DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095026	A. BUILDING ______ B. WING ______	06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

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F 000	INITIAL COMMENTS	F 000		

An unannounced Long-Term Care Survey was conducted at Knollwood HSC from May 25, 2021 through June 2, 2021. Survey activities consisted of a review of 18 sampled residents. The following deficiencies are based on observation, record review, resident, and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census during the survey was 43.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

AMS - Altered Mental Status

ARD - Assessment Reference Date

AV- Arteriovenous

BID - Twice- a-day

BIMS - Brief Interview for Mental Status

B/P - Blood Pressure

cm - Centimeters

CPR - Cardiopulmonary resuscitation

CMS - Centers for Medicare and Medicaid Services

This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Knollwood HSC does not admit that the deficiencies listed on the CMS Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna L Epps | TITLE: Administrator | (X6) DATE: 7-5-21

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

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F 000	Continued From page 1 CNA- Certified Nurse Aide CRF - Community Residential Facility DVT - Deep Vein Thrombosis D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EHR - Electronic Healrh Record EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) ESRD - End Stage Renal Disease G-tube Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter	F 000		

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F 000	Continued From page 2 Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN - midnight Neuro - Neurological NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PPE - Personal Protective Equipment PO- by mouth POS - physician's order sheet Prn - As needed	F 000		

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F 000	Continued From page 3 Pt - Patient Q- Every QIS - Quality Indicator Survey RN - Registered Nurse ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record TSH- Thyroid Stimulating Hormone TV- Television Ug - Microgram	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 18 sampled residents, facility's staff failed to accurately code a resident's Quarterly Minimum Data Set (MDS) to include a Stage 3 pressure ulcer. Resident #5. The findings include:	F 641	It is Knollwood's policy to accurately code residents' status on the Minimum Data Set (MDS) 1- Resident's #5 pressure ulcer was accurately coded in the correction MDS dated 6/4/21.	

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F 641	Continued From page 4 Resident #5 was admitted to the facility on 09/05/2019, with multiple diagnoses including, Parkinson's Disease, Coronary Artery Disease, Atrial Fibrillation, Legal Blindness, and Spinal Stenosis. Review of a Quarterly MDS (Assessment Reference Date of 05/24/2021), documented the following: In Section M0300 (Current Number of Unhealed Pressure Ulcers/Injuries at each Stage), the resident was coded for having one (1) Stage 4 pressure ulcer. Review of the Wound/Skin Record documented the following: "05/13/21 site - A (coccyx), stage - Stage III, size - 5 X 5 cm (centimeters), depth - 0, exudate - 0, odor - 0, wound bed - redness with scattered pinpoint areas within, surrounding skin color - WNL (within normal limits), surrounding tissue/wound edges - this area was left blank." "05/20/21 site - A (coccyx), stage - Stage III, size - 5 X 5 cm (centimeters), depth "-", exudate "-", odor "-", wound bed - red, surrounding skin color"-", surrounding tissue/wound edges " It should be noted that Resident #5's coccyx wound had an onset date on 11/05/2020. During a face-to-face interview conducted on 05/28/2021, at approximately 1:30 PM, Employee #11 (MDS Coordinator stated, "I clicked Stage 4 pressure ulcer in error. The resident has a healing Stage 3 sacral (coccyx) pressure ulcer. I will correct the MDS right now."	F 641	2- The Section M0300 in the minimum data set of residents identified with pressure ulcers was audited. All residents' pressure ulcers were accurately coded in the MDS at that time. 3- The MDS Coordinator and the MDS nurses will be in serviced to ensure that the completed assessment reflect the resident's current status. 4- MDS Section M0300, residents with pressure ulcers, will be audited monthly X 6 then quarterly X 2 to ensure that pressure ulcers are accurately coded in Section M of the MDS. The result of these audits will be presented to the Quality Assurance Performance Improvement Committee for review and further recommendations as warranted.	7-28-21

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F 657	Continued From page 5	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to implement supervision as outlined in the Fall's Care Plan for one (1) of 18 sampled residents. Resident #5. The finding include:	F 657	It is Knollwood's practice to implement supervision of residents as outlined in the care plan and according to resident needs. 1-Care plan interventions that were in place for resident # 5 include: placing a bed alarm on her bed and checking every shift that it is functioning, providing supervision during shift rounds, medication administration, meal delivery, and during Activity of Daily Living (ADL). Resident also participated in Occupational Therapy. 2- Residents who have sustained a fall in the past 60 days have been identified. The MDS Coordinator or designee will conduct audits to ensure that supervision and interventions are being conducted by staff as reflected in the falls care plans.	

