitation. (ii) How allegations of abuse, neglect, and exploitation will be handled by the facility. (iii) Resident confidentiality. (iv) Admission and continued stay criteria. (v) Discharge criteria and notification procedures for residents and sponsors. (vi) Facility responsibility when a resident's personal belongings are lost. (vii) What services the facility is capable and not capable of providing. (viii) Medication management. (ix) Infection control. (x) Meal service, timing, menus and food preparation, storage, and handling. (xi) Fire safety and emergency plan, fire drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall	A 302		

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A 302	Continued From page 2 develop written policies and procedures for the guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address: (I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling. (II) The attire and cleanliness of staff members who prepare, handle, or serve food. (III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids. (IV) Food substitutions or alternatives. (V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs. (VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat. (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs.	A 302		

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A 302	Continued From page 3 (IX) Storage of food. (X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to follow its own policies. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED 06/10/2015. Findings: The facility's Abuse policy titled, "IDENTIFYING AND REPORTING ABUSE, NEGLECT AND EXPLOITATION" revealed, "...Abuse 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. Please refer to deficiency 608 for additional information. The facility's policy titled, "Medication POLICY & PROCEDURE" revealed, "...POLICY The RN (Registered Nurse)/LPN (Licensed Practical Nurse) is responsible for administering medications to the residents in this community. He/she may administer medication to residents only in accordance with the physician orders and the Nurse Practice Act. PROCEDURE: ...13. New Resident Procedures...b. LPN/Program Director	A 302		

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A 302	Continued From page 4 must verify all prescription, ...meds (medications) with the doctor. ...d. The LPN/Program Director will initiate the resident's MAR (Medication Administration Record) ...". The facility did not ensure physician orders were followed. Please refer to deficiency 601 for additional information. The facility's policy titled, "RESIDENT ASSESSMENT AND SERVICE PLANNING (CARE PLAN) POLICY & PROCEDURE" revealed, "...PURPOSE: The purpose of the Resident Service Plan is to maximize the physical, functional, social and emotional well-being of the resident in order to attain or maintain the highest possible level of independence. POLICY: It is the policy of this facility to have a comprehensive service plan on all residents...The service plan will thereafter, be updated on any change of condition, re-admission, annually and as indicted (indicated) by level of care. The resident service plan is created as the result of an initial assessment and continuous reappraisal of the resident...4. Plan of care shall contain listing of resident's needs or problems that require intervention by the facility, ...". The facility did not develop care plans to address the special needs of residents. Please refer to deficiency 611 for additional information. The facility's "Assessment Policy" revealed, "...Policy aims to ensure thorough assessments, timely identification of changes, and appropriate interventions to maintain the well-being of our residents. ...2. Monthly Assessments: (a) The facility will conduct monthly assessments for each resident, or more frequently if needed, to identify changes in the resident's status. (b) Monthly assessments shall include: ...3. Documentation of identified changes in resident status. 4. Assessment of the appropriateness of	A 302		

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A 302	Continued From page 5 each resident's care plan. - Immediate implementation and documentation of interventions or reassessment are required for any decline in resident status. ...". The facility did not accurately assess residents. Please refer to deficiency 604 for additional information. The facility's "PROTECTION OF FOOD FROM CONTAMINATION POLICY & PROCEDURE" revealed, "...POLICY: To ensure that food stored, prepared and served in this facility is protected from contamination and potentially hazardous foods are handled in the appropriate manner to protect against contamination and food borne illnesses. PROCEDURE: General 1. Food and food ingredients shall be stored, handled...so as to be protected from pests, dust, ...and any other contamination. ...6. All leftovers shall be saved in a sealed container, labeled with month, day, year, contents and disposed of after three days. ...". The facility did not store food properly. Please refer to deficiency 702 for additional information. The facility's policy titled, "MEDICATION ASSISTANCE - ALF (Assisted Living Facility) POLICY & PROCEDURE" revealed, "...POLICY: To provide staff assistance with the self-administration of medication to any resident who is aware of his or her medication as defined below. PROCEDURE: ...5. No medication shall be left in a resident's room. ...". The facility did not have a physician order for a resident to self administer medication. Please refer to deficiency 601 for additional information. The facility's policy titled, "FIRE DRILLS, FIRE ALRM (ALARM) SYSTEM, SPRINKLER & FIRE EXTINGUISHER CHECKS POLICY & PROCEDURE" revealed, "...POLICY: To ensure the safety of the residents, employees and	A 302		

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A 302	Continued From page 6 visitors is maintained at all times. PROCEDURE: ...Fire Alarm and Sprinkler Systems 1. The fire alarm system and the sprinkler system shall be inspected by licensed, trained and qualified personnel at least semiannually for compliance with the respective codes. ..." The facility did not ensure the fire alarm system was inspected semi-annually as required. Please refer to deficiency 1101 for additional information. The facility's policy titled, "Retention Policy" revealed, "...Our commitment is to provide a safe, supportive, and comfortable environment that promotes the well-being of our residents. ...4. Regulatory Compliance: ...In the event that changes in care needs exceed our regulatory capacity, we will work collaboratively with residents and families to explore alternative arrangements within the bounds of communities' state regulations. ...". The facility retained a resident whose care exceeded the capabilities and licensure of the facility. Please refer to deficiency 621 for additional information.	A 302		
A 303	420-5-4-.03 (2) (a) Administration. The Administrator. (a) Responsibility. 1. The administrator shall be a direct representative of the governing authority in the management of the assisted living facility and shall be responsible to the governing authority for the proper performance of his or her duties. 2. Any individual employed as an administrator shall be properly licensed.	A 303		

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A 303	Continued From page 7 3. Any individual employed as an administrator shall meet all applicable statutory requirements. 4. There must be an individual with experience in the day-to-day operation of the facility, who is authorized in writing, to act for the administrator during absences. 5. The administrator and any individual authorized to act as a substitute shall be at least 19 years of age.	A 303		
	6. The administrator and any individual authorized to act as a substitute shall be of reputable and responsible character. 7. The administrator shall ensure that adequate personnel are employed and on duty to meet the care needs of all residents 24 hours a day, 7 days a week. 8. The administrator shall manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment and adequate care being provided at all times. If a facility has an adequate number of staff members on duty to meet the care and safety needs of all residents, but adequate care and safety is not being provided, then the facility does not meet this administration and management requirement. 9. The facility administrator is responsible for ensuring that required training is provided to all staff. 10. The administrator shall ensure that residents who have health or safety needs			

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A 303	Continued From page 8 beyond the capability of the facility will be safely transferred or discharged to an appropriate setting. 11. The administrator shall ensure that facility staff members observe each resident for changes in health and physical abilities and obtain appropriate medical attention when needed. 12. The administrator shall ensure that plans of care for all residents are current and appropriate. This shall include the prearranged discharge plan. 13. The administrator shall ensure that all deficient practices cited by the Department are corrected in a timely manner and that corrections are maintained. This Rule is not met as evidenced by: Based on interview and record review, the Administrator, Employee Identifier (EI) #1, failed to ensure Resident Identifier (RI) #1 was not retained at the facility when RI#1's care needs required a higher level of care. This deficient practice resulted in potential harm for all 17 residents currently residing at the assisted living facility. Findings: RI#1 was admitted to the facility on June 29, 2023, with diagnoses to include hypertension and age related cognitive decline. On January 16, 2024 at approximately 3:15 pm, EI#1, the Administrator, was interviewed. EI#1	A 303		

