STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025020	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denali Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50031 50078 Based on interview and record review, the facility failed to provide resident care with respect and dignity for two residents (#'s 27 and 50), out of 20 sampled residents. This failure placed the residents at risk of negatively affect the resident's quality of life. Findings: Resident #50 Resident #50 was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease) and cerebrovascular accident (stroke). During an interview on 1/6/25 at 2:06 PM, Resident #50 stated he/she requested an evening snack a couple weeks ago. Resident #50 further stated, a CNA [Certified Nurse Assistant - unknown] told me to get up and get my own damn self to get ice cream and cookies. Resident #50 stated the CNA refused to get the snack for him/her. Resident #50 stated his/her nurse noticed him/her trying to get his/her own evening snack and asked what he/she was doing. Resident #50 told the nurse what the CNA said. Afterwards, the nurse brought him/her the requested ice cream and cookies. Resident #50 further stated he/she felt the comments made by the CNA made him/her feel discriminated against. During an interview on 1/8/25 at 5:16 PM, when asked about Resident #50's allegations that occurred a few weeks ago, Resident Care Coordinator (RCC) #2 stated he/she was aware and familiar with the event. RCC #2 stated there was no investigation completed regarding the known alleged mistreatment. RCC #2 stated this was a missed opportunity. Review of Resident #50's Denali Center H & P [History and Physical], dated 1/11/24, revealed: . resident no longer able to care for [him/herself] . does independently get up from bed and ambulate [a] short distance to bathroom, but no more activity than that. evaluated at bedside, has O2 [oxygen] on by NC [nasal cannula] mild exertion ie [i.e.] moving from supine to sitting at bedside does become tachypneic still able to say a few words at a time. Assessment/Plan . severe protein - calorie malnutrition . related to [his/her] end stage [COPD]. prognosis poor . (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #50's Denali Center Progress Note, dated 12/19/24, revealed: . [he/she] had gotten up to the shower without oxygen supplementation and became very dizzy, started to have fairly severe dry heaving. Once [he/she] got back to bed and laid down, [he/she] had some sharp left upper chest pain . Assessment and Plan: . continue with oxygen at 3 L [liters] per nasal cannula at rest. Okay to increase for short term only . Review of Resident #50's LTC Care Plan Summary, dated 1/10/25, revealed: Evaluate Effectiveness of O2 and Respiratory Therapy, Evaluate Need to Pace Activities and Plan Rest Periods. Staff to Use Gait Belt With all Transfers and Ambulation. Promote gradual weight gain r/t [related to] severe PCM [protein calorie malnutrition], hx [history] of significant wt. [weight] loss. Encourage Snacks Between Meals and With Activities. Offer Meal Substitutes. Review of the facility's policy, Abuse and Neglect, dated 3/5/24, revealed: . III. Policy: 2. Each resident must be provided individualized care with dignity and respect. During the delivery of personal care and services . 7. The managerial staff provides feedback regarding the concerns that have been expressed . Resident #27 Resident #27 was admitted to the facility with diagnoses that included paraplegia (paralysis of the legs), neurogenic bladder (bladder control loss due to nerve issues), anemia (low blood oxygen), anxiety disorder and depression (mood disorder). During an interview and concurrent observation on 1/6/25 at 2:06 PM, Resident #27 stated he/she had pressed the call light right before this surveyor came into his/her room, with the intent of asking staff for bathroom assistance. The resident stated he/she had a bowel movement and had been sitting in it. Resident #27 continued to explain he/she had asked RCC #3 to call his/her CNA right after RCC #3 finished changing the resident's catheter. The resident further stated RCC #3 had left the room around 1:50 PM. This was verified by this surveyor, who had encountered RCC #3 in the hallway 10 minutes prior. Resident #27 commented that his/her assigned CNA often ran behind. The resident stated he/she did not believe there was enough staffing available on the unit. Resident #27 stated he/she wondered if staff looked at the call lights and decided to ignore them. Resident #27 further stated: It depends on who's working . I've complained verbally but they always say to us [residents] we are short staffed. Continuing the observation at 2:16 PM, LN #5 went into Resident #27's room to administer the resident's medication and acknowledged the resident's need for bathroom assistance. The LN told the resident that he/she was going to call the assigned CNA, after administering the medication. In the minutes that followed, no assistance arrived, and Resident #27 pressed the call light again. At 2:27 PM, CNA #3 stopped by the room and asked how he/she could help the resident. Resident #27, once again, explained he/she needed bathroom assistance. CNA #3 stated he/she would call for someone. After no response, Resident #27 pressed his/her call light again. At 2:56 PM, CNA #4 entered the room and asked how they could help. Resident #27 explained what had happen and requested bathroom assistance. CNA #4, stated: Let me just get my papers for the shift [referring to report] and I will come back to change you if no one else does it in the meantime. CNA #4 returned to the room at 3:17 PM and proceeded to change Resident #27. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the continued observation from 2:06 PM to 3:17 PM, Resident #27 had been sitting in his/her bed and had been requesting for a change [toileting assistance] because he/she had had a bowel movement (BM) earlier. Further observation revealed a fecal odor in the room. Resident #27 waited for toileting assistance for one hour and 11 minutes. Review of the Call Light Log, dated 1/8/25 pertaining to Resident #27's room revealed the following calls logged around the bathroom assistance request timeframe: - 1/6/25 1:45:50 PM - 1/6/25 1:45:55 PM - 1/6/25 1:45:56 PM - 1/6/25 1:55:01 PM - 1/6/25 2:07:23 PM - 1/6/25 2:36:26 PM - 1/6/25 2:51:23 PM - 1/6/25 2:55:08 PM - 1/6/25 3:13:55 PM - 1/6/25 3:16:49 PM Review of the Tamarak Unit's Assignment Sheet, dated 1/6/25 revealed the Tamarak Unit was staffed with 1 RCC, 2 nurses and 3 CNA's at the time of the call light request for bathroom assistance. During an interview on 1/8/25 at 10:38 AM, RCC #3 stated the CNA's were responsible for providing overall full care such as emptying foleys, turning residents, providing bed pans, ambulating residents to the bathroom, operating lifts and providing assistance with toileting. RCC #3 also stated that in Resident #27's case he/she would have changed him/her (Resident #27) [himself/herself], if he/she had known earlier while he/she was in the room. The RCC stated Resident #27 just asked me to call his/her CNA and was not specific about the need to be changed. The RCC further stated: Otherwise, I would have done it myself right away. The RCC continued: Still, there is no excuse for what happened . they [the CNA's] should have come and changed resident immediately. During an interview with LN #5 on 1/8/25 at 3:17 PM, he/she stated: Anybody can answer a call light, but I don't recall all of Mondays [1/6/25] and how all went down [referring to the call for assistance toileting of Resident #27]. LN #5 confirmed he/she remembered being in the room to administer medications. During an interview on 1/8/25 at 3:17 PM, CNA #1 stated: I was busy in the middle and did not see a call light . I was probably helping a different resident . no one told me that Resident #27 needed to be changed. During an interview with CNA #4 on 1/8/25 at 8:00 PM, stated he/she recalled answering the call light repeating what Resident #27 had said to him/her: [Resident #27] needed help to get changed, so I went to grab my papers [report] and then came back to help. CNA #4 further stated: [Resident #27] was happy that I came back and told me that previous staff had left the resident for a few hours without assistance . he/she [resident] was a little irritated and uncomfortable. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #27's care plan, undated, revealed: .resident dependent for toileting .provide AM-HS [morning - bedtime] cares set up to assist with washing .peri-area .remind and cue resident to call for assistance . evaluate bowel regularity, BM color, bleeding .evaluate possible causes for change in BM consistency .evaluate skin and provide skin care to manage skin integrity .offer toileting to encourage regular elimination .evaluate for abdominal distension, tenderness, bowel motility. Review of the facility's Resident Rights, dated 3/5/24, revealed: .Denali Center will make every effort to assist each resident in exercising his/her rights and to ensure residents are always treated with respect, kindness, and dignity Residents have the right to expect the Denali Center staff to provide: 1. Considerate and respectful treatment.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 42377 50078 51613 Based on observation, interviews and record review, the facility failed to ensure three residents (#s 19, 22, 25) out of 20 sampled residents were given the opportunity to make choices about aspects of their lives that were significant to them. Specifically, the facility failed to ensure residents' rights to choose and participate in activities consistent with his/her interest. This failed practice had the potential to affect residents' quality of life. Findings: Activities participation: An observation on 1/6/25 at 1:14 PM revealed a white board by the Activity Room, stated, January 6th, 2025. Happy New Year! No group activities today, sorry for inconvenience . Resident #19 Record review on 1/6-10/25, revealed Resident #19 was admitted to the facility with diagnoses that included morbid obesity (a complex chronic disease that is characterized by a Body Mass Index [BMI] of 40 or higher), major depressive disorder (a mood disorder that causes persistent feelings of sadness and loss of interest), anxiety, and hemiplegia (neurological condition that involves paralysis of one side of the body). During an interview on 1/6/25 at 11:46 AM, Resident #19 stated he/she did not like how they are on lockdown and stated that, he/she enjoys bingo and socializing with others. Furthermore, he/she added that bingo hasn't happened since this lockdown. Review of the resident's care plan, undated, revealed: . Participate in Activity of Choice Daily . Encourage Active participation for Social Interaction Needs . Activities will Post Calendar in room . Remind Resident of Upcoming Activities of Interest . Resident #22 Resident #22 was diagnosed with anxiety, aphasia (impairment in a person's ability to comprehend or formulate language because of damage to specific brain regions), hemiplegia, and major depressive disorder. During an interview on 1/6/25 at 2:19 PM, the Resident stated that he/she was not able to go to activities due to being on lockdown. Furthermore, he/she added that there were no alternative activities offered for church. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, undated, revealed: .Encourage Active Participation for Social Interaction Needs . Encourage Active Participation for Religious Spiritual Needs . Invite and Assist to Group Activities of Interest . Resident #25 Resident #25 was diagnosed with morbid obesity, chronic obstructive pulmonary disease (lung obstruction), hypertensive heart disease with heart failure (high-pressure heart), type 2 diabetes mellitus (insulin resistance), and major depressive disorder. During an interview on 1/7/25 at 11:24 AM, Resident #25 stated: Upper management are the ones making the rules. We are not allowed to go to church. We were told we couldn't go, not even with a mask. Visitors can come in and have a mask. We are not allowed to visit out there [referring to the common areas] anymore. This affects activities too, because if everyone wanted to play Bingo there is not enough room in the sunroom to have things as they should. During a meeting with the Resident Council on 1/8/25 at 2:05 PM, Resident #25 further stated they closed down our store, church and we can't walk around freely. During the same meeting, all residents in attendance confirmed that the option of Church [religious services] happening via Zoom (an online video conferencing tool) was not presented to them. During an interview with the Medical Director on 1/10/25 at 11:00 AM, he stated suspending activities just happens by default . the point is to not have people near each other. During an interview with Activities Assistant #1 on 1/9/25 at 12:00 PM, he/she stated that church was cancelled on two different days due to the lockdown. He/she further stated the facility had not considered Church activity via Zoom as an option. Review of the resident's care plan, undated, revealed: .involve in activities of choice and interest . adapt care and environment to optimize independence .engage in daily independent activities.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50078 Based on interview, observation and record review, the facility failed to ensure residents were provided with clear instructions on how to file a grievance while units were quarantined and segregated due to an Influenza outbreak, along with easy access to the grievance box during this time. This failed practice denied all residents and/or their representatives based on a census of 71, the right to submit grievances without fear of discrimination or reprisal. Findings: During a meeting with the Resident Council on 1/8/25 at 2:05 PM, when asked if they knew how to file a grievance, Resident #48 stated: there is one by the Administrator's office, the problem is that we are on full lockdown that started 10 days ago, and we are stuck in our wings [Units] so we cannot go get it, we cannot file a grievance. Resident #27, Resident #25 and Resident #51 also expressed confusion regarding the process of who handled the grievances and how to access the grievance forms and the grievance box. When asked if residents can file a grievance without fear of retaliation, Resident #25, and Resident #27, both stated they fear retaliation if they complained about their care. During observations from 1/6-10/25, all units were quarantined and segregated due to an Influenza outbreak, with doors to all the units closed. The units did not have any indications on how to file a grievance. Further observation revealed the grievance drop box was located next to the entry door of the Administrator's office. The Administrator's office was located by the front entrance of the facility, away from where the units were located. Review of the document Denali Center Grievance Procedure, date unknown, revealed the Denali Center Grievance Official was the Administrator. During an interview with Resident Care Coordinator #1 (RCC) on 1/10/25 at 8:17 AM, when asked how residents were able to file grievances, the RCC stated: Most of the time they [the residents] come find me or tell a nurse and I do an investigation and then take it to the Director of Nursing [DON], depending on what it is and its severity. The RCC further stated they did not have a grievance box on the units and that the grievance box was located away from all the resident rooms, outside the administrator's office. During an interview on 1/10/25 at 8:20 AM, regarding how to file a grievance, RCC #3 stated: there is a board near the cafeteria with a form they can fill out and there is a box by the administrator's office, but normally what happens is that they [the residents] come to me and either myself or the social worker fills out a formal grievance. They can also call Ombudsman and fill out an anonymous grievance that way. During random observations from 1/6-10/25, both the Denali Center Grievance Procedure and Denali Concern Form were located on the bulletin board near the common Dining Room (room [ROOM NUMBER]) in the Mall area of the facility, outside the care units. No other instructions were available on the bulletin board to indicate where the physical location of the grievance box or where to deposit the Denali Concern Form. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/8/25 at 4:35 PM, the Administrator confirmed that the box used for grievances was a wooden box located outside of her office, which was by the Long-Term Care entrance of the building, away from the care units. The Administrator further stated she did not want to take the risk of spreading Influenza A to the vulnerable residents, which was the reason why the facility was on lockdown. She stated the measures implemented were like COVID-19 measures, where resident interactions were kept minimal. She further stated the residents were able to access the grievance box despite this lockdown measure. When informed of the Resident Council concerns, she stated: What am I supposed to do, move a box to the units for 5- or 6-days' worth of a lockdown? She further added that residents can go through their social worker to submit the form or that residents can still come out to submit their grievances. When asked about the confidentiality aspect of the grievance process due to the location of the box, the Administrator said that confidentiality was maintained despite of the box being in front of her office. She further added that there would not be a difference whether the box was on the units or in front of her office. She further stated they can still be seen dropping a form. She further stated, she was concerned the forms would be missed if there were multiple boxes in different areas of the facility and she may not have time to check multiple places daily. Review of the document Denali Center Grievance Procedure, date unknown, revealed: . to assist you [Residents] when a problem does arise, we have prepared the following guide. In following the steps indicated, we will be able to provide a timely response to your concerns. It is our preference to resolve issues with our internal process, but we have included steps to contact outside agencies should you feel it appropriate . Step 1. We encourage you to speak up about the things that concern you. Step 2. If you have a concern or complaints, ask to see the charge nurse or social worker. Step 3. You may voice your concerns to any staff member you wish. They will help you by first remedying the problem if they can and notifying the charge nurse or social worker for follow up. Step 4. You have the right to file grievances anonymously. Step 5. You should expect a visit from the Charge Nurse/RCC [Resident Care Coordinator] or social worker within 1 hour of voicing your concerns. Step 6. We will discuss your concerns and begin a process to investigate and correct or make changes to resolve any problems identified. Your concern will be reported to our administrator and any departments involved. Step 7. Within seven (7) working days you can expect to receive a follow up about the concerns you have raised. Step 8. Within fourteen (14) working days you will receive a written or a verbal response from our administrator/nurse/manager/case manager with the findings of our investigation about your complaint. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review of this document, there were no clear instructions on how to file a grievance and where to deposit the grievance form. Review of the document Denali Concern Form, revised on 5/2019, revealed the following: Reporter's name (may be anonymous); Date; Contact Information (address/telephone); Location [options to select the location] (Aspen, Birch, Tamarack, Willow, Spruce, Court Mall, Lobby or Other; Department (Nursing, Environmental .); Summary of Statement; List of Any Witnesses; Date Received by Grievance Officer; Name of the person completing the form if different; Steps to investigate; Summary of Findings; Formal grievance confirmed [checkboxes for Yes/ No]. Review of the Denali Center Concern Form and the Denali Center Grievances Procedure documents did not provide details on how to turn in a grievance form, or where the location of the grievance box was. Review of the policy and procedure titled Denali Center: Grievance Process dated 3/5/24, revealed: A. All residents have the right to voice grievances without decriminalization or reprisal or fear of discrimination or reprisal .E. Residents are notified through postings of the right to file grievances orally or in writing: the right to file grievances anonymously; the contact of information of the grievance official with who a grievance can be filed and a reasonable time frame for completing the review of the grievance: the right to obtain a written decision regarding his or her grievance, and the contact information of independence [independent] entities with whom grievances may be filed.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 50031 Based on record review, interview and observation, the facility failed to monitor, evaluate, and determine the use of assistive devices as physical restraints for two residents (#31and #61) out of 20 sampled residents. This failed practice placed residents at an increased risk for unnecessary physical restraints, inadequate monitoring of devices, and physical injury. Findings: Resident #31 Record review on 1/6-10/25, revealed Resident #31 was admitted to the facility with diagnoses that included dementia (a condition that affects memory and thinking) and Parkinson's disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination). During an observation and simultaneous interview on 1/7/25 at 11:56 AM, Resident #31 was wearing a belt around his/her waist that was attached to the wheelchair. In the center of the belt was a plastic piece that resembled a belt buckle. When resident was asked if he/she could remove the belt, he/she said no. Resident #31 further stated maintenance personnel or clinical staff were the only ones that could remove the belt. When asked what the belt was for, Resident #31 stated it keeps me from falling out. During an interview on 1/9/25 at 4:39 PM, Resident Care Coordinator (RCC) #2 stated Resident #31 started wearing the seat belt on 6/19/24 after a fall. When asked if Resident #31 was able to remove the belt, RCC #2 stated he/she was not aware. RCC #2 was unable to locate in the EHR (electronic health record) if Resident #31 was able to remove his/her seat belt. RCC #2 stated Resident #31 transfers with one person assist. RCC #2 further stated Resident #31 transfers with the use of a sit to stand device. RCC #2 explained residents must have strength to use a sit to stand device being able to hang on and bear weight with their legs. During an interview on 1/9/25 at 5:01 PM, when the Director of Nursing (DON) was asked if Resident #31 could remove his/her wheelchair seat belt, she stated I think so, he/she can paint. When further asked if there was an evaluation completed to verify that the resident was assessed, she stated I sure hope so, it would be if I was on the floor. Review of the facility's, Quarterly Assessment, dated 12/2/24, revealed: . Other: tremors . Mobility Braden: Very limited . Can resident appropriately call for assistance?: Yes . Morse Mental Status . Orientated to own ability .Does the resident have a hx [history] of falls?: Yes . Is resident able to communicate needs?: Yes . Free of restraints . (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS (Minimum Data Set, a federally required nursing assessment) OBRA Quarterly Review Assessment, dated 12/4/24, revealed: P0100. Physical Restraints, Physical restraints are any manual method or physical or mechanical device, mater or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body . Used in Chair or Out of Bed. G. Chair prevents rising. 0 = Not used. H. Other. 0 = Not used. P0200. Alarms. An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected . F. Other alarm. 