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F 657	Continued From page 6 Resident #5 was admitted to the facility on 09/05/2019, with multiple diagnoses including, Parkinson's Disease, Coronary Artery Disease, Atrial Fibrillation, Legal Blindness and Spinal Stenosis. Review of a Quarterly Minimum Data Set (Assessment Reference Date of 06/05/2020), documented the following: In Section C0500 (Brief Interview for Mental Status), the resident had a summary score of 12, indicating the resident was cognitively intact. In Section E (Behavior), resident was not coded for psychosis, rejection of care or wandering. In Section G (Functional Status), the resident was coded for needing extensive assistance with the assistance of one person for ambulation in room and toileting use. In Section H (Bladder and Bowel) - the resident was coded for frequent incontinence of both bladder and bowel. In Section I (Active Diagnosis)- the resident was coded for diagnoses of Dementia, Parkinson s Disease, and Manic Depression. And in Section J (Health Condition) - the resident was coded for having one (1) fall with major injury since admission/entry/reentry. Review of the resident's record revealed the following sequence of events: "03/07/20 at 8:30AM (Nursing Note) Resident observed sitting on the floor in bathroom. Alert, oriented, able to verbalize what happened. Resident stated she lost her balance while doing oral care in sink ...Verbalized she hit right side of her head and right side of her shoulder in the toilet bowl ..." Review of the radiology report revealed:	F 657	3- Licensed nurses will be in-serviced By the MDS Coordinator or designee by 7/23/2021 regarding: -the identification of residents' needs during assessment - implementation of person centered interventions noted in the care plan -documentation of monitoring of interventions in the clinical record 4- An audit of 10% of residents identified as at risk for falls will be completed weekly X 4 then Monthly X 4 then Quarterly to ensure that interventions in the care plan are documented to show staff monitoring of resident safety. This audit will be performed by the DON or Designee. The result of these audits will be reported to the Quality Assurance Performance Improvement committee for review and further recommendations as warranted.	7-28-27

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F 657	Continued From page 7	F 657		

"03/09/20 at 6:47 PM (Bilateral Ribs and AP [anteroposterior] chest X-ray) - There is a diffuse sever bony demineralization, which limits the diagnostic capability of the study. There is a fracture of the 2nd right rib posteriorly with minimal displacement. No other acute bony abnormalities are seen. Irregularities are seen of the left ribs compatible with old fractures and there is an old fracture of the left clavicle. Impression: 1. Fracture of the right 2nd rib posteriorly. 2. No acute pulmonary infiltrates."

"03/09/20 at 10:47 PM (Nursing Note) Resident alert and verbal. Xray done, result of chest C-Rays (sp) shows fracture of right 2nd rib posteriorly ..."

Review of the care plan (fall) with a start date of 03/10/2020 revealed:
Goal: will minimize injuries related to falls.
The care plan outlined multiple approaches for the facility's staff to address the resident problem of falls that included:
-Increased staff supervision with intensity based on resident's need.
-Bed alarm in place.
-Implement [an] exercise program that targets strength, gait, and balance.

Care Plan (Activity of Daily Living (ADL)/ Rehabilitation Potential Self-Care) with a start date of 03/10/20.
Goal: All her ASL (sp) will be anticipated and met by staff on daily basis.
The care plan outlined multiple approaches for the facility's staff to address the resident problem with ADLs that included:

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F 657	Continued From page 8 -Assist with ... personal hygiene... -Assist with ... mobility, transfers, and locomotion. "06/17/20 at 4:23 PM (Nursing Progress Note)- This writer was at the end of the hall at 4:05 PM, Resident seen coming out of room. Upon getting closer to resident's room, a audible screeching sound heard. Upon entering resident's room, resident noted in supine position in entrance way of room door. Commented she was looking for bathroom assist and went to turn around and go into bathroom and fell on left hip. Resident c/o (complained of) left hip pain ..." "06/17/20 at 5:22 PM (Nursing Progress Note) - 2 Ambulance staff arrived. Resident transferred via stretcher, resident conversing with ambulance staff at this point. No change mentation. Scheduled to go to [hospital's name] for evaluation ..." "06/18/20 (Physician's Order)- Transfer to [hospital ' s name] ER (emergency room) for Further eval (evaluation) & TX (treat) left hip pain and fall." "06/21/20 (Nursing Progress Note)- Admission Note: Resident alert and oriented to time, place and person, arrived on the unit at 1:15PM accompanied by 2 paramedics, readmitted to room [room number] ...left hip noted with two surgical incision sites, upper left hip site with six intact staples and slight serosangenous (sp) exudate, lower left hip with nine intact staples with no drainage noted, resident is non weight bearing at this time ..." Review of nursing notes, medication and	F 657		

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F 657	Continued From page 9 treatment records from 03/10/2020, to 06/17/2020, lacked documented evidence that facility staff provided intense supervision (to include to type and frequency) based on the resident's assessed needs to minimize injuries related to falls, as outlined in the previously mentioned care plan. During a face-to-face interview on 06/02/2021, at approximately 3:00 PM, Employee #5 (RN/ Unit Charge Nurse) stated that intense supervision is every two hours. She also said that nurses may or may not document supervision in their nursing notes.	F 657		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility's staff failed to ensure that Resident #5, who had a history of pressure ulcers in the coccyx area, received continuous	F 686	It is Knollwood's practice to ensure that residents with a recent history of pressure ulcer receive monitoring of the area to decrease the potential of reoccurrence. Note: Documented monitoring was in place for resident #5. This included observation of her skin by the Certified Nursing Assistant during bed bath and incontinence care as documented in the ADL support section of MatrixCare (the electronic medical record – EMR).	

