

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Denali Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 19th Avenue Fairbanks, AK 99701	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>40259</p> <p>Based on record review and interview, the facility failed to adhere to facility's standards of care expectations, in the form of regular resident location and safety checks (called walking rounds), for 1 resident (#14), out of 4 residents reviewed. This failed practice resulted in the staff not being aware of the resident's elopement from the facility for an extended period, causing a delay in action to locate, which placed the resident at an increased risk for injury and accidents.</p> <p>Findings:</p> <p>Record review on 6/28/24 revealed Resident #14 was admitted to the facility with diagnoses that included dementia, cardiovascular accident with hemiplegia (weakness or paralysis of one side of the body) effecting the right side, and seizures.</p> <p>Resident #14 had a chronic history of alcohol use and had a history of repeated attempts to leave the facility seeking alcohol. Due to these repeated attempts, Resident #14 was placed with a wander guard device (a safety assistance device placed on a resident at risk for wandering and possible elopement. This device would trigger an alarm at any exit equipped with a wander guard sensor, alerting staff to a possible elopement attempt).</p> <p>Review of the facility's Denali Center Notes and Concerns report, dated 5/27/24, revealed that Resident #14 was discovered to be missing from the facility on 5/26/24 at 11:00 PM. At this point, the facility initiated its protocol to alert leadership, facility security, family, and the police to aid in finding the resident. It was determined, through security camera review, that Resident #14 left the long term care (LTC) section of the building and entered the acute hospital side at 5:17 PM, 6 hours and 13 minutes prior to staff realizing the resident was no longer in the facility. Resident #14 eloped that building sometime later, an exact time could not be determined. Resident #14 was later located in the community by police and returned to the facility at 3:00 AM. Resident #14 had consumed alcohol while in the community.</p> <p>Review of the facility's staffing on Resident #14's unit, on 5/26/24, revealed they were fully staffed. One licensed nurse (LN), a traveler staff, and two certified nursing assistants (CNAs) worked the dayshift (7:00 AM to 3:30 PM), and even though evening shift was a split shift (two LNs and four CNAs shared the shift, the dayshift LN and two CNAs worked first half and another set of one LN and two CNAs would work the second half), there was enough staff to cover the 8-hour evening shift (3:00 PM to 11:30 PM).</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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's investigation final report, dated 5/31/24, concerning Resident #14's elopement on 5/26/24, revealed the nursing staff that worked that day didn't perform their duties in accordance with the facility's established standards of care for resident safety:</p> <p>1. Walking Rounds</p> <p>Review of the facility's policy Standard Operating Procedure: CNA Expectations and Standards of Care, last reviewed 5/6/24, revealed: . Listen to verbal/taped report with neighborhood [units of the facility] nurse [at the beginning of the shift] . After having received clinical report, neighborhood nurse will update CNA on any pertinent information . Read the Reds [high alert items needing attention during the shift] on CNA worksheet . Walking rounds completed . walking rounds report information will include the following . Residents on LOA [leave of absence], at the [hospital] and other updates . safety interventions: functioning alarms [wander guard devices] . Rounds are made every two hours unless care planned for more frequent checks .</p> <p>Review of the facilities investigation revealed that clinical report at shift change, between day shift and evening shift at 3:00 PM, was not completed due to a fall with another resident. Also, the walking round at this shift change was also not completed. The investigation also revealed that the two-hour walking rounds, to be completed throughout the evening shift, hadn't been completed as expected for Resident #14. Interviews with the staff working that shift revealed they assumed Resident #14 was somewhere else in the facility, as he/she tended to roam often.</p> <p>2. Wander Guard Monitoring</p> <p>Review of the facility's policy Secure Care Bracelet, Residents Appropriate For, approved 2/6/24, revealed: . Residents with secure care guards [wander guards] will have a safety check every day, to assure it is operating properly. The safety check will include that the bracelet is placed properly on the resident and checking bracelet with Secure Care Tester, which is located at the nurse's station. This will be documented in CareTracker [electronic medical record CNA documentation].</p> <p>Review of the facilities investigation revealed that this safety check for function and placement was not documented as completed the day prior to the elopement (5/25/24), or the day of the elopement.</p> <p>When Resident #14 was returned to the facility, the Resident's wander guard was in place however did not trigger the sensor at the door when he/she reentered the building. It was discovered that that the wander guard battery was dead and did not trigger the sensor when the resident originally eloped.</p> <p>During the facility's investigation, they completed a root cause analysis. All nursing staff that worked on 5/26/24 knew of the expectation of rounding at shift change and every two hours, however, did not follow this expectation.</p> <p>The facility took corrective measures with the staff involved, and also completed a facility-wide reeducation on policies of wander guards, safety round, and CNA expectations.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/28/24 at 1:05 PM, the Administrator stated that during the root cause analysis, there was also an identified gap in training traveler staff on the safety standards of practice regarding rounding and the facility developed specific competencies to bridge this gap and ensure all travelers completed this training as part of their orientation.</p> <p>The facility also initiated an elopement risk assessment for all residents and performed 10 audits a week, 6/14-27/24, to verify wander guards were correctly placed and functioning.</p>		