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A 303	Continued From page 9 said RI#1 was going to transfer to the Specialty Care unit because that was the level of care RI#1 required. After reviewing the nurse's notes, EI#1 said this transfer should have been considered as early as October, 2023.	A 303		
A 403	420-5-4-.04 (4) Personnel. (4) Personnel Records. An assisted living facility shall maintain a personnel record for each employee. This record shall contain: (a) An application for employment which contains information regarding the employee's education, training, and experience. (b) Verification of current certification or licensure, if applicable. (c) Record of required physical examinations and vaccinations. (d) Verification the facility has not hired an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. (e) Date of hire. (f) Date of initial resident contact. (g) Date employment ceased. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a personnel file for EI#5, a former Certified Nursing Assistant (CNA).	A 403		

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A 403	Continued From page 10 THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED 06/10/2015. Findings: During a complaint investigation, an employee file was requested for a witness of an incident. The file was not provided. On January 16, 2024, at approximately 5:15 pm, EI#1, the Administrator, reported the personnel file for EI#5 could not be found. EI#1 acknowledged those files are supposed to be retained.	A 403		
A 504	420-5-4-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to	A 504		

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A 504	Continued From page 11 live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. 6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions. 7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so. 8. Every resident shall have the right to a reasonable opportunity for regular exercise	A 504		

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A 504	Continued From page 12 several times a week and to be outdoors at regular and frequent intervals. 9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident. 10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases. 11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion,	A 504		

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A 504	Continued From page 13 discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file. 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that: (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation; and (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse. 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges.	A 504		

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A 504	Continued From page 14 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area. 18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges. 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to	A 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D4943	A. BUILDING: _____ B. WING _____	01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD POINTE ASSISTED LIVING	5601 GIRBY ROAD MOBILE, AL 36695

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 504	Continued From page 15 wear his or her own clothes, to keep and use his or her own personal possessions including toilet articles except for personal possessions too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours and to freely come and go from the home. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: 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. Findings: On January 9, 2024, at approximately 9:00 am, the surveyor observed the most recent survey was not posted. On January 9, 2024, at approximately 9:15 am, EI#1, the Administrator observed the last survey and Plan of Correction was not available. She	A 504		

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A 504	Continued From page 16 said they should be accessible to be viewed. RI#8 was admitted to the facility on September 7, 2022, with diagnoses to include hypertension, diabetes mellitus II, legal blindness, dementia, chronic congestive heart failure and depressive disorder. RI#8 sustained a fall shortly after midnight on May 9, 2023. RI#8 was then transferred to a wheelchair, taken to the activity room, and restrained by a bed sheet to prevent him/her from rising from the wheelchair. RI#8 was still in the activity room, in his/her wheelchair, restrained with a bed sheet when EI#2, the Licensed Practical Nurse (LPN)/Resident Care Coordinator (RCC) arrived for her shift at 7:00 am on May 9,2023. On January 16, 2024, at approximately 2:45 pm, EI#2, was interviewed. After EI#2 described how RI#8 was wrapped and tied with a bed sheet in a wheelchair, EI#2 acknowledged an environment where a resident is physically restrained was not safe. On January 16, 2024, at approximately 3:45 pm, EI#1, the Administrator, was interviewed. EI#1 said an environment where a resident was restrained would not be considered safe. When asked why, EI#1 answered because it violated their rights and had the potential for harm. She added the facility staff were not taking care of residents if they have them in an environment where they have to be restrained.	A 504		
A 508	420.5.4-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an	A 508		

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A 508	Continued From page 17 incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as bruising, pain, or injury that is not consistent with actions necessary in providing day to day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid, including but not limited to: a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office. (iii) The onset of wandering behavior by any resident who is not fully cognitively intact. (iv) Elopement by a resident. (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal	A 508		

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A 508	Continued From page 18 abuse as defined in these rules. (vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules. (viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I of Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus). (ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of	A 508		

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A 508	Continued From page 19 the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents. (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified.	A 508		

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A 508	Continued From page 20 (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies. (xx) Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. 3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention as defined in these rules.	A 508		

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A 508	Continued From page 21 (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, or witnessed abuse, neglect, or exploitation of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file. (iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (vi) An unplanned occurrence that results in media attention. (vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility medical director, or back-up physician. (viii) Ingestion by a resident of a toxic substance that requires medical attention. (ix) Notifiable diseases and health	A 508		

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A 508	Continued From page 22 conditions listed in Appendix I of the Alabama Administrative Code Sec. 420-4-1-.04. shall be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than 3 years. (x) Any indication of malfunction of the sprinkler system, or fire alarm system.	A 508		
	4. The report to the Department's Online Incident Reporting System shall include the following: (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of the incident. (vi) Date and time of the incident. (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident.			

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A 508	Continued From page 23 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to investigate an incident of abuse and also failed to report incidents to the Online Incident Reporting System in a timely manner. ~~THIS IS A REPEAT DEFICIENCY THAT WAS~~ CITED DURING THE SURVEYS COMPLETED ON 06/10/2015 AND 12/04/2014. Findings: RI#8 RI#8 was admitted to the facility on September 7, 2022, with diagnoses to include hypertension, diabetes mellitus II, legal blindness, dementia, chronic congestive heart failure and depressive disorder. On May 09, 2023, an incident was reported to the Alabama Department of Public Health Online Incident Reporting System from the Knollwood Pointe Assisted Living facility indicating at 12:17 AM on May 09, 2023, "...Overnight nurse called and stated that (Name of RI#8) was on the floor by (his/her) bed, helped lift (him/her) to get (him/her) in the wheelchair. Then I rolled (him/her) to the activity room and up to the table, got a sheet and tied around the resident and tucked it in on both sides of the chair...Names of staff on duty at time of the incident: (Listed the name of Employee Identifier{EI} #3, a Registered Nurse, EI#4, a Certified Nursing Assistant (CNA),	A 508		

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A 508	Continued From page 24 and EI#5, a CNA) Action(s) taken by the facility in response to the incident: Employees involved suspended pending investigation. ...". No investigation of this occurrence was provided by the facility Administrator or by the corporation. On January 16, 2024, at approximately 5:10 pm, EI#1, the Administrator, said the file with the investigation of the incident regarding RI#8 being restrained with a bed sheet could not be found and she had no evidence that the occurrence had been investigated. RI#9 RI#9 was admitted to the facility on June 22, 2020, with diagnoses of hypertension, hypothyroidism, osteoporosis, and anxiety disorder. On May 15, 2023, at 10:36 am, an incident was reported to the Alabama Department of Public Health Online Incident Reporting System from the Knollwood Pointe Assisted Living facility indicating, "...An incident report has been submitted at 5/15/2023 10:36:09 AM...6) Select Category: Resident Incident...Incident Detail 8) Name(s) of resident(s) involved: (Names RI#9)...10) Date and time of incident: 05/13/2023 11) Time: 01:25 PM ..." On January 16, 2024, at approximately 5:30 pm, EI#1 said RI#9's incident should have been reported within 24 hours and it was not.	A 508		
A 601	420-5-4-.06 (1) Care of Residents. (1) Medical Direction and Supervision.	A 601		

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A 601	Continued From page 25 The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or another emergency call). (b) Back-up Physician Support. Each assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in an assisted living facility. (c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be	A 601		

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A 601	Continued From page 26 dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order.	A 601		
	This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to follow physician orders for RI#3. This failure placed RI#3 at significant risk for harm. Also, the facility failed to have a physician's order for oxygen therapy for RI#5 and for RI#6 to have possession of his/her medication. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED 06/10/2015. Findings: RI#3 RI#3 was admitted to the facility on October 31, 2023, with diagnoses to include depression, dementia, hypertension, legal blindness, agitation and hypercholesterolemia. Review of the Resident Medical Examination for RI#3 dated October 19, 2023, revealed, "... Crestor 5 mg (milligram) 1 every 3 days ..." Review of a facsimile dated November 6, 2023			