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F 686	Continued From page 10 monitoring, consistent with professional standards of practice, to prevent the reoccurring of an unstageable pressure ulcer in the sacral region for one (1) of 18 sampled residents. This failure resulted in actual harm to Resident #5. The findings include: Resident #5 was admitted to the facility on 09/05/2019, with multiple diagnoses including, Parkinson's Disease, Coronary Artery Disease, Atrial Fibrillation, and Hypothyroidism. Review of the Significant Change Minimum Data Set (Assessment Reference Date of 11/25/2020), documented the following: In Section C0500 (Brief Interview for Mental Status), the resident had a summary score of 14, indicating the resident was cognitively intact. In Section I, 18000-(Additional Active Diagnoses) coded the resident for Pressure Ulcer of Sacral Region, Stage 3. In Section G (Functional Status) coded the resident for extensive assistance with the assistance of one (1) person for bed mobility and personal hygiene. In Section H (Bladder and Bowel)- the resident was coded as frequently incontinent of both bladder and bowel. In section, M0300 (Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage) coded the resident for having one (1) Stage 3 pressure ulcer. In section, M 1200 (Skin and Ulcer/Injury Treatments), coded the resident for pressure ulcer/injury care and applications of ointments/medications. Observation:	F 686	It is Knollwood's Certified Nursing Assistants practice to report any change in skin integrity to the Charge Nurse that they might observe during care. This was verified as the surveyor interviewed several of our Certified Nursing Assistants during the survey. Also, the Treatment Administration record shows that resident # 5 received daily application of Calmoseptine by the Medication Nurse between 10/30/20 and 11/4/2021.	

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F 686	Continued From page 11 On 05/25/21 at 2:45 PM, observation of Resident #5's sacral wound showed approximately three (3) pinpoint open areas, red in color, no drainage, no smell, no depth, surrounding tissue was pink and intact. Also noted was barrier cream on the resident's buttock area. At the time of the observation, Resident #5 was lying on an air mattress, awake, alert, oriented to name, denied pain and continent of bladder and bowel. Review of the resident's care plan revealed the following: Care Plan (Pressure Ulcer) with a start date of 03/10/20. Goal: will minimize skin irritation and skin will remain intact. Approaches (start date of 06/29/20) included: -Monitor for skin irritation, document, report. -Turn and reposition Q (every) 2 hrs (hours) and prn (as needed), maintain pressure relieving device in bed and in w/c (wheelchair) monitor for placement. -Provide gentle care avoid friction. Provide incont (incontinent) care q (every) 2 hrs (hours) and prn (as needed), keep skin dry and oder [odor] free, apply [cream], lotion with incont. (incontinent) care ... Review of the resident's medical record revealed the following: 06/24/2020, to 07/30/2020, (Wound/Skin Records) showed the resident had a Stage II (pressure ulcer) in the sacral area with a start date of 06/24/2020 and a "healed" date of 07/30/2020. 09/11/2020, to 10/26/2020 (Wound/Skin Records)	F 686	1- Resident # 5 pressure ulcer on the coccyx is healed. 2-Residents who have sustained a pressure injury that healed within 30 days were reviewed on 7/13/2021 to verify that interventions to decrease the potential for the area to reopen are in place. One resident was identified and this resident has interventions in place to prevent the reoccurrence of the pressure ulcer. 3- To enhance currently compliant process regarding management of healed pressure ulcers, Certified Nursing Assistants will be re-in-serviced to report any changes in skin integrity with bathing, shower, and incontinence care. Licensed Nurses will be re-in-serviced as follows: - that a newly closed pressure area is fragile - the importance of treatment to protect the newly healed area to decrease the potential of it reopening.	

