

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Wrangell Medical Center Ltc		STREET ADDRESS, CITY, STATE, ZIP CODE 232 Wood Street Wrangell, AK 99929	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>.Based on record review and interview, the facility failed to update and revise a care plan for 1 resident (#5), out of 8 sampled residents. Specifically, the facility failed to revise Resident #5's care plan to reflect a new diagnosis of post-traumatic stress disorder (PTSD). This failed practice placed the resident at risk for not receiving appropriate care and services to maintain the resident's highest practicable mental, physical, and psychosocial well-being. Findings: Record review on 3/9-12/26 revealed Resident #5 was admitted to the facility with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (partial weakness on one side of the body) following a cerebral infarction (when a blood vessel in the brain becomes blocked, cutting off blood and oxygen to that area, which cause brain tissue death).Further review revealed Resident #5 had a diagnosis, first entered on 9/10/25, of: Chronic post-traumatic stress disorder (PTSD). A second diagnosis of: PTSD (post traumatic stress disorder) was later entered on 2/25/26.Review of the MDS (Minimum Data Set, a federally required nursing assessment) quarterly assessment, dated 12/8/25, revealed: . Active Diagnoses. Post-traumatic stress disorder, chronic. This active diagnosis remained on all subsequent assessments after. Review of Resident #5's quarterly, LTC Care Conference. notes from 9/24/25, 12/25/25, and 3/9/26, revealed no discussion of the resident's PTSD diagnosis. Review of Resident #5's Care Plan, last reviewed 3/5/26, did not show a problem, outcomes, or interventions addressing the resident's PTSD.During an interview on 3/11/26 at 11:45 AM, Resident #5 stated loud noises, such as when doors were slammed or when the snow removal machine was outside of his/her room, and the bucket was hit against the ground, the noise brought back memories of . mortar shells exploding. or . rockets going off back from the war .During an interview on 3/11/26 at 2:55 PM, the Director of Nursing (DON) stated she was unaware of Resident #5's specific PTSD triggers. The DON confirmed the diagnosis should have been incorporated into the care plan and pointed out that the resident was receiving services related to PTSD.Review of the facility provided policy, Care Planning, last reviewed on 7/22/25, revealed: Care plans will incorporate the resident's goals, preferences. and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change.</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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>.Based on record review, interview, and observation, the facility failed to provide pharmaceutical services, that included procedures to ensure 1 resident (Resident #3) of 8 sampled residents, consistently received ordered insulin as prescribed. Specifically, the facility did not ensure Resident #3 received the prescribed mealtime sliding scale insulin on 74 occasions between 10/3/25 and 3/11/26. This deficient practice placed the resident at risk for uncontrolled blood glucose and related complications.Findings: Resident #3 Record review on 3/9-12/26 revealed Resident #3 was admitted with diagnoses that included diabetes mellitus (a chronic metabolic disorder characterized by elevated blood glucose levels due to impaired insulin production or utilization), mild dementia, and anemia. Review of Resident #3's Care Plan, last reviewed on 3/5/26, revealed: .Medication Management. I require medication management daily for various health conditions. I will be provided with medications as ordered. Encourage [Resident #3] to take medication. I have a medical dx [diagnosis] of DMII [diabetes mellitus type 2] with other complications. Diabetes medication as ordered by doctor.During an interview on 3/12/26 at 8:30 AM, Resident #3 stated, My insulin is very important. I expect to be woken up when I'm supposed to have it. An observation on 3/11/26 at 8:20 AM revealed Licensed Nurse (LN) #1 withheld Resident #3's morning dose of insulin. LN #1 stated the facility's process was to document the medication as not administered when the resident was sleeping. LN #1 further stated there was a communication order written by the physician permitting medications to be held if the resident was asleep. LN #1 attempted to locate the referenced communication order in the electronic health record (EHR) but was unable to produce documentation supporting this statement. Review of Resident #3's physician orders revealed: .Insulin Aspart Pen [novoLOG FLEXPEN] See Dose Instructions SQ [subcutaneous] AC [after meals]. Dose Instruction. Inject per sliding scale if: 151-200 = 4 units. 201-250 = 6 units. 251-300 = 8 units. 301-350 = 10 units. 351-400 = 12 units. 