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A 601	Continued From page 27 directed to EI#2, Licensed Practical Nurse (LPN)/Resident Care Coordinator (RCC), revealed, "... RE (In reference): (Name of RI#3) ... Crestor, continue med (medication) ..." A review of RI#3's Medication Administration Record (MAR) revealed one dose of Rosuvastin Calcium (Crestor) 5 milligrams had been administered since the November 6, 2023, confirmation was received from RI#3's doctor to administer the medicine. The one dose documented as given was for January 16, 2024, which was in fact an error. SEE CITATION 615. On January 16, 2024, at approximately 1:00 pm, EI#2 was interviewed. EI#2 said RI#3's Crestor was prescribed for 5 milligrams by mouth every three days. EI#2 said she had contacted the prescribing physician who had confirmed the medication was to be given. The facsimile from the physician was dated November 6, 2023. She was unaware the physician had responded regarding the Crestor and the medication had never been administered until the surveyor asked for the MAR for RI#3. She (EI#2) had failed to initiate the prescription because it was an oversight. She did not know the facsimile had been received and failed to follow up. RI#5 RI#5 was admitted to the facility on January 23, 2023, with diagnoses to include acute respiratory failure, heart failure, hypertension and diabetes mellitus II. On January 9, 2024, at approximately 11:00 am, RI#5 was observed in their room using oxygen therapy via nasal cannula at 2 liters per minute.	A 601		

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A 601	Continued From page 28 On January 10, 2024, at approximately 11:15 am, RI#5's medical record was reviewed and there was no physicians' order for oxygen therapy. On January 16, 2024, at approximately 3:15 pm, EI#1, the Administrator, admitted there should be a physicians' order for the oxygen therapy. RI#6 RI#6 was admitted to the facility on May 30, 2023, with diagnoses to include atrial fibrillation, deep vein thrombosis of lower extremity and myocardial infarction. On January 9, 2024, at approximately 11:30 am, RI#6 was interviewed and he/she showed the surveyor four (4) vials of Albuterol 0.63 milligrams/milliliter in the nebulizer machine in the resident's room. On January 10, 2024, at approximately 3:15 pm, RI#6's medical record was reviewed. The "RESIDENT MEDICAL EXAMINATION AND PLAN OF CARE" documented, "... Resident can Self-Administer and Have Custody of His/Her own Medications ... NO (checked for applicable) ..." On January 16, 2024, at approximately 3:15 pm, EI#1 said RI#6 should have an order to have possession of their medication.	A 601		
A 604	420-5-4-.06 (3) (a) (b) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility shall assess	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D4943	A. BUILDING: _____ B. WING _____	01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD POINTE ASSISTED LIVING	5601 GIRBY ROAD MOBILE, AL 36695

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 604	Continued From page 29 prospective residents for facility eligibility. This assessment shall document identified care needs and serve as a baseline for future assessments. (b) Monthly Assessments. The facility shall assess each resident monthly and more often when necessary to identify changes in resident's status. In addition to other items that may be required by the facility's own policies and procedures, the monthly assessment shall: 1. Assess the resident's ability to safely self-manage medications or safely self-administer medications with assistance. 2. Accurately weigh and record the weight of each resident. A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half or greater weight loss in a period of three months or less, or a ten percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. 3. Document identified changes in resident status. 4. Assess the appropriateness of each resident's plan of care. Any decline in resident status requires immediate implementation and documentation of interventions or reassessment of existing interventions.	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 604	Continued From page 30 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the accuracy of monthly assessments for RI#1. This failure contributed to the retention of an ineligible resident in the assisted living facility. Findings: RI#1 was admitted to the facility on June 29, 2023, with diagnoses to include hypertension and age related cognitive decline. On January 9, 2024 at approximately 9:30 am, the surveyor interviewed RI#1. RI#1 claimed to have only been at the facility for two nights. RI#1 claimed to manage his/her own medications and only took medicine for reflux. RI#1 looked around the room and could not find the reflux medicine that he/she takes. RI#1 gave a date of birth for themselves that was inaccurate. On January 10, 2024 at approximately 10:00 am, RI#1's medical record was reviewed. The "RESIDENT MEDICAL EXAMINATION AND PLAN OF CARE" revealed. "... Diagnosis(s) 1. Hypertension 2. Age Related Cognitive Decline 3. GERD (Gastroesophageal Reflux Disease) 4. Blood loss Anemia...MEDICATION NAME Ferrous Sulfate Cholecalciferol Losartan hydrochlorothiazide Norvasc pantaprazole Acetaminophen Aricept...Resident can Self-Administer and Have Custody of His/Her own Medications...NO (checked as applicable) LIST RESIDENT NEEDS OR PROBLEMS THAT REQUIRE INTERVENTION (Behavioral Symptoms, Elopement, ...1) Memory	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KNOLLWOOD POINTE ASSISTED LIVING	5601 GIRBY ROAD MOBILE, AL 36695

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 604	Continued From page 31 loss-Moderate..." RI#1's care plan revealed, "...6/29/23 AGE RELATED COGNITIVE DECLINE *OBSERVE FOR...FORGETTING THINGS MORE OFTEN " RI#1's Monthly Assessment/Review document was reviewed for July 2023 through December 2023. For each month "Significant health changes" had a zero documented. This assessment documented, "...Monthly Narrative Summaries If any issues are identified above, a comprehensive assessment, behavior screen, and PSMS (Physical Self-Maintenance Scale)need to be completed. ..." EI#2, the LPN (Licensed Practical Nurse)/RCC (Resident Care Coordinator) had documented no changes and to continue with Plan of Care each month. Nurses' notes for RI#1 revealed, "...7/15/2023...Behavior Resident was assisted to dining room by another resident that stated (RI#1) was acting irrational, resident stated to me she needed me to take her to the elevator to alert the police that her car had been stolen, reassured resident that (he/she) lived at KP (Knollwood Pointe) and did not have a car to be stolen. Resident became upset, angry, stating she had just got here and had driven (his/her) car here, and three white men had stolen (his/her) car from (him/her). Resident again informed (that he/she) lived here, had breakfast, lunch here, had taken a nap and woke up confused. This went on through supper...throughout supper other women friends at (his/her) table tried to assure (RI#1 that they) lived here and was confused, (he/she) reiterated (reiterated) (he/she) wasn't confused and that they were... 7/16/2023...Behavior Resident confused asking where (his/her) car is, who took (his/her) keys,	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KNOLLWOOD POINTE ASSISTED LIVING	5601 GIRBY ROAD MOBILE, AL 36695

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A 604	Continued From page 32 stating three men took (his/her) car, not easily redirected, ...Resident continued to state she did not have enough money to stay here, worrying about the cost of staying here, told resident not to worry, (his/her) niece takes care of all that. ... 7/19/2023...Resident very confused stated (he/she) needed to get (his/her) Escalade from (his/her) niece and that (he/she) needed to get on the elevator tried to redirect...stated (he/she) was calling the police if (he/she) could not leave to look for (his/her) car CNA (Certified Nursing Assistant) assisted (RI#1)...(RI#1) was dressed for bed and (CNA) stated (RI#1) was in bed 20 minutes. Later, (RI#1) was fully dress(ed) with purse in (his/her) hand ready to leave again... 7/21/2023...Nursing Resident was confused about where (his/her) location was and how to tell (his/her) niece where to come... 7/23/2023...Monthly it is taking some time for the resident to get acclimated to (his/her) new surroundings. (He/She) continues to have periods of confusion and make statement of wanting to leave facility. (He/She) requires redirecting and reminder throughout day of location of (his/her) apartment. ... 8/28/2023...does present with confusion at times. ... 10/2/2023 11:54 PM...Resident is very confused tonight (he/she) refuse(d) to go back to (his/her) apartment...cannot be redirected This nurse and CNAs been sitting up front watching (RI#1) since 8:30 pm tonight so (RI#1) will not try to go out the front door Resident is still sitting on the sofa near the front entrance being monitored by CNA... 10/3/2023...(RI#1) made no mention of leaving this morning or of last night attempt to leave facility. ...". On January 16, 2024 at approximately 1:30 pm, EI#2 was interviewed. EI#2 said RI#1 was	A 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KNOLLWOOD POINTE ASSISTED LIVING	5601 GIRBY ROAD MOBILE, AL 36695