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F 686	Continued From page 12 showed that the resident had a Stage II (pressure ulcer) in the coccyx area with a start date of 09/11/2020, and a "resolved" date of 10/26/2020. The record included bi-weekly Bath/Shower Days Skin Observation Sheets where the facility's staff documented their observation of Resident #5's skin. However, there were no Bath/Shower Sheets to reflect observations of the resident skin integrity from 10/30/2020, to 11/04/2020. The medical record also lacked documented of staff observations of Resident #5 's skin during incontinent care." "11/05/20 (Wound/Skin Record) site - A (coccyx), stage - unstageable, size - 1.2 X 1.2 cm (centimeters), depth "-", exudate - 0, odor - 0, wound bed - dark red, surrounding skin color - WNL (with in normal limits), surrounding tissue/wound edges" - this area was left blank. A nursing note dated 11/05/2020, at 10:51 AM revealed " ...Resident noted with recurrent open are on coccyx approx (approximately)1.2 By 1.2 CM (centimeters) area with deep red appearance. At baseline, no significant muscle mass in sacral region (very boney). No active bleeding noted. Denies discomfort tx (treatment) order given ..." The physician's order dated 11/05/2020 directed staff to, "cleanse [coccyx area] with NS (normal saline), pat dry, apply Xeroform (fine mesh gauze occlusive dressing)/dry gauze dressing and cover with Mepilex (border lite foam adhesive dressings) BID (twice-a-day) until healed." "11/10/20 (Wound/Skin Record) site - A (coccyx), stage - unstageable, size - 3.5 X 3.5 cm (centimeters), depth " - ", exudate - small serous	F 686	4- An audit of residents with healed pressure ulcers will be completed weekly X 4 then monthly X 4 then quarterly to ensure that there is evidence of monitoring of healed pressure ulcers to decrease the potential of reoccurrence. The result of these audits will be presented to the Quality Assurance Performance Improvement Committee for review and further recommendations as warranted.	7-28-21

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F 686	Continued From page 13 sanguenous (sp), odor - 0 ,wound bed - dark red [and] yellow 10%, surrounding skin color - this area left blank, surrounding tissue/wound edges-granulation tissue". The nursing note dated 11/10/2020, at 2:03 PM, revealed, "Followed up with previously noted coccyx wound area is spreading toward left buttock. Cluster measurement of affected area is approx. approximately) 3.5 by 3.5 CM (centimeters). Small amt (amount) of serous sanquenous (sp) drainage noted. Denies discomfort. Center of wound bed with a deep red appearance and some yellow covering (10%) granulation tissue noted at edges ...ADON (Assistant Director of Nursing) assessed, MD (physician) updated. TX (treatment) order written ...ADON ...request for full air mattress." The physician's order dated 11/10/2020, directed, "sacral opened area: cleanse with NS (normal saline), pat dry, apply Intrasite (autolytic debridement agent) gel and dry gauze dressing, cover with Mepilex BID (twice-a-day) until healed." There was no documented evidence that facility's staff assessed and/or monitored Resident #5's skin to identify potential changes in the resident's skin from 10/30/2020, to 11/04/20, subsequently ten days (11/05/2020) after the sacral wound was resolved on 10/26/2020, the staff documented that Resident #5 had an unstageable wound in the same (coccyx) area. During a face-to-face interview on 06/02/2021, at approximately 2:30 PM, Employee #8 (Licensed Practical Nurse/Wound Nurse) stated that nurses	F 686		

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F 686	Continued From page 14 and certified nursing assistants conduct observations (skin rounds) of the residents' skin twice a week (shower days). The staff then documents "all" observations on the Bath/Shower Days Skin Observation Sheets. During a face-to-face interview on 06/02/2021, at approximately 3:30 PM, Employee #2 (Director of Nursing) and Employee #3 (Assistant Director of Nursing) acknowledged the finding and stated that staff assessed Resident #5's skin frequently during incontinent care and shower days. However, they did not have documented evidence of the skin assessment(s) performed during shower day(s) from 10/30/2020, to 11/08/2020.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 18 sampled residents, the facility's staff failed to provide adequate supervision and monitoring to prevent falls with major injuries (fractures) for Residents' #5 and #31. This failure resulted in actual harm to Residents' #5 and #31.	F 689	It is Knollwood's practice to provide adequate supervision of residents to decrease the potential of major injuries. 1-a- Ongoing supervision provided to resident #5 includes: reminders during rounds to call for assistance when she needs help, by reminding her to use her walker during charge nurse rounds, and certified nursing	

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F 689	Continued From page 15	F 689		

Continued From page 15

The findings include:

1. The facility's staff failed to provide adequate supervision to prevent a fall with major injuries (fractures) for Resident #5.

Resident #5 was admitted to the facility on 09/05/2019, with multiple diagnoses including, Parkinson's Disease, Coronary Artery Disease, Atrial Fibrillation, Legal Blindness, and Spinal Stenosis.

Review of a Quarterly Minimum Data Set with an Assessment Reference Date of 06/05/2020, documented the following: In Section C0500 (Brief Interview for Mental Status), the resident had a summary score of 12, indicating the resident was cognitively intact. In Section E (Behavior), resident was not coded for psychosis, rejection of care or wandering. In Section G (Functional Status), the resident was coded for needing extensive assistance with the assistance of one person for ambulation in room and toileting use. In Section H (Bladder and Bowel) - the resident was coded for frequent incontinence of both bladder and bowel. In Section I (Active Diagnosis) - the resident was coded for diagnoses of Dementia, Parkinson's Disease, and Manic Depression. And in Section J (Health Condition), - the resident was coded for having one (1) fall with major injury since admission/entry/reentry (9/5/2019).