0 = Not used. Review of the Care Plan Summary, dated 1/9/25, revealed: . Interventions . Ensure Resident Can Remove Velcro Seatbelt Independently. Resident #61 Record review on 1/6-10/25, revealed Resident #61 was admitted to the facility with diagnoses that included failure to thrive (weight loss of more than 5%, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction, and low cholesterol) and Schizophrenia (a severe mental disorder characterized by delusions [false beliefs], hallucinations [perception of sights, sounds, etc. that are not actually present], incoherence and physical agitation). During an observation and simultaneous interview on 1/6/25 at 2:48 PM, Resident #61 was sitting in a manual wheelchair in his/her room. Resident #61 had a belt around his/her waist that was attached to the wheelchair. In the center of the belt was a plastic piece that resembled a belt buckle, which would alarm when it was released. When the Resident was asked if he/she could remove the belt, he/she stated no and was shaking his/her head back in forth. Resident #61 was observed with upper extremity tremors when trying to grab the belt to demonstrate the inability to remove it. Certified Nursing Assistant (CNA) #2 walked into Resident #61's room during the conversation and stated, the strap is to prevent a fall, if the Resident tries to stand up, it alarms. CNA #2 stated to Resident #61, I am going to set off the alarm and then pulled the hook and loop belt apart, which set off the alarm. When asked if Resident #61 was able to remove the seat belt, CNA #2 stated he/she did not know. During an interview on 1/9/25 at 4:30 PM, RCC #2 stated Resident #61's seat belt alarm was initiated on 10/28/24 after a fall. RCC #2 stated residents must be able to open the belt independently or it was a restraint. RCC #2 stated there were no documented seat belt evaluations for Resident #61. RCC #2 further stated he/she was not aware who verified that the resident was able to physically remove the belt. During an interview on 1/9/25 at 4:54 PM, the Administrator stated residents must be able to remove seat belts prior to the initiation of the device. She further stated if the resident was unable to remove the seat belt, a seat alarm [chair pad alarm] should be used. Review of the Post Fall Evaluation Long Term Care, dated 1/6/25, revealed: . Mechanism of Fall: . resident found by staff in [his/her] room .and [his/her] w/c [wheelchair] which was tipped over. Orientation Assessment: Disoriented x 4. (continued on next page)

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	025020	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denali Center	1510 19th Avenue Fairbanks, AK 99701

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MDS OBRA Quarterly Review Assessment, dated 10/23/24, revealed: . Section P - Restraints . P0200. Alarms. An alarm is a physical or electronic device that monitors resident movement and alerts the staff when movement is detected. D. Motion sensor alarm. 1 = used less than daily. No other documentation for alarms reviewed. Review of the facility's Quarterly Assessment LTC, dated 10/23/24, revealed: . Ambulates with 1 person assist, . Free of restraints, Other: ez stand [sit to stand lift] . Review of the facility's policy, Restraints/Resident Behavior and Practices, effective date 10/15/24, revealed: Purpose/Expected Outcome: A. This facility believes that each resident has the right to be free from any physical restraints imposed. for purposes of discipline or convenience. If physical restraints . are utilized, they must treat the resident's medical symptoms. Definitions: A. Physical Restraints: any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety belts, and geri-chairs can be physical restraints. 2. A seat belt is a restraint when: a. When the resident can move self from sitting position to standing and is unable to remove the seat belt.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 50078 Based on record review and interview the facility failed to implement written polices and procedures that prohibited and prevented mistreatment of residents, investigation, and reporting for 1 resident (#50) out of 20 sampled residents. Specifically, the facility failed to report an allegation of mistreatment to the Administrator within 24 hours if the events that cause the allegation do not involve abuse. This failed practice placed Resident#50 at risk of further exposure to mistreatment and/or mental anguish. Findings: Record review on 1/6-10/24, revealed Resident #50 was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease) and cerebrovascular accident (stroke). Resident #50 BIMS (Brief Interview for Mental Status) test score was 14 (which indicated intact cognitive status). During an interview on 1/6/25 at 2:06 PM, Resident #50 stated he/she requested an evening snack a couple weeks ago. Resident #50 further stated, a CNA [Certified Nurse Assistant] told me to get up my own damn self to get ice cream and cookies. Resident #50 stated the CNA refused to get the snack for him/her. Resident #50 stated his/her nurse [unknown] had seen him/her trying to get his/her own evening snack and asked what he/she was doing. Resident #50 told the nurse what the CNA stated to him/her and the nurse got him/her the requested ice cream and cookies. Resident #50 further stated he/she felt the comments made by the CNA made him/her feel discriminated against. Record review of the facility's policy, Denali Center Abuse and Neglect, effective date 3/5/24 revealed A. The Law: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals . Further review of the same policy, dated 3/5/24, revealed the reference to (S483.13) Reference F 223, 224, 225, 22. Review of the State Operation's Manual, Appendix PP, Revision 211, dated 2/3/23 revealed (S483.13) Reference F 223, 224, 225, 22. was no longer a valid section of the Social Security Act. During an interview on 1/8/25 at 5:16 PM, when asked about Resident #50's allegations that occurred a few weeks ago, LN #1[Resident Care Coordinator (RCC)] stated he/she was aware and familiar with the event. LN #1 stated there was no investigation completed regarding the known alleged mistreatment. LN #1 stated this was a missed opportunity. Record review of the facility's policy, Denali Center Abuse and Neglect, effective date 3/5/24, revealed . Mandatory Reporting requirements 1. Any physician, nurse, or other employee who has reasonable cause to believe that a resident has been abused, exploited, mistreated, or neglected must report it immediately to the Administrator or Director of Nurses for investigation. 2. Any physician, nurse, or other employee who has reasonable cause to believe that a resident has been abused, exploited, mistreated, or neglected must report to the local law enforcement for investigation within 24 hours of becoming aware. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/25 at 6:00 PM, the Administrator stated she was not aware of the allegations of mistreatment reported by Resident #50 and the allegation was not investigated or reported. Record review of the facility's policy, Denali Center Abuse and Neglect, effective date 3/5/24 revealed Investigation of abuse and neglect: Denali Center identifies and investigates every allegation of abuse. The Associate Administrator/Assigned Individual for Denali Center is responsible for ensuring that all instances or allegations of suspected abuse are investigated in an organized, efficient, and timely manner. The key steps in the investigatory process include the following. 1. Identifying who is responsible for the initial reporting, investigation of alleged violations, and reporting results to the proper authorities 2. Ensuring the residents are protected from harm during an investigation 3. The reporting of all instances and allegations of abuse to appropriate State agencies as required. During an interview on 1/10/25 at 11:00 AM, when asked about Resident #50's allegations of mistreatment, the Medical Director stated he was not aware of the allegations prior to the survey. Further stated he should have been aware, and this should have been investigated and reported to the State agency. Record of the facility's policy, Denali Center Abuse and Neglect, effective date 3/5/24 revealed: Abuse- The willful infliction of . intimidation, or punishment with resulting physical harm, pain or mental anguish. This includes the deprivation of goods or services . It includes verbal abuse. Willful, as used in definition of abuse, means the individual must have acted deliberately . Neglect is the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Verbal abuse is the use of oral, written, or gestured language that willfully includes the use of disparaging and derogatory terms to residents . Mental abuse includes humiliation, harassment, threats of punishment, or deprivation . Mistreatment means inappropriate treatment or exploitation of a resident. M. Alleged violation is a situation or occurrence that is observed or reported by staff, resident . but has not yet been investigated . Each resident has the right to be free from abuse . Residents must not be subjected to abuse by anyone including, but not limited to, facility staff . Each resident must be provided individualized care with dignity and respect . Denali Center is committed to an abuse free environment, and as such: 1. Recognizes the seriousness of the problem . Denali Center provides information to staff. on the importance of reporting concerns, incidents, and grievances . 