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A 604	Continued From page 33 occasionally forgetful when admitted to the facility. When asked at what point RI#1 became unable to direct their care, EI#2 said a few months after he/she was admitted. When asked where that was reflected in the monthly assessments, EI#2 said she did not think it was, but it should be. When asked why it was not documented in the assessments, EI#2 said she was trained that residents only had to recognize their name to be eligible to reside in the facility. EI#2 was asked why she did not indicate RI#1's decline, that she acknowledged existed, in the monthly assessments. She (EI#2) responded it was in the nurse's notes. When EI#2 was asked why the nurse's notes would reflect the change in RI#1 and not the monthly assessments, EI#2 said it should have been reflected in both. On January 16, 2024 at approximately 3:15 pm, EI#1, the Administrator, was interviewed. EI#1 was asked why RI#1's decline and ineligibility should have been reflected in the monthly assessments. EI#1 responded so RI#1 could be in a facility where he/she was best suited to get proper care. EI#1 said the monthly assessments should be accurate so they could best care for the residents.	A 604		
A 605	420-5-4-.06 (3) (c) Care of Residents. (c) Observation. Each assisted living facility shall provide general observation and health supervision of the residents to identify changes in all residents' health conditions and physical abilities, and awareness of the need for medical attention or nursing services as the changes develop. Whenever a resident requires medical attention, nursing services, or changes in personal care and assistance with activities of	A 605		

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KNOLLWOOD POINTE ASSISTED LIVING	5601 GIRBY ROAD MOBILE, AL 36695

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A 605	Continued From page 34 daily living provided by the facility, the facility shall arrange for or assist the residents in obtaining necessary services. This Rule is not met as evidenced by: 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. Findings: RI#1 was admitted to the facility on June 29, 2023, with diagnoses to include hypertension and age related cognitive decline. On January 9, 2024 at approximately 9:30 am, the surveyor interviewed RI#1. RI#1 claimed to have only been at the facility for two nights. RI#1 claimed to manage his/her own medications and only took medicine for reflux. RI#1 looked around the room and could not find the reflux medicine that he/she takes. RI#1 gave a date of birth for themselves that was inaccurate. On January 10, 2024 at approximately 10:00 am, RI#1's medical record was reviewed. The "RESIDENT MEDICAL EXAMINATION AND PLAN OF CARE" revealed. "... Diagnosis(s) 1. Hypertension 2. Age Related Cognitive Decline 3. GERD (Gastroesophageal Reflux Disease) 4. Blood loss Anemia...MEDICATION NAME Ferrous Sulfate Cholecalciferol Losartan hydrochlorothiazide Norvasc pantaprazole	A 605		

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A 605	Continued From page 35 Acetaminophen Aricept...Resident can Self-Administer and Have Custody of His/Her own Medications...NO (checked as applicable) LIST RESIDENT NEEDS OR PROBLEMS THAT REQUIRE INTERVENTION (Behavioral Symptoms, Elopement, ...1) Memory loss-Moderate..." RI#1's care plan revealed, "...6/29/23 AGE RELATED COGNITIVE DECLINE *OBSERVE FOR...FORGETTING THINGS MORE OFTEN " RI#1's Monthly Assessment/Review document was reviewed for July 2023 through December 2023. For each month "Significant health changes" had a zero documented. This assessment documented, "...Monthly Narrative Summaries If any issues are identified above, a comprehensive assessment, behavior screen, and PSMS (Physical Self-Maintenance Scale)need to be completed. ..." EI#2, the LPN (Licensed Practical Nurse)/RCC (Resident Care Coordinator) had documented no changes and to continue with Plan of Care each month. Nurses' notes for RI#1 revealed, "...7/15/2023...Behavior Resident was assisted to dining room by another resident that stated (RI#1) was acting irrational, resident stated to me she needed me to take her to the elevator to alert the police that her car had been stolen, reassured resident that (he/she) lived at KP (Knollwood Pointe) and did not have a car to be stolen. Resident became upset, angry, stating she had just got here and had driven (his/her) car here, and three white men had stolen (his/her) car from (him/her). Resident again informed (that he/she) lived here, had breakfast, lunch here, had taken a nap and woke up confused. This went on through supper...throughout supper other women friends	A 605		

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A 605	Continued From page 36 at (his/her) table tried to assure (RI#1 that they) lived here and was confused, (he/she) reiterated (reiterated) (he/she) wasn't confused and that they were... 7/16/2023...Behavior Resident confused asking where (his/her) car is, who took (his/her) keys, stating three men took (his/her) car, not easily redirected, ...Resident continued to state she did not have enough money to stay here, worrying about the cost of staying here, told resident not to worry, (his/her) niece takes care of all that. ... 7/19/2023...Resident very confused stated (he/she) needed to get (his/her) Escalade from (his/her) niece and that (he/she) needed to get on the elevator tried to redirect...stated (he/she) was calling the police if (he/she) could not leave to look for (his/her) car CNA (Certified Nursing Assistant) assisted (RI#1)...(RI#1) was dressed for bed and (CNA) stated (RI#1) was in bed 20 minutes. Later, (RI#1) was fully dress(ed) with purse in (his/her) hand ready to leave again... 7/21/2023...Nursing Resident was confused about where (his/her) location was and how to tell (his/her) niece where to come... 7/23/2023...Monthly It is taking some time for the resident to get acclimated to (his/her) new surroundings. (He/She) continues to have periods of confusion and make statement of wanting to leave facility. (He/She) requires redirecting and reminder throughout day of location of (his/her) apartment. ... 8/28/2023...does present with confusion at times. ... 10/2/2023 11:54 PM...Resident is very confused tonight (he/she) refuse(d) to go back to (his/her) apartment...cannot be redirected This nurse and CNAs been sitting up front watching (RI#1) since 8:30 pm tonight so (RI#1) will not try to go out the front door Resident is still sitting on the sofa near the front entrance being monitored by CNA...	A 605		

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A 605	Continued From page 37 10/3/2023...(RI#1) made no mention of leaving this morning or of last night attempt to leave facility. ...". On January 16, 2024 at approximately 1:30 pm, EI#2 was interviewed. When asked at what point RI#1 became unable to direct their care, EI#2 said a few months after he/she was admitted. On January 16, 2024 at approximately 3:15 pm, EI#1, the Administrator, was interviewed. EI#1 said RI#1 was going to transfer to the Specialty Care unit because that was the level of care he/she required. After reviewing the nurses' notes, EI#1 said the monthly assessments were inaccurate and this transfer should have been considered as early as October, 2023.	A 605		
A 606	420-5-4-.06 (3) (d) Care of Residents. (d) Services Beyond Capability of Assisted Living Facility. Whenever a resident requires hospitalization, medical, nursing, or other care beyond the capabilities and facilities of the assisted living facility, arrangements shall be made to discharge the resident to an appropriate setting, or to transfer the resident promptly to a hospital or other health care facility able to provide the appropriate level of care. This Rule is not met as evidenced by: 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	A 606		