Review of the medical record revealed the following:

assistants rounds. Housekeeping will alert staff if the resident is observed engaging in an unsafe activity while in the resident room and activity staff provides activities that are logged for each resident.

1-b- Ongoing supervision provided to resident # 31 includes: hourly rounds by charge nurses as documented on the Monitoring of resident who are ambulatory or able to self-propel on the wheelchair form, our Certified Nursing assistants rounds. Housekeeping will alert staff if the resident is observed engaging in an unsafe activity while in the resident room and activity staff provides activities that are logged for each resident.

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F 689	Continued From page 16 03/07/20 at 8:30AM (Nursing Note) documented, "Resident observed sitting on the floor in bathroom. Alert, oriented, able to verbalize what happened. Resident stated she lost her balance while doing oral care in sink ...Verbalized she hit right side of her head and right side of her shoulder in the toilet bowl ..." Review of the Physician's order dated 03/09/2020 stipulated, "bilateral rib xray (sp) and lubar [lumbar]/sacral spine xray to r/o (rule out) fracture" Review of the radiology report dated 03/09/2020, at 6:47 PM, revealed, "(Bilateral Ribs and AP [anteroposterior] chest) - There is a diffuse sever bony demineralization, which limits the diagnostic capability of the study. There is a fracture of the 2nd right rib posteriorly with minimal displacement. No other acute bony abnormalities are seen. Irregularities are seen of the left ribs compatible with old fractures and there is an old fracture of the left clavicle. Impression: 1. Fracture of the right 2nd rib posteriorly. 2. No acute pulmonary infiltrates." "03/09/20 at 10:47 PM (Nursing Note) Resident alert and verbal. Xray [x-ray] done, result of chest C-Rays (sp) shows fracture of right 2nd rib posteriorly ..." Review of the care plan section of the record revealed: The "fall" care plan with a start date of 03/10/2020. Goal: will minimize injuries related to falls. The care plan outlined multiple approaches for	F 689	2-a-b- Residents who are mobile by moving independently or those using an assistive device will be reviewed to ensure that the medical record reflects that the facility is providing supervision based on residents assessed need. 3-a-b- To enhance the compliance regarding the supervision of our residents to decrease the potential of falls with major injuries, staff will be in serviced by the DON or Designee regarding: - identification of residents at risk for falls - Identifying personalized interventions to decrease the potential for falls with major injuries - Documenting supervision of those residents in the clinical record	

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F 689	Continued From page 17 the facility's staff to address the resident problem of falls that included: -Increased staff supervision with intensity based on resident's need. -Bed alarm in place. -Implement [an] exercise program that targets strength, gait, and balance. The "Activity of Daily Living (ADL)/ Rehabilitation Potential Self-Care" care plan with a start date of 03/10/2020. Goal: All her ASL (sp) will be anticipated and met by staff on daily basis. The care plan outlined multiple approaches for the facility's staff to address the resident problem with ADLs that included: - "Assist with ... personal hygiene... mobility, transfers, and locomotion." Review of the nursing note dated 06/17/20 at 4:23 PM revealed..."This writer was at the end of the hall at 4:05 PM, Resident seen coming out of room. Upon getting closer to resident's room, a audible screeching sound heard. Upon entering resident's room, resident noted in supine position in entrance way of room door. Commented she was looking for bathroom assist and went to turn around and go into bathroom and fell on left hip. Resident c/o (complained of) left hip pain ..." "06/17/20 at 5:22 PM (Nursing Note) - 2 Ambulance staff arrived. Resident transferred via stretcher, resident conversing with ambulance staff at this point. No change mentation. Scheduled to go to [hospital's name] for evaluation ...]." The physician's order dated 06/18/20 directed,	F 689	4-a-b- An audit of 10% residents who are mobile by moving independently or those using an assistive device will be conducted weekly X 4, then monthly X 4 then Quarterly. The result of these audits will be presented to the Quality Assurance Performance Improvement Committee for review and further recommendations as warranted.	7-28-21

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F 689	Continued From page 18 "Transfer to [hospital's name] ER (emergency room) for Further eval (evaluation) & TX (treat) left hip pain and fall." The Nursing Progress noted dated 06/21/20 revealed, "Admission Note: Resident alert and oriented to time, place and person, arrived on the unit at 1:15PM accompanied by 2 paramedics, readmitted to room [room number] ...left hip noted with two surgical incision sites, upper left hip site with six intact staples and slight serosangenous (sp) exudate, lower left hip with nine intact staples with no drainage noted, resident is non weight bearing at this time ..." Review of nursing notes, medication and treatment records from 03/10/2020, to 06/17/2020, lacked documented evidence that facility staff provided intense supervision (to include to type and frequency) based on the resident's assessed needs to minimize injuries related to falls, as outlined in the previously mentioned care plan. During a face-to-face interview on 06/02/2021, at approximately 3:00 PM, Employee #5 (RN/ Unit Charge Nurse) stated that intense supervision is every two hours. She also said that nurses may or may not document supervision in their nursing notes. 2. The facility's staff failed to provide adequate supervision to prevent a fall with major injuries (fractures) for Resident #31. Resident #31 was admitted to the facility on	F 689		

