

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  025010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/15/2024
NAME OF PROVIDER OR SUPPLIER  Ketchikan Med Ctr New Horizons Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 Tongass Avenue Ketchikan, AK 99901	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>47929</p> <p>Based on record review and interview, the facility failed to provide a program of meaningful activities for 1 resident (#44), out of 13 sampled residents based on an individualized assessment and care plan. This failed practice denied the resident opportunities that contributed to quality of life and placed the resident at risk for depression, loneliness, and boredom. Findings:</p> <p>Record review on 3/11-15/24 revealed Resident #44 was admitted to the facility with diagnoses that included pressure injury of the left heel, post-surgical left hip fracture repair, anxiety disorder, schizoaffective disorder bipolar type (a chronic mental health disorder that sometimes included episodes of mania and major depression), and moderate Alzheimer's dementia.</p> <p>During an interview on 3/11/24 at 5:03 PM, Resident #44 stated the activities in the facility did not appeal to him/her. The resident stated he/she preferred to listen to music, go to the store of his/her preference, and avoid large loud crowds. He/she further stated that his/her major interest was shooting. The resident also stated no one at the facility had discussed what he/she liked to do.</p> <p>During an interview on 3/14/24 at 9:34 AM, the Activity Coordinator (AC) stated a resident centered activities program for each newly admitted resident was developed from an initial activity assessment form. This assessment was normally completed within 1-2 weeks after admission. When asked if an activities program was developed for Resident #44, the AC stated it was not. When asked if activities that were offered to residents were documented, the AC stated they were not. The AC stated she kept all resident assessments on paper in her assessment folder.</p> <p>Review of the AC's activity assessment folder revealed a resident list titled: Daily Resident Attendance List . assessments we have [handwritten at the top of the page], not dated. Resident #44 was not included on this list.</p> <p>During an interview on 3/15/24 at 10:48 AM, the Long-Term Care (LTC) Administrator stated the AC determined residents' activity preferences in order to develop an activities program, then those preferences were included in the care plan. The LTC Administrator located one activity related to service dog visits on Resident #44's care plan. The LTC Administrator further stated that Resident #44 was to have an activities program created by the end of the day. The AC presented Resident #44's Activity Initial Assessment form, dated 3/15/24 at 2:14 PM, the last day of the survey.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  025010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/15/2024
NAME OF PROVIDER OR SUPPLIER  Ketchikan Med Ctr New Horizons Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE  3100 Tongass Avenue Ketchikan, AK 99901	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the policy LTC: Activities Therapy Scope of Service, dated 3/2/24, revealed: Assessment . Complete Activity Initial Assessment upon admission .Assist with development of initial care plan. Reassess at any time when change in level of care .Assess each resident upon admission to ensure appropriate level of activities. Implement activities for each resident. Provide individual, group, and/or one on one in room activities.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  025010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/15/2024
NAME OF PROVIDER OR SUPPLIER  Ketchikan Med Ctr New Horizons Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 Tongass Avenue Ketchikan, AK 99901	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>42377</p> <p>Based on record review and interview, the facility failed to ensure 1 resident (#9), out of 13 sampled residents, received ordered restorative exercises. This failed practice placed the resident at risk of not maintaining or decreasing his/her highest level of range of motion and mobility. Findings:</p> <p>Record review on 3/11-15/24 revealed Resident #9 was admitted to the facility with diagnoses that included primary osteoarthritis (a degenerative joint and bone disease) of both knees, leg swelling bilateral, and weakness of both lower extremities.</p> <p>During an interview on 3/12/24 at 10:34 AM, Resident #9 stated he/she did not remember when the last time he/she had physical therapy.</p> <p>Review of Active Order, dated 2/9/24, revealed: Nursing Communication RA (Restorative Aide) Goal: To promote lower extremity circulation and maintain flexibility. Exercise: Ankle pumps 20, hip reduction 5R[right] 5L[left] . Priority: Routine.</p> <p>Review of Resident #9's Care plan' with start date on 3/22/21, revealed: .Problem: Impaired strength and mobility as evidenced by need for extensive assist with ADL cares.</p> <p>Goal: To maximize resident's own strength and mobility by end of the restorative program .</p> <p>Intervention . Document . [Resident #9's] participation in RA program .</p> <p>During an interview on 3/14/24 at 11:47 AM, when asked how he/she provided restorative exercises to the resident based on the order, the RA stated ankle pumps were the only exercise that popped-up in his/her documentation so he/she provided ankle pumps only.</p> <p>Review of the Restorative Aide Plan of Care, with a written note: verified [on] 1/9/23, revealed: .Exercises: 1. Ankle pumps x 20 .</p> <p>During an interview on 3/14/24 at 12:20 PM, when asked if there was a new restorative order for Resident #9 other than the order on 2/9/24, the RA stated the order on 2/9/24 was the current order but did not make it through smartphrase (a facility's electronic messaging).</p> <p>Interview and concurrent review on 3/14/24 at 3:36 PM, of RA's documentations in the electronic health record, revealed the RA provided ankle pumps only to Resident #9 since 2/9/24. When asked if another restorative aide had provided exercises to the resident, the RA stated no. This surveyor requested the RA to provide a copy of RA's documentation since 2/9/24 to 3/14/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  025010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/15/2024
NAME OF PROVIDER OR SUPPLIER  Ketchikan Med Ctr New Horizons Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE  3100 Tongass Avenue Ketchikan, AK 99901	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the RA's documentation from 2/9/24-3/7/24, revealed: Goal: Maintain strength and mobility .Plan: supervise/assist .with the following three to six times per week .ROM [range of motion] active or active assist exercises performed by resident, with cueing, supervision, or physical assist by staff .Ankle pumps 20 . Further review of the document revealed the RA provided ankle pumps only on the following dates: 2/9/24, 2/12/24, 2/14/24, 2/15/24, 2/16/24, 2/19/24, 2/20/24, 2/22/24, 2/23/24, 2/26/24, 2/27/24, 2/29/24, 3/01/24, 3/4/24, 3/5/24, 3/6/24, 3/7/24. Hip reduction 5R[right] 5L[left] was not provided and no restorative exercises provided from 3/7-14/24.</p> <p>During an interview on 3/15/24 at 9:13 AM, the Administrator stated the facility had no policy regarding restorative exercises.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  025010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/15/2024
NAME OF PROVIDER OR SUPPLIER  Ketchikan Med Ctr New Horizons Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE  3100 Tongass Avenue Ketchikan, AK 99901	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>42377</p> <p>Based on observation, interview, and record review, the facility failed to post the total number and the actual hours worked by Certified Nurse Assistants (CNAs), Licensed Practical Nurses (LPNs), and Registered Nurses (RNs) per shift. This failed practice provided inaccurate information to the residents and their representatives. Findings:</p> <p>An observation on 3/15/24 at 9:20 AM, of the Direct staffing hours posted, dated 3/15/24, on the bulletin board along the hallway, revealed information which included the facility's census and the nursing staff (CNA, LPN, RN and other staff) scheduled for the day. Further review of the posting revealed the total number and actual work hours of nursing staff per shift was not documented.</p> <p>During an interview on 3/15/24 at 9:25 AM, when asked about the staffing hours poster, the Unit Clerk (UC) stated the total staffing hours of CNAs, LPNs, RNs and other staff were posted per day. The UC stated the total work hours per day was the same as actual work hours because the facility provided coverage as needed. The UC also stated she was not aware that the actual and total hours per shift was required to be posted.</p> <p>Review of the Daily Staffing Sheet provided by the UC from 3/11-14/24, the actual and total hours per shift were not documented.</p>