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A 606	Continued From page 38 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. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED 06/10/2015. Findings: RI#1 was admitted to the facility on June 29, 2023, with diagnoses to include hypertension and age related cognitive decline. On January 9, 2024 at approximately 9:30 am, the surveyor interviewed RI#1. RI#1 claimed to have been at the facility for only two nights. RI#1 claimed to manage his/her own medications and stated he/she only took medicine for reflux. RI#1 looked around the room but could not find the reflux medicine he/she takes. RI#1 gave a date of birth that was incorrect. On January 10, 2024 at approximately 10:00 am, RI#1's medical record was reviewed. The "RESIDENT MEDICAL EXAMINATION AND PLAN OF CARE" revealed. "...Diagnosis(s) 1. Hypertension 2. Age Related Cognitive Decline 3. GERD (Gastroesophageal Reflux Disease) 4. Blood loss Anemia...MEDICATION NAME Ferrous Sulfate Cholecalciferol Losartan hydrochlorothiazide Norvasc pantaprazole Acetaminophen Aricept...Resident can Self-Administer and Have Custody of His/Her own Medications...NO (checked as applicable) LIST RESIDENT NEEDS OR PROBLEMS THAT REQUIRE INTERVENTION (Behavioral Symptoms, Elopement, ...1) Memory loss-Moderate..."	A 606		

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A 606	Continued From page 39 RI#1's care plan revealed, "...6/29/23 AGE RELATED COGNITIVE DECLINE *OBSERVE FOR...FORGETTING THINGS MORE OFTEN " RI#1's Monthly Assessment/Review documents were reviewed for July 2023 through December 2023. For each month "Significant health changes" had a 'zero' documented. This assessment included the instruction, "...Monthly Narrative Summaries If any issues are identified above, a comprehensive assessment, behavior screen, and PSMS (Physical Self-Maintenance Scale)need to be completed. ...DATE: 9/14/23 Assessment Review and Plan of Care Outcomes Notes ... 0 (zero) needs changes this month. Continue current POC (Plan of Care). (signed by EI#2, the LPN (Licensed Practical Nurse)/RCC (Resident Care Coordinator))...DATE: 10/23/23 Assessment Review and Plan of Care Outcomes Notes ... Will cont (continue) current POC. (signed by EI#2)...DATE: 11/27/23 Assessment Review and Plan of Care Outcomes Notes...Will continue current Plan of care...(signed by EI#2)...DATE: 11/27/23 Assessment Review and Plan of Care Outcomes Notes...continue current POC. ...(signed by EI#2)..." RI#1's nurse's notes revealed, "...7/15/2023...Behavior Resident was assisted to dining room by another resident that stated (RI#1) was acting irrational, resident (RI#1) stated to me (he/she) needed me to take (him/her) to the elevator to alert the police that (his/her) car had been stolen, reassured resident that (he/she) lived at KP (Knollwood Pointe) and did not have a car to be stolen. Resident became upset, angry, stating (he/she) had just got here and had driven (his/her) car here, and three white men had stolen (his/her) car from (him/her). Resident	A 606		

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KNOLLWOOD POINTE ASSISTED LIVING	5601 GIRBY ROAD MOBILE, AL 36695

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A 606	Continued From page 40 again informed (he/she) lived here, had breakfast, lunch here, had taken a nap and woke up confused. This went on through supper...throughout supper other women friends at (his/her) table tried to assure (RI#1 that he/she) lived here and was confused, (he/she) reinerated (reiterated) (he/she) wasn't confused and that they were... 7/16/2023...Behavior Resident confused asking where (his/her) car is, who took (his/her) keys, stating three men took (his/her) car, not easily redirected, ...Resident continued to state she did not have enough money to stay here, worrying about the cost of staying here, told resident not to worry, (his/her) niece takes care of all that. ... 7/19/2023...Resident very confused stated (he/she) needed to get (his/her) Escalade from (his/her) niece and that (he/she) needed to get on the elevator tried to redirect...stated (he/she) was calling the police if (he/she) could not leave to look for (his/her) car CNA (Certified Nursing Assistant) assisted (RI#1)...was dressed for bed and stated (RI#1) was in bed 20 minutes...later, (RI#1) was fully dress(ed) with purse in (his/her) hand ready to leave again... 7/21/2023...Nursing Resident was confused about where (his/her) location was and how to tell (his/her) niece where to come... 7/23/2023...Monthly It is taking some time for the resident to get acclimated to (his/her) new surroundings. (He/She) continues to have periods of confusion and make statement of wanting to leave facility. (He/She) requires redirecting and reminder throughout day of location of (his/her) apartment. ... 8/28/2023...does present with confusion at times. ... 10/2/2023 11:54 PM...Resident is very confused tonight (he/she) refuse(d) to go back to (his/her) apartment...cannot be redirected This nurse and	A 606		

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A 606	Continued From page 41 CNAs been sitting up front watching (RI#1) since 8:30 pm tonight so (RI#1) will not try to go out the front door Resident is still sitting on the sofa near the front entrance being monitored by CNA... 10/3/2023...(RI#1) made no mention of leaving this morning or of last night attempt to leave facility. ..." On January 11, 2024 at approximately 3:00 pm, the surveyor observed EI#2 attempt a medication awareness test of RI#1 to demonstrate RI#1's ability to protect themselves from a medication error. EI#2 asked RI#1 if he/she would show what medications he/she takes and when. RI#1 said he/she must talk to his/her doctor first. RI#1 denied the medications that EI#2 had for were his/hers. RI#1 added they fill him/her up when he/she comes to the facility then the doctor takes him/her off of them. When EI#2 asked RI#1 if the medications she was holding were what RI#1 had taken that morning, RI#1 said, "No." On January 11, 2024 at approximately 3:30 pm, EI#2 was interviewed. EI#2 said RI#1 failed the medication awareness test and was ineligible for the assisted living facility setting. On January 16, 2024 at approximately 1:30 pm, EI#2 was interviewed. EI#2 said RI#1's inability to know his/her date of birth, how long they had live at the facility and the inability to pass a medication awareness test made RI#1 ineligible for the assisted living facility setting. When asked what RI#1's status was, EI#2 answered RI#1 was going to transfer to the Specialty Care Assisted Living Facility (SCALF). EI#2 said RI#1 was occasionally forgetful when first admitted to the facility. When asked at what point RI#1 became unable to direct his/her care, EI#2 said a few months after RI#1 was admitted. EI#2 was asked	A 606		

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A 606	Continued From page 42 what the concern was of a resident becoming ineligible for the assisted living setting and it not being documented in the monthly assessments. EI#2 answered the concern of injuries or potential elopement. On January 16, 2024 at approximately 3:15 pm, EI#1, the Administrator, was interviewed. EI#1 said residents have to be able to identify their medications as their own. EI#1 said the concern of RI#1 remaining in the facility after becoming ineligible was concern for elopement. EI#1 said RI#1 was going to transfer to the Specialty Care unit because that was the level of care he/she required. After reviewing the nurses' notes, EI#1 said the monthly assessments were inaccurate and this transfer should have been considered as early as October, 2023.	A 606		
A 608	420-5-4-.06 (3) (g) Care of Residents. (g) Mechanical Restraint and Seclusion. No form of physical restraint or seclusion shall be applied to residents of an assisted living facility except in extreme emergency situations when the resident presents a danger of harm to himself or herself or to other residents. In such an event, the facility shall use the least restrictive intervention that will be effective to protect residents, immediately notify the resident's physician and sponsor, and appropriate treatment, transfer to an appropriate health care facility, or both shall be provided without any avoidable delay. In no event shall emergency behavioral symptoms of residents be treated with sedative medications, anti-psychotic medications, anti-anxiety medications, or other psychoactive medications in an assisted living facility.	A 608		