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F 689	Continued From page 19 10/19/2019, with multiple diagnoses that included: Dementia, Parkinson's Disease, Hypertension, Diabetes Mellitus, Heart Failure, Ulcerative Blepharitis Right Eye and History of Repeated Falls. Review of the Quarterly Minimum Data Set dated 01/09/2021, showed the following: In Section C0500 BIMS (Brief Interview for Mental Status), the resident had a summary score of 4, indicating that the resident was severely cognitively impacted. Under Section G0110 (Activities of Daily Living Assistance), the resident was coded as requiring extensive assistance (two (2) person physical assist with bed mobility. Transfers (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position), the resident was coded as requiring one (1) person physical assist. Under section G0300 (Balance during transitions and walking), the resident was coded as not steady and required staff physical assistant for stability when moving from a seated to standing position. Under Section J1800 (Any Falls Since Admission/Entry or Reentry or Prior Assessment), the resident was coded as having one (1) fall. And under J1900 (Any Falls Since Admission/Entry or Reentry or Prior Assessment), the resident was coded as having one (1) fall without injury. Review of Resident #31's medical record revealed the following: 04/13/20 at 5:59 PM [Nursing Note] documented, "Staff heard bed alarm, upon entering resident room, resident was observed sitting on floor in front of her bed ...no injuries noted ..."	F 689		

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F 689	Continued From page 20 12/15/20 at 4:32 PM [Nursing Note] documented, "Resident ...loss her balance while trying to sit [in] wheelchair and then sat on floor ...no injury and no c/o (complaint of) pain ..." 01/28/21 at 12:30 PM [Nursing Note] documented, "At about 12:30 PM CNA (certified nursing assistant) reported that she observed resident lying on the floor in her room on her back ...Upon assessment resident pointed to her r/arm (right arm). She did show facial grymasing (sp) for pain/discomfort ...staff medicated resident with Tylenol 650 mg (milligrams) ...for pain ...order was obtained to transfer ... to ER (emergency room) to be evaluated for FX (fracture) ..." 01/28/21 at 8:27 PM [Nursing Note] documented, " ...Received a call from [hospital name] spoke with nurse ... who stated, "patient will be coming back after midnight with a sling to the right side due to clavicle displacement/fracture and antibiotic for UTI (urinary tract infection) ..." 01/29/21 at 10:30 AM [Nursing Note] documented, "Resident returned from [hospital name] ... at 0800 (8:00 AM) ... Resident is alert and verbally responsive and confused. Resident has a sling on the right upper extremity. ER (emergency room) diagnoses revealed closed displaced fracture of unspecified part right clavicle ..." Review of the nurses progress notes from 04/13/2020, to 01/28/2021, lacked documented evidence of how staff were monitoring (type and frequency) and supervising the resident to ensure her safety from potential accidents (falls).	F 689		

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F 689	Continued From page 21 Review of the care plan section of the record showed: The "fall" care plan with a start date of 01/16/20 and updated on the following dates: 2/4/20 and 7/21/20. Goal: resident will function safely within environment; injuries will be minimized. The care plan failed to include approaches or interventions of how staff was to supervise or monitor (to include type and frequency) the resident to mitigate or prevent falls (accidents) with or without injury. There was no update to the falls care plan between 7/21/20 to 1/27/21 ensuring that interventions are implemented correctly and consistently and were evaluated for the effectiveness. Subsequently Resident #31 fell and sustain a fractured right clavicle on 1/28/21. During a face-to-face interview on 06/02/2021, at 1:00 PM, Employee #12 (Registered Nurse] stated that the resident's fall [1/28/2021] was not witnessed by staff and she believed the fall was due to the resident's "new slippers". Employee #12 then stated, "She [Resident #31] refused therapy that is why she is not walking."	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 693		

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F 693	Continued From page 22 §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for one (1) of 18 sampled residents, facility staff failed to ensure a resident receiving enteral feedings received appropriate care to prevent complications. Resident #10. The findings include: Resident #10 was admitted to the facility 03/11/2020, with diagnoses that included: Anemia, Hypertension, Dysphagia (Oropharyngeal Phase), and Gastrostomy Status. A physician's order dated 03/11/2020, revealed, " Enteral Feeding: Change G [gastrostomy] Tube irrigation set QD [every day] Once a Day 09:00 AM". Review of Resident #10's care plan for the focus area, "Feeding Tube" created on 11/04/2020, revealed the approach, "change feeding syringe	F 693	It is Knollwood's policy to label irrigation syringes used with gastrostomy tubes. 1- The irrigation syringe used for resident # 10 gastrostomy tube was changed immediately on 5/25/21 and labelled with the correct date. 2- There are no other residents with a gastrostomy tube. 3- Licensed nurses will be in-serviced to check the date on the Gastrostomy syringe before using it to make sure that the syringe is the one they need to use for that day. Licensed nurses also will be in-serviced to follow physician's order on when to change the irrigation syringe. 4- An audit of residents with a gastrostomy tube will be conducted to ensure that the irrigation syringe is appropriately dated and labelled. The audits will be conducted weekly X 8 then monthly 4 then quarterly.	