5. Utilizing resident and staff interviews, documentation and other evidence as appropriate, Denali Center will compile evidence that all allegations of abuse, neglect, or mistreatment have been thoroughly investigated and that further potential abuse has been prevented while the investigation is in progress. 6. The results of the investigation are reported to the State agency for Certification and Licensure, and appropriate corrective action is implemented to prevent a recurrence. Results must be reported within 5 working days of the incident .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 50031 50078 Based on record review and interview, the facility failed to: 1) investigate an alleged report of mistreatment; 2) prevent further potential mistreatment once the allegation was made; and 3) report the allegation, by submitting the results of the investigation to the State Agency, administrator, or his or her designated representative within 5 working days, for 1 resident (#50), out of 20 sampled residents This failed practice placed Resident #50 at risk of further exposure to mistreatment and/or mental anguish. Findings: Record review on 1/6-10/25, revealed Resident #50 was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease) and cerebrovascular accident (stroke). Resident #50 BIMS (Brief Interview for Mental Status) test score was 14 (which indicated intact cognitive status). During an interview on 1/6/25 at 2:06 PM, Resident #50 stated he/she requested an evening snack a couple weeks ago. Resident #50 further stated, a CNA [Certified nurse Assistant-unknown] told me to get up my own damn self to get ice cream and cookies. Resident #50 stated the CNA refused to get the snack for him/her. Resident #50 stated his/her nurse had seen him/her trying to get his/her own evening snack and asked what he/she was doing. Resident #50 told the nurse what the CNA stated to him/her and the nurse got him/her the requested ice cream and cookies. Resident #50 further stated he/she felt the comments made by the CNA made him/her feel discriminated against. During an interview on 1/ 8/25 at 5:16 PM, when asked about Resident #50's allegations that occurred a few weeks ago, LN #1[Resident Care Coordinator (RCC)] stated he/she was aware and familiar with the event. LN #1 stated there was no investigation completed regarding the known alleged mistreatment. LN #1 stated this was a missed opportunity. During an interview on 1/8/25 at 6:00 PM, Administrator stated she was not aware of the allegations of mistreatment reported by Resident #50 and the allegation was not investigated or reported. During an interview on 1/10/25 at 11:00 AM , when asked about Resident #50's allegations of mistreatment, the Medical Director stated he was not aware of the allegations prior to the survey. Further stated he should have been aware, and this should have been investigated and reported to the State agency. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Denali Center Abuse and Neglect, effective date 3/5/24, revealed . Definitions: A. Abuse- The willful infliction of . intimidation, or punishment with resulting physical harm, pain or mental anguish. This includes the deprivation of goods or services . It includes verbal abuse. Willful, as used in definition of abuse, means the individual must have acted deliberately . Verbal abuse is the use of oral, written, or gestured language that willfully includes the use of disparaging and derogatory terms to residents . M. Alleged violation is a situation or occurrence that is observed or reported by staff, resident . but has not yet been investigated . Policy: A. Law: Each resident has the right to be free from abuse . 2. Residents must not be subjected to abuse by anyone including, but not limited to, facility staff . Each resident must be provided individualized care with dignity and respect . C. Denali Center is committed to an abuse free environment, and as such: 1. Recognizes the seriousness of the problem . 6. Denali Center provides information to staff. on the importance of reporting concerns, incidents, and grievances . F. Investigation of abuse and neglect: Denali Center identifies and investigates every allegation of abuse. G. The Associate Administrator/Assigned Individual for Denali Center is responsible for ensuring that all instances or allegations of suspected abuse are investigated in an organized, efficient, and timely manner. The key steps in the investigatory process include the following. 1. Identifying who is responsible for the initial reporting, investigation of alleged violations, and reporting results to the proper authorities 2. Ensuring the residents are protected from harm during an investigation 3. The reporting of all instances and allegations of abuse to appropriate State agencies as required . H. Mandatory Reporting Requirements 1. Any physician, nurse, or other employee who has reasonable cause to believe that a resident has been abused, exploited, mistreated, or neglected must report it immediately to the Administrator or Director of Nurses for investigation. 2.Any physician, nurse, or other employee who has reasonable cause to believe that a resident has been abused . must report it to the local law enforcement for investigation within 24 hours of becoming aware of the event or within 2 hours if serious bodily injury. Contact Administration prior to calling law enforcement. 4. Once notified, the Administrator or Director of Nursing is required to immediately notify the State agency for Certification and Licensure, to report the allegation, and ensure that an investigation is conducted. Immediately means as soon as possible, and never to exceed 24 hours. 6. The results of the investigation are reported to the State agency for Certification and Licensure, and appropriate corrective action is implemented to prevent a recurrence. Results must be reported within 5 working days of the incident .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50078 Based on record review, observation, and interview, the facility failed to ensure the comprehensive care plan reflected the current status and care for one resident (#31) out of two sampled residents with assistive seat belt devices. This failed practice placed the resident at risk for not receiving adequate care and increased risk for injuries. Findings: Record review on 1/6-10/25, revealed Resident #31 was admitted to the facility with diagnoses that included dementia (a condition that affects memory and thinking) and Parkinson's disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination). Review of the facility's Quarterly Assessment, dated 12/2/24, revealed: . Other: tremors . Mobility Braden: Very limited . Can resident appropriately call for assistance?: Yes . Morse Mental Status . Orientated to own ability . Does the resident have a hx [history] of falls?: Yes . Is resident able to communicate needs?: Yes . Free of restraints . Minimum Data Set (MDS -a federally required nursing assessment) Review: Review of the MDS OBRA Quarterly Review Assessment, dated 12/4/24, revealed: . P0100. Physical Restraints, Physical restraints are any manual method or physical or mechanical device, mater or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body . Used in Chair or Out of Bed. G. Chair prevents rising. 0 = Not used. H. Other. 0 = Not used. P0200. Alarms. An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected . F. Other alarm. 0 = Not used. Care Plan Review: Review of Care Plan Summary, dated 1/9/25, revealed . Current Interdisciplinary Plan of Care, LTC [Long Term Care] Falls. Interventions . Do Not Leave Alone in Wheelchair in Room, Ensure Resident Can Remove Velcro Seatbelt Independently. Resident Review: During an observation and simultaneous interview on 1/6/25 at 2:48 PM, revealed Resident #31 was sitting in a manual wheelchair in his/her room alone. Resident #31 had a belt around his/her waist that was attached to the wheelchair. In the center of the belt was a plastic piece that resembled a belt buckle. When resident was asked if he/she could remove the belt, he/she stated no. Resident #31 was observed to exhibit bilateral upper extremity tremors when trying to grab the belt to demonstrate the inability to remove it. Certified Nurse Assistant (CNA) #2 walked into Resident #31's room during this interview, he/she did not know if Resident #31 was able to remove independently. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 4:30 PM, Resident Care Coordinator (RCC) #2 stated there was no documented seat belt evaluation for Resident #31. RCC #2 further stated he/she was not aware who verified that the resident was able to physically remove the belt. During an interview on 1/9/25 at 5:01 PM, when the Director of Nursing (DON) was asked if Resident #31 could remove his/her wheelchair seat belt, she stated I think so, he can paint. When further asked if there was an evaluation completed to verify that the resident was assessed, she stated I sure hope so, it would be if I was on the floor. Review of facility's policy, Denali Center- Care Plan Process, last reviewed 7/26/23, revealed: . 1. To assure all residents admitted and residing at Denali Center will have current care plans reflecting care received from all disciplines. 2. INTERDISCIPLINARY CARE PLAN: . e. identify the professional services/team members that are responsible for each element of care. c. Approach to be used-CNA/LN [Licensed Nurse] task list are developed from plan of care .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 42377 51613 Based on record review, interviews, and observations, the facility failed to ensure activities of daily living (ADLs) were provided to two residents (#s 19 and 67), out of 20 sampled residents. Specifically, showers or baths were not provided to the residents as specified in their individualized plans of care. This failed practice resulted in residents not receiving ADLs to maintain personal care and hygiene . Findings: Resident #19 Record review on 1/6-10/25, revealed Resident #19 was admitted to the facility with diagnoses that included morbid obesity (a complex chronic disease characterized by a Body Mass Index [BMI] of 40 or higher), and hemiplegia (neurological condition that involves paralysis of one side of the body). Review of the facility's .Bath/Shower Schedule, dated 12/12/24, revealed Resident #19 was noted to have scheduled shower days on Tuesdays and Saturdays. During an interview on 1/6/25 at 11:15 AM, Licensed Nurse (LN) #2 stated the Bath/Shower schedule was the most recent version. During an interview on 1/6/25 at 11:20 AM, when asked if he/she was provided with a shower or bath, Resident #19 stated, I can't remember when the last time was . During an interview on 1/9/25 at 8:31 AM, LN #4 stated that when ADL cares were completed it would be documented in the Electronic Health Record (EHR). Review of the MDS (Minimum Data Set, a federally required nursing assessment) Quarterly Assessment, dated 11/14/24, revealed Resident #19 was assessed as dependent in Section GG. GG0130. Self-Care E. Shower/bathe self. Review of the Resident #19's Care Plan, undated, revealed: .Goals Functions at Optimal Level with ADLs, Interventions .Provide Total Assistance x2 with Maxi Lift Transfers .Provide Bath/Shower- 2 times a Week . Resident needs extensive assist .may use shower gurney . Review on 1/9/25, of the facility's Resident Bathing Chart, dated 11/11/24 to 1/9/25, revealed no shower or bath was provided for Resident #19 since 12/31/24 (9 days prior). Further review of the Resident #19's Bathing Chart, revealed no documentation for a tub bath, bed bath, whirlpool bath, and other form of bathing provided. During an interview on 1/9/25 at 8:42 AM, the Administrator acknowledged that the resident had no documented shower from 1/1-9/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #67 Record review on 1/6-10/25, revealed Resident #67 was admitted to the facility with diagnoses that included atherosclerotic heart disease (hardening of the arteries from plaque), cerebral edema (swelling of the brain) and compression of brain. During an interview on 1/7/25 at 10:33 AM, when asked if he/she was provided with shower or bath, Resident #67 stated no, Review of the MDS Admission Assessment, dated 12/2/24, revealed Resident #67 was assessed as dependent in Section GG. GG0130. Self-Care E. Shower/bathe self. Review of the Resident #67's Care Plan, undated, revealed: .Goals Functions at Optimal Level with ADLs, Interventions .Provide Bath/Shower- 2 times a Week . Review of the facility's Resident Bathing Chart from 11/29/24 -1/8/25, revealed no shower or bath provided on the following periods: 12/2-7/24- 6 days had passed since last shower on 12/1/24 12/11-14/24- 4 days had passed since last shower on 12/10/24 12/16-23/24- 8 days had passed since last shower on 12/15/24 12/25/24-1/6/25 - 13 days had passed since last shower on 12/24/24 Further review of the Resident #67's Bathing Chart, revealed no documentation for a tub, bed bath, whirlpool, and other form of bathing provided. During an interview on 1/8/25 at 1:46 PM, the Administrator stated the staff provided a bed bath to Resident #67 when the resident was unable to shower but was not documented. During a joint interview on 1/8/25 at 3:22 PM, Certified Nurse Assistant (CNA) #1, stated the residents were provided with a shower . When asked what the process was if the resident was unable to take a shower, LN #5 stated, the CNAs would provide a bed bath. When asked if the CNAs documented once the bed bath was provided to the residents, CNA #1 stated he/she would document it. Review of the facility's policy, CNA Expectations and Standards of Care, last updated 5/6/24 revealed: .2. Bathing/Personal Hygiene . a. bath/shower 2x a week, or as care planned .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50031 50078 Based on record review, observation and interview the facility failed to obtain residents' consent for bedrails use and conduct accurate risks and benefits assessments for four residents (#'s 4, 8, 31 and 61) out of 20 sampled residents and one unsampled resident (#11) reviewed for bedrails use. This failed practice had the potential to place residents at risk of falls, entrapment, and other preventable accidents and potentially place residents at risk of feelings of isolation and helplessness . Findings: Resident #4 Record review on 1/6-10/25, revealed Resident #4 was admitted to the facility with diagnosis that included cerebral palsy (congenital disorder of movement, muscle tone, or posture). During an observation and simultaneous interview on 1/7/25 at 11:12 AM, Resident #4 had right upper extremity (RUE) contractions. Resident #4's bed had both upper side rails, and the right lower side rail raised. The raised and uncovered upper bed rails began at the top of the bed and ended by Resident #4's lower chest and the raised right lower side rail began at his/her right hip and ended by his/her right knee. Resident #4's bedside table was placed along the opened left lower side of bed. When asked if he/she could lower the bed rails, Resident #4 stated he/she did not think so. When asked why the bed rails were raised, Resident #4 stated staff put the rails up and not sure why they are up. Review of the most recent Quarterly Assessment LTC [Long Term Care], dated 5/21/24, revealed: . Has resident requested to have side rails up for use of bed controls?: No, Has the resident requested to have side rails up for comfort or security?: No . Bed Safety PT/OT Recommend Side Rails: No . Does resident have a hx [history] of falls from the bed?: yes . Bed Safety Side Rail Use: Left Upper side rail, Left Lower side rail, Right Upper side rail, Right Lower side rail . Bed Safety Review W [with] Resident/Legal Rep: No . Review of the most recent MDS (Minimum Data Set, a federally required nursing assessment), OBRA Quarterly Review Assessment, dated 11/20/24, revealed: . Section P - Restraints, P0100 . Used in Bed. A. Bed rail. 0 = Not used. Review of the Care Plan Summary, dated 1/9/25, revealed: . LTC Falls . Intervene for Unsafe Behaviors Effecting Fall Risk . Keep bed controls out of reach and locked when in bed . upper side rails up with seizure pads . Further review of Resident #4's medical record revealed no physician order and/or informed consent regarding the use of bed rails was found. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denali Center	1510 19th Avenue Fairbanks, AK 99701