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A 608	Continued From page 43 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure a resident was not physically restrained. This resulted in harm for RI#8 and had the potential for serious harm for the 17 residents residing at the facility. THIS DEFICIENCY WAS CITED AS A RESULT OF THE COMPLAINT INVESTIGATION. Findings: On May 9, 2023, an incident was reported to the Alabama Department of Public Health Online Incident Reporting System from the Knollwood Pointe Assisted Living facility indicating at 12:17 AM on May 9, 2023, "...Overnight nurse called and stated that (Name of RI#8) was on the floor by (his/her) bed, helped lift (him/her) to get (him/her) in the wheelchair. Then I rolled (him/her) to the activity room and up to the table, got a sheet and tied around the resident and tucked it in on both sides of the chair...Names of staff on duty at time of the incident: (Listed the name of Employee Identifier{EI} #3, a Registered Nurse, EI#4, a Certified Nursing Assistant (CNA), and EI#5, a CNA) Action(s) taken by the facility in response to the incident: Employees involved suspended pending investigation. ...". According to a facility policy titled, "Identifying and Reporting Abuse, Neglect and Exploitation ...Abuse is defined as the willful infliction of injury, confinement, intimidation or punishment with resulting physical abuse and mental anguish. ...".	A 608		

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A 608	Continued From page 44 RI#8 was admitted to the facility on September 7, 2022, with diagnoses to include hypertension, diabetes mellitus II, legal blindness, dementia, chronic congestive heart failure and depressive disorder. RI#8 sustained a fall shortly after 12:00 am on May 9, 2023. RI#8 was then transferred to a wheelchair, taken to the activity room and restrained by a bed sheet to prevent him/her from rising from the wheelchair. RI#8 was still in the activity room, in his/her wheelchair, restrained with a bed sheet when EI#2, the Licensed Practical Nurse (LPN)/Resident Care Coordinator (RCC) arrived for her shift at 7:00 am on May 9,2023. SEE INTERVIEWS BELOW WITH EI#'s 2, 3, 4, and 8. According to nurse's note documentation dated May 9, 2023 at 8:18 PM, the resident (RI#8) who was not allowed back to bed after a fall, "...has slept most of the day, (he/she) had a rough night, not much of an appetite for lunch or dinner. ...". EI#3's witness statement dated May 9, 2023 documented, "On 5/9/23 at 12:17 AM I was called to (RI#8's room). There I found (RI#8) lying on the floor. ...After getting (him/her) to the wheel chair I rolled (him/her) to the activity Room and wraped (wrapped) a sheet between (his/her) legs then around to the back of the chair & tucked the ends on each other. I pushed the chair up to the table & instructed the staff to watch (him/her) to keep (him/her) safe. ...". EI#4's witness statement dated May 9, 2023 documented, "I was sitting in the television room ...when (EI#8, former Dietary Manager) entered the room screaming at me. I told him I did not tie	A 608		

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A 608	Continued From page 45 (names RI#8) up and he needed to take that up with nurse (named EI#3). EI#5's witness statement dated May 10, 2023 documented, "... The nurse told me to open the wheelchair as they picked (RI#8) up and placed (RI#8) in it. She (the nurse) asked "Did (RI#8) have a sheet?" (this was quoted in EI#5's statement) The other aide started looking through (RI#8's) things and found one. The nurse started rolling (RI#8) in the dining (Activity) area. The nurse asked us did anyone want to sit in (RI#8's) room with (him/her) or did we want her to just leave (RI#8) in there with us. I proceeded to say "Yes I will" ...Then the other aide just insisted on (RI#8) to just stay in the dining (Activity room with a table) area with us because she didn't want (RI#8) to fall again. So, then the nurse started putting the sheet across (RI#8) in the front going under one of (his/her) legs then tied a loose knot with the sheets in the back of (his/her) wheelchair and scooted (him/her) up to the table. ...". On January 16, 2024, at approximately 9:15 am, EI#4, the former CNA, was interviewed. EI#4 acknowledged RI#8 was physically restrained. EI#4 said it should have been reported to the Administrator, but felt she would not answer after midnight because she had called earlier in her shift before and she did not answer the phone. EI#4 said she told EI#3 that it was not a good idea to restrain RI#8. However, EI#3 said she would take full responsibility at the time of the incident. EI#4 defined a physical restraint as something that keeps residents from moving like they want to. On January 16, 2024, at approximately 2:00 pm, EI#3, the former RN, was interviewed. EI#3 said a physical restraint is when you prevent someone	A 608		

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A 608	Continued From page 46 from freely moving about. She claimed the bed sheet was not intended to restrain RI#8. When EI#3 was asked why she needed a bed sheet for staff to watch RI#8, she would not answer the question. When asked how the bed sheet helped staff to keep eyes on RI#8, she answered it was tucked on the sides and behind RI#8. When asked who restrained RI#8, EI#3 responded she did. EI#5 was unable to be contacted. Her personnel file was not found. SEE CITATION 403.	A 608		
	On January 16, 2024, at approximately 2:30 pm, EI#8, the former Dietary Manager, was interviewed. EI#8 said a physical restraint tied or trapped someone to keep them from moving by themselves. EI#8 witnessed RI#8 in the wheelchair with the bed sheet tied in the back. EI#8 reported what he saw to EI#2, the Licensed Practical Nurse (LPN)/Resident Care Coordinator (RCC). On January 16, 2024, at approximately 2:45 pm, EI#2 was interviewed. EI#2 said she witnessed RI#8 in a wheelchair with a bed sheet wrapped around each thigh and pulled to the back and tied. EI#2 added that the bed sheet was a restraint because it restricted RI#8 from moving. EI#2 said a physical restraint prevented someone from moving freely.			
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records	A 611		

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A 611	Continued From page 47 necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility. 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current	A 611		

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A 611	Continued From page 48 Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of assisted living facilities shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Resident's hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented.	A 611		

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A 611	Continued From page 49 This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to include RI#5's oxygen therapy in their care plan. The facility also failed to include RI#2's hearing deficit in their plan of care. The facility's lack of implementing care plans for specific care needs of the residents placed RI#2 and RI#5 at risk for harm.	A 611		
	THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEYS COMPLETED ON 06/10/2015 AND 12/04/2014. Findings: RI#2 RI#2 was admitted to the facility on October 23, 2023 with diagnoses to include coronary artery disease, atrial fibrillation, and chronic obstructive pulmonary disease. On January 9, 2024, at approximately 12:30 pm, RI#2 was interviewed while being observed for his/her meal intake. RI#2 said the staff do not tell him/her what is being served and said they should. The surveyor had overheard EI#10, a Certified Nursing Assistant (CNA) speaking to the resident when she delivered the meal. On January 9, 2024, at approximately 3:00 pm, EI#10, a Certified Nursing Assistant (CNA), was interviewed. EI#10 said when she delivered lunch to RI#2, she told the resident that he/she had been served chicken and dumplings, but RI#2 was very hard of hearing. EI#10 said RI#2's care			