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F 693	Continued From page 23 label with date and time daily". During an observation inside of Resident #10's room on 05/25/2021, at approximately 11:15 AM, it was noted that there was an unlabeled syringe irrigation set at the resident's bedside. During a face-to-face interview conducted on 05/25/2021, at approximately 11:15 AM with Employee #4 (Licensed Practical Nurse), when asked if she used the irrigation set observed at Resident #10's bedside, she stated that she did use that syringe irrigation set to feed and administer Resident #10's morning medications and feeding. At the time of the interview, Employee #4 acknowledged the findings and proceeded to change and label a new syringe irrigation set.	F 693	The result of these audits will be presented to the Quality Assurance Performance Improvement Committee for review and further recommendations as warranted.	7-28-21
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for one (1) of 18 sampled residents, facility staff failed to provide the specialized care needs for a resident receiving nebulizer treatments in accordance with the professional standards of practice. Resident #19.	F 695	It is Knollwood policy to change masks used to provide nebulizer treatments weekly. 1- The nebulizer mask for resident #19 was changed immediately on 6/2/21 during the survey.	

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F 695	Continued From page 24 The findings include: Resident #19 was admitted to the facility on 03/09/2021, with diagnoses that included: Asthma, Hyperlipidemia, Muscle Weakness, and Hypertension. A physician's order dated 03/09/2021, revealed, "Start Date Change neb [nebulizer] mask every week on Wednesdays (3-11 PM shift) ...". Review of the Treatment Administration Record for May 2021 revealed that facility staff signed off in the area that documented, "Change neb [nebulizer] mask every week on Wednesdays (3-11 PM shift)" indicating that it was done on the date 05/26/2021. During an observation of Resident #19's room on 06/02/2021, at approximately 10:30 AM, revealed a nebulizer treatment set at the resident's bedside with a pink label that was dated, "5/19/21". During a face-to-face interview conducted with Employee #5 (Charge Nurse) on 06/02/2021, at approximately 10:35 AM, she stated, "The nebulizer mask should have been changed. There's an order to it change every Wednesday."	F 695	2- An audit of residents receiving a nebulizer treatment was conducted on 7/6/21. All masks were changed within the week as appropriate. 3- Licensed nurses will be re-in-serviced to change and date masks used to administer nebulizer treatments as ordered. 4- An audit of residents receiving nebulizer treatment will be conducted weekly X 8 then monthly X 4 then quarterly to ensure that mask used to administer nebulizer treatments are changed weekly as ordered. The result of these audits will be presented to the Quality Assurance Performance Improvement Committee for review and further recommendation as warranted.	7-28-21
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		

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	095026	A. BUILDING ______ B. WING ______	06/02/2021

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F 755	Continued From page 25 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 18 sampled residents, the facility staff failed to ensure that the pharmacist progress notes mentioned whether there were irregularities and recommendations for the Monthly Medication Regimen Review (MRR). Resident's #28 and #31. The findings include: 1. Resident #28 was admitted to the facility on	F 755	It is Knollwood policy for the Pharmacy Consultant's progress note to document whether there were irregularities and recommendations for the Monthly Medication regimen review. 1-a- Resident # 28 regimen review progress note for the month of May was not rewritten to show that there were no recommendations. 1-b- Resident #31 regimen review for July 2020 could not be re-written. 2-a- b- An audit revealed that the pharmacist was not documenting a progress note in the residents' medicals record to indicate whether there were any irregularities and or whether a recommendation was given. Reports were generated for residents who had any irregularities or recommendations.	