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25 at 4:06 PM, Resident Care Coordinator (RCC) #2 stated Resident #4 should only have both upper side rails raised. RCC #2 was asked if Resident #4 had a bed rail assessment. RCC #2 was unable to locate a bed rail assessment in the medical record. Resident #8 Record review on 1/6-10/25, revealed Resident #8 was admitted to the facility with diagnoses that included a fracture of the lower end of the left tibia (shin bone) and diabetes mellitus. During an observation and simultaneous interview on 1/10/25 at 9:00 AM, revealed Resident #8 had four side rails raised on his/her bed. Resident #8 stated he/she was not sure why all side rails were raised. Record review of the most recent MDS OBRA Quarterly Review Assessment, dated 11/27/24, revealed: . Section P- Restraints, P0100 . Used in Bed. A. Bed Rail. 0 = Not used . Further review of Resident #8's medical record revealed no physician order and/or informed consent regarding the use of bed rails was found. Resident #11 Record review on 1/6-10/25 revealed Resident #11 was admitted to the facility with diagnoses that included pressure ulcer (bed sore) of the sacral (end of spine) region and diabetes mellitus. An observation on 1/10/25 at 9:15 AM, revealed Resident #11 had three side rails raised on his/her bed. Resident #11 stated he/she was not sure why the side rails were raised. Record review of the most recent MDS OBRA Quarterly Review assessment dated [DATE], revealed: . Section P- Restraints, P0100 . Used in Bed. A. Bed Rail. 0 = Not used . Further review of Resident #11's medical record revealed no physician order and/or informed consent regarding the use of bed rails was found. Resident #31 Record review on 1/6-10/25, revealed Resident #31 was admitted to the facility with diagnoses that included dementia (a condition that affects memory and thinking) and Parkinson's disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination). During an observation and simultaneous interview on 1/7/25 at 11:56 AM, Resident #31 had both upper side rails raised. The raised upper side rails began at the top of the bed and ended by Resident #31's lower chest. When asked if he/she could lower the side rails, Resident #31 stated: No but staff can. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #31's Quarterly Assessment LTC, dated 12/2/24, revealed: . Bed Safety Assessment . Has resident requested to have side rails up for use of bed controls?: No Has resident requested to have side rails for comfort or security?: No . Bed Safety PT/OT Recommend Side Rails: No . Bed Safety Side Rail Use: Left Upper side rail, Left Lower side rail, Right Upper side rail, Right Lower side rail . Bed Safety Review w/ Resident/Legal Rep: No . Record review of the most recent MDS OBRA Quarterly Review Assessment, dated 12/4/24, revealed: . Section P- Restraints, P0100 . Used in Bed. A. Bed Rail. 0 = Not used. Review of Resident #31's Care Plan Summary, dated 1/9/25, revealed: . LTC ADL [Activities of Daily Living] Function Rehab [rehabilitation] . Assist Resident With Transfers . Staff Will Not Leave Resident Alone Sitting on Bed . LTC Falls . Use High Low Bed. Keep in Low Position . During an interview on 1/9/25 at 4:06 PM, when asked RCC #2 if Resident #31 had a bed rail assessment. RCC #2 was unable to locate a bed rail assessment in the medical record. Further review of Resident #31's medical record revealed no physician order and/or informed consent regarding the use of bed rails was found. Resident #61 Record review on 1/6-10/25, revealed Resident #61 was admitted to the facility with diagnoses that included failure to thrive (weight loss of more than 5%, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction, and low cholesterol) and Schizophrenia (a severe mental disorder characterized by delusions [false beliefs], hallucinations [perception of sights, sounds, etc. that are not actually present], incoherence and physical agitation). During an observation and simultaneous interview on 1/6/25 at 2:48 PM, Resident #61 had both upper side rails raised, and a right lower side rail raised. The raised upper bed rails began by the top of the bed and extended down the side of the bed and ended by Resident #61's lower chest, and the raised right lower side rail started by the resident's right hip and extended down the side of the bed ending by his/her right knee. When asked if he/she could lower the side rails, Resident #61stated: No. Review of Resident #61's PT [physical therapy] Evaluation LTC II dated 10/22/24 revealed: . answers questions limited to yes/no or short phrases . been found out of bed sitting in a chair in [his/her] room with all 4 bed rails up, self-transferring unwitnessed . Bed Mobility: . did not use rails . Review of the most recent MDS, OBRA Admission Assessment, dated 10/23/24, revealed: . Section P-Restraints, P0100 . Used in Bed. A. Bed Rail. 0 = Not used . Review of Resident #61's Quarterly Assessment LTC, dated 1/9/25, revealed: . Orientation Assessment: Disorientated x 4 . Is resident able to state preferences about side rail use?: No (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Has resident requested to have side rails up for use of bed controls?: No Has resident requested to have side rails for comfort or security?: No . Is resident able to change position in bed without using side rails?: Yes . Bed Safety PT/OT Recommend Side Rails: No . Bed Safety Side Rail Use: Left Upper side rail, Right Upper side rail. Bed Safety Review W Resident/Legal Rep: No . Review of Resident #61's Care Plan Summary, dated 1/9/25, revealed: . LTC Delirium . Interventions . Adapt Care and Environment to Optimize Comfort and Safety . LTC ADL Function Rehab. Assist Resident With Transfers . Staff Will Not Leave Resident Alone Sitting on Bed . LTC Falls . Use High Low Bed. Keep in Low Position . Further review of Resident #61's medical record revealed no physician order and/or informed consent regarding the use of bed rails was found. During an interview on 1/9/25 at 12:25 PM, surveyors requested individual resident assessments to include bed safety from the Director of Nursing (DON). The DON stated there were no bed rail assessments completed. During an interview on 1/9/25 at 4:06 PM, when asked RCC #2 if Resident #61 had a bed rail assessment. RCC #2 was unable to locate a bed rail assessment in the medical record. Review of the facility's policy Bed Safety Assessment Process, effective date 10/11/24, revealed: . 1. Side rails present an inherent safety risk, particularly when the patient is elderly or disoriented . patients may become trapped between the mattress or bed frame and the side rail. Disoriented patients may view a raised side rail as a barrier to climb over, may slide between raised, segmented side rails, or may scoot to the end of the bed to get around a raised side rail. When attempting to exit the bed by any of these routes, the patient is at risk for entrapment, entanglement, or falling from a greater height posed by the raised side rail, with a possibility for sustaining greater injury or death . Policy, A. Registered Nurse, with resident/family, and interdisciplinary (social work, rehab) participation, will complete an individual resident assessment to include bed safety . B. No resident will be placed with all four side rails unless it is clearly demonstrated and documented in the assessment . C. risks and benefits will be presented to the resident and/or responsible party . D. The Resident Care Coordinator/LPN[Licensed Practical Nurse]Manager will review all bed safety assessments. E. The Interdisciplinary Care Plan will be completed by day 21 of admission and the Registered Nurse will develop the plan for bed safety . Review of the facility's A Guide to Bed Safety [a pamphlet provided in residents' admission packet], undated, revealed: The Benefits and Risks of Bed Rails . more serious injuries from falls when patients climb over rails. inducing agitated behavior when bed rails are used as a restraint. Feeling isolated or unnecessarily restricted . Meeting Patients' Needs for Safety, Most patients can be in bed safely without bed rails. Consider the following: Use beds that can be raised and lowered close to the floor to accommodate both patient and health care worker needs. Keep the bed in the lowest position with wheels locked . When bed rails are used, perform an on-going assessment of the patient's physical and mental status; closely monitoring high-risk patients. .