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A 611	Continued From page 50 plan did not address a hearing issue, but it should. RI#10 said the care plan should address the resident's hearing deficit so everybody knows how to care for him/her. On January 10, 2024, at approximately 11:30 am, RI#2's care plan was reviewed and their hearing deficit was not care planned. On January 11, 2024, at approximately 2:00 pm, EI#2 was observed with RI#3 for a medication awareness test for the resident. EI#2 was observed to enter the room and ask the resident if she could turn the television down. Once EI#2 lowered the volume, the resident was able to hear well when EI#2 spoke loudly. When EI#2 was asked why she lowered the volume before talking to the resident, EI#2 said that is how RI#2 can hear. EI#2 was told of the resident assuming staff had not made him/her aware of what he/she was served at meal time because they did not know to accommodate RI#2's hearing deficit. When asked if that should be care planned, EI#2 said yes. RI#5 RI#5 was admitted to the facility on January 23, 2023 with diagnoses to include acute respiratory failure with hypoxia, chronic pain, heart disease, hypertension and diabetes mellitus II. On January 9, 2024, at approximately 11:00 am, RI#5 was observed in their room with oxygen therapy in use via nasal cannula at 2 liters per minute. On January 10, 2024, at approximately 11:15 am, RI#5's care plan was reviewed and the oxygen therapy was not care planned.	A 611		

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A 611	Continued From page 51 On January 16, 2024, at approximately 3:15 pm, EI#1, the Administrator, said the oxygen should have been care planned.	A 611		
A 613	420-5-4-.06 (5) (a) (b) (c) (d) (e) Care of Residents. (5) Medications. (a) Medications as defined in these rules, may be administered to a resident of an assisted living facility only after the drugs have been prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama. A currently licensed physician in good standing with the Medical Licensure Commission of any state may prescribe medications to a resident of an assisted living facility only during the initial physical examination. (b) A physician order is required for a resident to manage and have custody of his or her own medications. (c) A resident may have custody of and manage over the counter topical medications with the written approval of a physician. A physician order is not required for over the counter topical medications that are self-administered by residents and approved by the physician for resident possession. (d) Nothing in these rules shall preclude a facility from using a licensed nurse employed by the facility or nursing agency to administer medication to any resident. An RN or LPN shall administer medications to residents in the	A 613		

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A 613	Continued From page 52 assisted living facility only in accordance with physician orders and the Nurse Practice Act. (e) A resident who is incapable of recognizing his or her name, or understanding the facility unit dose medication system, or does not have the ability to protect himself or herself from a medication error shall require medication administration. Medication administration shall be provided only by a physician or by an RN or LPN. If the resident cannot understand or be trained to understand the unit dose medication system used by the facility or cannot protect himself or herself from medication errors by facility staff, the resident will be appropriately discharged. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure Resident Identifier (RI) #1 was able to pass a medication awareness screening. This failure indicated RI#1 was unable to protect themselves for a medication error. Findings: RI#1 was admitted to the facility on June 29, 2023, with diagnoses to include hypertension and age related cognitive decline. On January 11, 2024 at approximately 3:00 pm, the surveyor observed EI#2 attempt a medication awareness test of RI#1 to demonstrate RI#1's ability to protect themselves from a medication error. EI#2 asked RI#1 if he/she would show what medications he/she takes and when. RI#1 said he/she must talk to his/her doctor first. RI#1 denied the medications that EI#2 had for were his/hers. RI#1 added they fill him/her up when he/she comes to the facility then the doctor takes	A 613		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 613	Continued From page 53 him/her off of them. When EI#2 asked RI#1 if the medications she was holding were what RI#1 had taken that morning, RI#1 said, "No." On January 11, 2024 at approximately 3:30 pm, EI#2 was interviewed. EI#2 said RI#1 failed the medication awareness test and was ineligible for the assisted living facility setting.	A 613		
A 615	420-5-4-.06 (7) (j) Care of Residents. (j) All medications administered to residents and all medications self-administered with assistance of facility staff in an assisted living facility shall be contemporaneously recorded on a standard medication administration or medication assistance record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication administration or medication assistance record shall include at least the following: 1. The name of the resident to whom the medication was administered or assisted. 2. The name of the medication administered or assisted. 3. The dosage of the medication administered or assisted. 4. The method of administration or assistance. 5. The site of injection or application, if the medication was injected or applied. 6. The date and time of the medication	A 615		

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	D4943	A. BUILDING: _____ B. WING _____	01/16/2024

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KNOLLWOOD POINTE ASSISTED LIVING	5601 GIRBY ROAD MOBILE, AL 36695

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A 615	Continued From page 54 administration or assistance. 7. Any adverse reaction to the medication. 8. The printed name, initials, and written signature of the individual administering the medication or assisting the resident with self-administration of the medication. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure EI#2, the Licensed Practical Nurse (LPN) charted contemporaneously when administering medications. Findings: RI#3 was admitted to the facility on October 31, 2023 with diagnoses to include depression, dementia, hypertension, legal blindness, agitation and hypercholesterolemia. Review of the Resident Medical Examination for RI#3 dated October 19, 2023, revealed, "... Crestor 5 mg (milligrams) 1 every 3 days ..." A review of RI#3's Medication Administration Record (MAR) revealed one dose of Rosuvastin Calcium (Crestor) 5 milligrams was documented as given since admission. It was documented for January 16, 2024. On January 16, 2024, at approximately 1:00 pm, EI#2 was interviewed. EI#2 said RI#3's Crestor was prescribed for 5 milligrams by mouth every three days. Regarding the only documented	A 615		

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A 615	Continued From page 55 administration of Crestor to RI#3, dated January 16, 2024, EI#2 said that was an error. EI#2 declared RI#3 had received a dose of Crestor on January 11, 2024 and January 14, 2024. She (EI#2) admitted she had not documented the two doses she had given. EI#2 admitted she was supposed to document when medications are given.	A 615		
A 702	420-5-4-.07 (2) Food Service (2) Food Handling Procedures. (a) Dish and Utensils Washing, Disinfection, and Storage. 1. Wash water shall be changed with sufficient frequency to avoid gross contamination, and final rinse water shall be kept clean and clear. 2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods: (i) Utensils and dishes shall be completely immersed for a period of not less than 30 seconds in water that is at least 171 degrees Fahrenheit (pouring scalding water over utensils and dishes does not meet this requirement); or (ii) A cold water sanitizer. A sanitizing solution shall be used in accordance with manufacturer's instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach, or 30	A 702		

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A 702	Continued From page 56 seconds in 12.5 ppm of iodine or the amount of time set by the manufacturer in a 200 ppm quaternary ammonium solution. Water temperature must be at least 75 degrees Fahrenheit. Water temperatures and chemical concentrations shall be monitored and documented prior to dishwashing. A record of each test shall be maintained for at least three months. 3. Dishes and utensils shall be allowed to air dry.	A 702		
	4. After washing, rinsing, sanitizing, and air-drying, all repeated use service ware (utensils and dishes) shall be stored in a clean, dry place that is protected from pests, dust, splash, and other contaminants. Utensils shall be handled in such a way as to prevent contamination from hands and clothing. 5. The results from the use of dishwashing machines shall be equivalent to those obtained from the method outlined above, as documented in material provided from the manufacturer and kept on file at the facility. (b) Ice. Crushed or chipped ice shall be protected from splash, drip, and hand contamination during storage and service. The ice scoop may be stored in the ice bin in a manner to prevent ice from coming into contact with the handle, or it may be stored in an airtight container outside the ice bin. (c) Protection of Food from Contamination. 1. Food and food ingredients shall be			