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F 755	Continued From page 26 07/08/20, with multiple diagnoses including Dementia, Depression, Anemia, Hyperlipidemia, Hypertension, Diabetes Mellitus, Gastro Esophageal Reflux Disease, and Osteoporosis. A review of the Medication Regimen Review progress notes dated 02/08/2021, to 05/10/2021, noted by the Pharmacist stated "Medication Regimen Review completed" however, there was no mention on whether there were any irregularities found and recommendation given. During a face-to-face interview on 05/12/21, at approximately 10:30 AM, Employee #12 reviewed the previously mentioned documents and acknowledged the finding. 2. Resident #31 was admitted to the facility on 10/15/19 with multiple diagnoses including Dementia, Depression, Parkinson, Disease, Hypertension, Diabetes Mellitus, Gastroesophageal Reflux Disease, Heart Failure, Acute Bronchitis, Ulcerative Blepharitis Right Eyes and History of Repeated falls. A review of the MRR progress notes dated from 04/20/2020, to 05/10/2021, revealed the pharmacist documented, "Medication Regimen Review completed" for each month reviewed; however the document failed to include if the pharmacist found irregularities or had recommendations. During a face-to-face interview conducted on 05/27/2021, with Employee #2 (Director of nursing) at 10:00 AM, she acknowledged the findings.	F 755	3-a-b- The pharmacist changed her process as of June 2nd 2021. She is now documenting in residents' medical records that the Medication Regimen Review was completed and is now adding " No recommendations" or " Recommendations forwarded". 4-a-b- An Audit of residents' progress notes will be completed monthly X 8 to ensure that the pharmacist's progress notes include whether the Medication Regimen Review had any irregularities and or any recommendations. These audits will be presented to the Quality Assurance Performance Improvement Committee for review and further recommendations as warranted.	7-28-21

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F 755	Continued From page 27 During a face-to-face interview on 05/27/2021, at approximately 11:00 AM, Employee #12 (Registered Nurse) acknowledged the finding.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	F 756	It is Knollwood's policy to complete monthly medication reviews for all residents. 1- The pharmacist could not go back to complete the Medication Regimen Review for July 2020 for resident #31. 2- An audit conducted 7/6/21 shows that the Pharmacist conducted Medication Regimen review for all residents and documented in the Medical record.	

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F 756	Continued From page 28 drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 18 sampled residents, facility staff failed to ensure that a resident's monthly Medication Regimen Review (MRR) was conducted on a monthly basis. Resident #31. The findings include: Resident #31 was admitted to the facility on 10/15/ 2019, with multiple diagnoses that included: Dementia, Depression, Parkinson, Disease, Hypertension, Diabetes Mellitus, Gastro Esophageal Reflux Disease, Heart Failure, Acute Bronchitis, Ulcerative Blepharitis right eyes and History of Repeated falls. A review of Resident #31's medical record lacked documented evidence the pharmacist conducted a MRR for July 2020. During a face-to-face interview conducted on 06/02/2021, at approximately 11:00 AM, Employee #12 (Registered Nurse) acknowledged the finding.	F 756	3- The Pharmacist was in-serviced by the DON, on 7/6/21, to ensure that the pharmacist reviews every residents' records. 4- An audit of residents reviewed by the Pharmacist will be audited monthly X 8 to ensure that every resident had a Medication Regimen review for the month. The result of these audits will be shared with the Quality Assurance Performance Improvement Committee for review and any further recommendations as appropriate.	7-28-21
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880	It is Knollwood's policy for staff to wear a mask and a face shield when within 6 feet of a resident.	

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F 880	Continued From page 29 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880	1- The Private Duty aid put her face shield on after her conversation with the State Surveyor. 2- No other private duty aid was observed without a face shield if they were within 6 feet of residents. 3- Staff will be re-in-serviced to have a mask and a face shield at all times when within 6 feet of residents during an outbreak or when dealing with a resident on quarantine. 4- Observations will be conducted weekly X 4 then monthly X 4 then Quarterly to ensure that staff wears their mask and face shield when they are within 6 feet of residents. This practice cannot be audited as the Department of Health guidance has been changed where face shields are now only required to provide care to a COVID positive resident.	

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F 880	Continued From page 30 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, in one (1) of one (1) observation, facility staff failed to maintain infection control prevention practices in accordance with standards of practice to minimize the potential spread of infections. The findings include: Review of the facility's document entitled, "Respiratory protection program" dated 03/30/2021, revealed, " ...HCP [health care professional] will have an N95 and a face shield when in resident's area or within 6 feet of a	F 880	The results of these observations will be presented to the Quality Assurance Performance Improvement Committee for further recommendations.	7-28-21

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F 880	Continued From page 31 resident ...". During an observation on 05/25/2021, at approximately 2:00 PM, Employee #6 (Private Duty Aide) was observed in resident room #13 A, sitting in a chair beside the resident (less than six feet away), wearing a N95 face mask but not wearing a face shield. It should be noted that the resident was not wearing a face mask or a face shield. During a face-to-face interview conducted on 05/25/2021, at approximately 2:00 PM, Employee #6 stated, "I put it [face shield] back on when I am doing care." During a face-to-face interview conducted on 06/02/2021, at approximately 2:20 PM, Employee #2 (Director of Nursing) stated, "The private duty aides receive the same infection control information as the facility staff. PPE (personal protective equipment) is provided to all the private duty aides and they are aware that the requirement in the facility is to have to on an N95 mask and a face shield at all times while on the units."	F 880		