401-500 = 14 units. Review of Resident #3's medication administration record (MAR) from 10/3/25-3/9/26 revealed:72 missed insulin administrations with documented rationale of Patient Asleep;2 missed insulin administrations with documented rationale of Nursing Judgement. Review of the blood glucose records, from 10/3/25 to 3/9/26, in relation to the 74 missed insulin opportunities, revealed the resident experienced elevated blood glucose levels during the period the insulin doses were not administered: 10/3/25, 5:07 PM - blood glucose 164;10/6/25, 5:05 PM - blood glucose 153;10/8/25, 9:13 AM - blood glucose 201;10/15/25, 5:23 PM - blood glucose 225;10/19/25, 11:49 AM - blood glucose 191;10/19/25, 4:35 PM - blood glucose 155;10/27/25, 11:27 AM - blood glucose 198;10/28/25, 11:30 AM - blood glucose 201;10/31/25, 11:26 AM - blood glucose 240;11/14/25, 9:13 AM - blood glucose 183;11/14/25, 11:27 AM - blood glucose 179;11/15/25, 8:01 AM - blood glucose 195;11/15/25, 5:10 PM - blood glucose 231;11/16/25, 11:28 AM - blood glucose 189;11/22/25, 11:18 AM - blood glucose 168;11/23/25, 11:27 AM - blood glucose 205;11/23/25, 5:14 PM - blood glucose 212;12/3/25, 5:15 PM - blood glucose 215;12/4/25, 5:07 PM - blood glucose 237;12/5/25, 5:05 PM - blood glucose 192;12/10/25, 12:57 PM - blood glucose 231;12/13/25, 10:55 AM - blood glucose 177;12/14/25, 9:00 AM - blood glucose 177;12/16/25, 4:42 PM - blood glucose 181;12/17/25, 11:26 AM - blood glucose 176;12/19/25, 7:29 AM - blood glucose 165;12/19/25, 11:19 AM - blood glucose 196;12/19/25, 5:21 PM - blood glucose 220;12/20/25, 11:07 AM - blood glucose 169;12/20/25, 4:56 PM - blood glucose 179;12/21/25, 10:59 AM - blood glucose 162;12/21/25, 5:24 PM - blood glucose 169;12/27/25, 5:01 PM - blood glucose 166;12/28/25, 11:23 AM - blood glucose 166;12/28/25, 4:51 PM - blood glucose 160;12/29/25, 5:04 PM - blood glucose 169;12/30/25, 11:02 AM - blood glucose 175;12/30/25, 4:27 PM - blood glucose 188;1/2/26, 7:12 AM - blood glucose 162;1/2/26, 11:21 AM - blood glucose 154;1/3/26, 7:09 AM - blood glucose 161;1/6/26, 11:23 AM - blood glucose 167;1/6/26, 5:04 PM - blood glucose 201;1/7/26, 5:13 PM - blood glucose 218;1/9/26, 11:14 AM - blood glucose 202;1/9/26, 4:57 PM - blood glucose 192;1/10/26, 7:16 AM - blood glucose (continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>181;1/10/26, 11:10 AM - blood glucose 176;1/10/26, 5:41 PM - blood glucose 250;1/11/26, 8:04 AM - blood glucose 238;1/11/26, 5:12 PM - blood glucose 153;1/12/26, 1:58 PM - blood glucose 281;1/15/26, 5:17 PM - blood glucose 215;1/16/26, 5:30 PM - blood glucose 240;1/18/26, 12:59 PM - blood glucose unknown;1/19/26, 4:58 PM - blood glucose 224;1/23/26, 7:27 AM - blood glucose 173;1/31/26, 12:16 PM - blood glucose 190;2/1/26, 11:20 AM - blood glucose 200;2/1/26, 5:02 PM - blood glucose 186;2/10/26, 12:06 PM - blood glucose 209;2/13/26, 4:53 PM - blood glucose 285;2/14/26, 4:40 PM - blood glucose 227;2/15/26, 11:50 AM - blood glucose 219;2/16/26, 1:49 PM - blood glucose 236;2/17/26, 12:57 PM - blood glucose 245;2/28/26, 11:21 AM - blood glucose 253;2/28/26, 5:15 PM - blood glucose 257;3/6/26, 11:08 AM - blood glucose 295;3/7/26, 7:22 AM - blood glucose 184;3/7/26, 12:09 PM - blood glucose 223;3/8/26, 5:36 PM - blood glucose 238;3/9/26, 7:59 AM - blood glucose 293, and;3/9/26, 10:57 AM - blood glucose 165. Review of the facility policy titled, Medication Administration, last revised 6/15/25, revealed: .Time-Critical Medication: Medications in which an early or late administration of greater than 30 minutes might cause harm or have significant, negative impact on the intended therapeutic or pharmacological effect. The individual administering the medication will verify the medication selected for administration is correct based on the medication order. The individual administering a medication will be aware of the following information concerning each medication before administration. Route and Frequency of administration. Appropriate timing of medication administration. Medications that require exact or precise timing of administration shall be administered at the scheduled time. Examples of Time-Critical medications include. insulin associated with food/mealtime doses. Review of the facility's nursing standard, Safe medication administration practices, long-term care, last revised 5/18/25, revealed: To promote a culture of safety and prevent medication errors, nurses must adhere to the five rights of medication administration. select the right medication, administer the right dose, administer the medication at the right time, and administer the medication by the right route. If any health care team member has questions about a medication, whether it's a new drug or part of the resident's existing regimen, contact the pharmacist on duty before administering it. Establish a standard schedule for maintenance medication doses that require administration every 4 hours or three times per day. Be sure to administer medications identified as time-critical within 30 minutes of the intended administration time. Documentation associated with safe medication administration practices includes. if a medication was not administered. the reason for not administering the medication. name of the practitioner (if notified). interventions performed. response to those interventions.</p>		