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A 702	Continued From page 57 stored, handled, and served so as to be protected from pests, dust, rodents, droplet infection, unsanitary handling, overhead leakage, sewage back flow, and any other contamination. Sugar, syrup, and condiment receptacles shall be provided with lids and shall be kept covered when not in use. 2. Medications, biologicals, poisons, detergents, and cleaning supplies shall not be kept in the refrigerator or in other areas used for storage of food. 3. Food shall not be stored on the floor. All food and food ingredients stored on shelving must be placed on shelving that is at least six inches above the floor. 4. Refrigerators shall maintain a maximum temperature of 41 degrees Fahrenheit. Freezers shall be maintained at a maximum temperature of 0 degrees Fahrenheit. Thermometers shall remain in refrigerators and freezers at all times. 5. All leftover foods shall be labeled and dated with a "use by date", so that it may be consumed or discarded by that date, which is no more than 3 days from the date it was prepared. 6. All food products shall be used by the manufacturer's indicated date or discarded. 7. Food shall be prepared either in the licensed facility or another location even when that location is not part of the licensed facility. All food preparation areas used by the facility shall be subject to the same inspections as though part of the licensed facility. The licensed facility is	A 702		

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A 702	Continued From page 58 responsible to ensure adequate equipment and measures are used to ensure that food is not contaminated in transport and that foods that are transported are held and served at the appropriate temperatures at all times. 8. Hot food shall be maintained at a minimum of 135 degrees Fahrenheit and cold foods at a maximum 41 degrees Fahrenheit. 9. Frozen food items (raw and cooked) shall be thawed under refrigeration or under running water prior to preparation. Frozen food may also be thawed as part of the cooking process when indicated by package directions. Raw meats shall be stored below and away from vegetables, fruits, and other foods to prevent contamination (meat juices dripping on other foods). 10. Laundry shall not be brought through the food preparation or service area. (d) Storage and Service of Milk and Ice Cream. 1. Milk and fluid milk products shall be served only from the original containers in which they were received from the distributor. This shall not apply to cream for coffee, cereals, and milk for milk drinks which may be dispensed from a readily cleanable container approved for such use. 2. Milk and fluid milk products shall be stored in such a manner that bottles or containers, from which the milk or milk product is to be poured or drunk, will not become contaminated from drip or contact with foods.	A 702		

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A 702	Continued From page 59 Milk shall be maintained and stored at a maximum temperature of 41 degrees Fahrenheit and shall not be served at a temperature warmer than 45 degrees Fahrenheit unless specifically requested to be served at a warmer temperature by a resident. 3. Contaminating substances shall not be stored with or over open containers of ice cream. Ice cream dippers, spatulas, and other serving utensils shall be cleaned between uses. (e) Kitchen Garbage and Trash Handling. 1. Kitchen garbage and trash shall be placed in suitable containers with tight-fitting lids and properly stored pending removal. Kitchen garbage and trash shall not be allowed to accumulate in the kitchen and shall be removed from the premises at frequent intervals. 2. After being emptied, all garbage cans and trash cans shall be washed and dried before reuse. (f) Employees' Cleanliness. 1. Employees engaged in the handling, preparation, and serving of food shall wear clean clothing at all times. Employees shall wear hair restraints, for example, hairnets, headbands, caps, or other adequate means to prevent contamination of food from hair. Employees whose duties include contact with residents shall change clothing or wear a clean covering over clothing before handling, preparing, or serving food.	A 702		

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A 702	Continued From page 60 2. Employees handling food shall wash their hands thoroughly before starting work each day, immediately after contact with any soiled matter, and before returning to work after each visit to the rest room. 3. Street clothing not worn by the employee shall be stored in lockers, dressing rooms, or closets designated for staff use. (g) Live Fowl or Animals. Live fowl or animals shall not be allowed in the food service area. (h) Smoking and Spitting. Smoking, other use of tobacco products, and spitting within the food service area shall be prohibited for all staff, residents, and visitors. (i) Dining in Kitchen. Dining in the kitchen shall not be permitted in congregate assisted living facilities. (j) Paper for Food Wrapping. Only new paper, foil, or plastic wrap shall be used for wrapping of foods. (k) Laundering of clothing shall not be permitted in food preparation or service areas. This Rule is not met as evidenced by: Based on observations and interview the facility failed to ensure foods stored in the walk-in cooler and freezer were covered, labeled, and dated for safe storage. Findings:	A 702		

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A 702	Continued From page 61 On January 11, 2024, at approximately 9:30 am, the surveyor observed a pan of jello uncovered and unlabeled in the kitchens' walk-in cooler. In the freezer an opened, partially used package of meat patties was found with no label. A package of frozen biscuits that were also partially used had no label. On January 16, 2024, at approximately 5:15 pm, EI#6, interim Dietary Manager was interviewed. EI#6 said stored items in the cooler and freezer that had been opened should be covered and labeled.	A 702		
A1002	420-5-4-.10 (2) Sanitation and Housekeeping. (2) Housekeeping and Physical Plant Maintenance. The facility must provide a safe, functional, sanitary, decent, and comfortable environment for residents, staff, and the public. (a) Equipment and Supplies. The home shall maintain an adequate quantity of housekeeping and maintenance equipment and supplies. (b) Bathtubs and Lavatories. Bathtubs and lavatories shall be kept clean and in proper working order, and shall not be used for laundering. (c) Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. (d) General Storage. 1. Broken beds, extra mattresses, mop	A1002		

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A1002	Continued From page 62 buckets, and dust rags shall not be kept in hallways, closets, corners, or occupied resident rooms. Such items must be stored neatly and orderly in designated storage rooms. 2. The use of attics for storage of combustible materials shall be prohibited unless protected by an automatic sprinkler system and then only in small quantities so as not to create a hazardous condition. 3. Basements used for storage shall meet acceptable standards for storage and shall be designed and constructed in a manner that protects against fire hazards. 4. Flammable materials such as gasoline, motor fuels, lighter fluid, turpentine, acetone, and oil-based paint shall not be stored in the facility. Unless prohibited by a facility's own policies, however, a cognitively intact resident who uses lighter fluid to fill a personal cigarette lighter, or one who uses flammable materials such as paint or glue in connection with a personal hobby, may store small quantities of those materials in a safe and secure manner within his or her own room. 5. Poisonous or External Use Substances. Facility cleaning supplies and poisons shall be attended at all times or shall be kept in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe and decent environment for all residents. This deficient practice placed all 17 residents at risk for harm.	A1002		

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A1002	Continued From page 63 Findings: On January 9, 2024, at approximately 9:15 am, the surveyor observed carpeting in the hallways of the facility to be stained and worn down. One area approximately 18 inches long and 24 inches wide at the intersection of the entrance hall and main hallway was noted to have 5 rows of buckling carpet. On January 16, 2024, at approximately 3:15 pm, EI#1, the Administrator, was interviewed. EI#1 said the environment concerns that have been identified included the carpet that needed replacing. EI#1 acknowledged the buckling carpet as a fall hazard. EI#1 added this was the resident's home.	A1002		
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in	A1101		

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A1101	Continued From page 64 adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs. (d) Roller latches are prohibited on doors separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that: 1. Minimizes leaks and spills. 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. (f) Fire Alarm and Sprinkler System. 1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply	A1101		

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A1101	Continued From page 65 with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements). 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously. 3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and testing reports shall be maintained in the facility for a period of at least 3 years. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the fire alarm system was checked semi-annually. Findings: On January 9, 2024, at approximately 11:45 am, a review of the fire alarm system inspection log revealed the fire alarm system was being	A1101		

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A1101	Continued From page 66 inspected annually. The last inspection of the fire alarm system was conducted on March 17, 2023. On January 11, 2024, at approximately 10:00 am, EI#9, the Maintenance Director, was interviewed. According to EI#9 the fire alarm system should be inspected semi-annually and the Knollwood Pointe Assisted Living Facility's fire alarm system had only been inspected annually. THERESA HARRISON, REGISTERED NURSE	A1101		