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51614 Based on observation, interview, and record review, the facility failed to properly store drugs and medical supplies. These failed practices had the potential to place all residents (based on a census of 71) at risk of receiving expired and non-sterile medications and supplies and subsequent adverse effects. Findings: Tamarack and [NAME] Medication Shared Room: An observation on 1/8/25 at 6:15 PM, revealed the following medical supplies were expired: - One box of 1.5 mL BD [[NAME], [NAME] and Company] ChloraPrep FREPP Clear applicators, expired on 10/24; - One quart bottle of Distilled [NAME] Vinegar in the ear irrigation tray, expired on 10/24. During an interview on 1/8/25 at 6:15 PM, Resident Care Coordinator (RCC) #3 confirmed expired supplies should have been discarded. Tamarack Medication Room: An observation on 1/8/25 at 6:28 PM, revealed the following medical supplies and medications were expired: - Two boxes of Nicotrol Inhaler 10 mg cartridges (smoking cessation aid), expired on 5/24; - One bottle of Children's Chewable Multivitamin, expired on 3/24; - One Stat Strip Xpress Glu Control Level 3, expired on 12/26/24; - Two Protexis PI Surgical Gloves, expired on 8/31/24 and 9/30/24; - Five 4 in. by 12 in. Mepilex Border AG dressings, expired 8/25/24; - One 4 in. by 4 in. Replicare Ultra dressing, expired on 10/22. During an interview on 1/8/25 at 6:28 PM, RCC #3 confirmed expired medications should have been returned to the pharmacy and the expired medical supplies should have been discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview, on 1/9/25 at 10:05 AM, Pharmacist #1 stated the Nicotrol Inhalers were home medications of a current resident. He/she further stated home medications stored in medication carts were not monitored by the pharmacy department. Pharmacist #1 confirmed expired home medications were typically returned to and discarded by the pharmacy department. The pharmacist added Nicotrol had not yet been discarded as Nicotrol cartridges were expensive and difficult to obtain as they were no longer produced. Pharmacist #1 stated the facility follows the retail pharmacy's provided label for expiration dates. Denali Center BLS (Basic Life Support) Cart: An observation on 1/9/25 at 7:49 AM, revealed the following expired medical supply: One 4-1/2 x 4-1/8 yd Kerlix bandage roll expired on 8/22. Record review on 1/9/25 at 7:49 AM, of the facility's Emergency Equipment Cart log revealed the following: Check Weekly .Restock when expired & After Use . 1-Drawer of dressing supplies . [last checked] 12/22/24. During an interview on 1/9/25 at 7:49 AM, RCC #1 stated night shift charge nurses were responsible for inspections of the crash (BLS) cart weekly. Review on 1/9/25 at 3:00 PM, of the facility's Night Charge Nurse Duties, undated, revealed: Check the Crash cart every Wednesday. Document in the notebook marked weekly checks located in [RCC's] office on the Emergency cart. Review on 1/9/25 at 3:00 PM, of the facility's 12 HOUR NIGHT CHARGE procedures, undated, revealed: CHECK CRASH CART ON WEDNESDAY. Birch Medication Room: An observation on 1/9/25 at 8:01 AM, revealed the following opened and expired medical supplies: - One 1000 ml 0.9% Sodium Chloride Injection USP bag not in original packaging; - One I.V. (Intravenous) dressing kit not in the original packaging; - One 1.5 mL BD Chloraprep FREPP Clear applicator, expired on 10/24; - One Adult Pulse Oximeter Adhesive Sensor, expired 11/1/21. During an interview on 1/9/25 at 8:01 AM, RCC #2 stated expired and opened supplies should have been discarded. He/she further stated nurses should have been responsible for ensuring no expired medications and/or expired medical supplies were stored in the medication rooms. During a follow up interview on 1/9/25 at 1:15 PM, RCC #2 stated, based on the LPN(Licensed Practical Nurse) manager job description, the RCCs were responsible for ensuring medications storage rooms do not have expired supplies. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's job description of LPN Mgr [Manager], undated, revealed Essential Functions . provides daily operational resource management including . supplies Aspen and Birch Medical Supply Room: An observation on 1/9/25 at 8:20 AM revealed the following expired products: - Seven .81 oz of Juven Therapeutic Nutrition Powder packets, expired on 8/1/24; - One .81 oz of Juven Therapeutic Nutrition Powder packets, expired on 3/1/24; - 32 .81 oz of Juven Therapeutic Nutrition Powder packets, expired on 11/1/24; - 43 0.14 oz Nutrisource fiber supplement packets, expired on 07/11/24. During an interview on 1/9/25 at 8:20 AM, RCC #2 stated expired nutritional supplements should have been discarded however it was the responsibility of Nutrition Services (NS) to ensure supplements stored in the storage rooms were not expired. During an interview on 1/9/25 at 2:59 PM, NS #3 confirmed NS were responsible for ensuring dietary products such as tube feeding formulas and nutritional supplements stored in the medical supplies room were not expired. He/she further stated, NS typically rounded every day to check the stock in the facility, but expired products were either missed or packaging was not checked for expiration dates. When asked about written policies and procedures regarding storage of dietary products, NS #3 stated there were none.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50031 Based on observation, interview and record review the facility failed to ensure potentially hazardous foods were stored, labeled and prepared foods in accordance with professional standards for food safety. Specifically, the facility failed to ensure: 1) foods were labeled and dated; 2) expired foods were discarded; 3) Nutrition Services staff performed hand hygiene with glove changes and during the cooking and the preparation of foods. These failed practices had the potential of causing or spreading foodborne illnesses to residents, based on a census of 70, who received food from the kitchen. Findings: An observation, during the initial main kitchen tour, on [DATE] at 10:50 AM, revealed: 1) Dry Storage in Fireweed Cafe: - 30 expired Alpine Spiced Apple Cider Original- single serving packets- with manufacture best by date of [DATE]; - 44 expired [NAME] Sweet & Sour Sauce- 1- ounce single serve containers-with a manufacture used by date of [DATE]; - One expired Kikkoman Less Sodium Soy Sauce-5-ounce bottle-with manufacture best by date of [DATE]; -One expired Monarch Mandarina Segmentos Enteros-6-pound 10 ounce can- received on [DATE] and expired on [DATE]; -One-expired Monarch California Sliced Yellow Cling Peaches-6-pound 9 ounce can- received on [DATE] and expired on [DATE]; -One-expired [NAME] Ploy Sweet Chili Sauce- 25-ounce bottle-with manufacture expiration date [DATE]; -16-expired Nutri Grain Apple Cinnamon Soft Baked Breakfast Bars-1.3-ounce packages, with manufacture expiration date [DATE]; -One-box Heinz Tartar Sauce- open box [full box quantity 200 count] ,d+[DATE] full box- 0.12-gram single serve packages, with manufacture expiration date [DATE]; -One-clear plastic bag [containing multiple] Kikkoman Soy Sauce ,d+[DATE] full- single served packets [size of packet unknown], with manufacture best by date [DATE]; -One- box [NAME] Fat Free Classic Ranch Dressing open box [full box quantity 200] ,d+[DATE] full- 12. 4-gram single served packet, with no best used by date or expiration date; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Two-boxes [NAME] Golden Italian Dressing open box [full box quantity 200] ,d+[DATE] full box-12.4- gram single served packet, no best used by date or expiration date; -One plastic container Chef's Pride Canola Oil-1 gallon bottle- no best used by date or expiration date; -One plastic container [NAME] Mayo Light-1 gallon container, no best used by date or expiration date; -One box Herb Ox Sodium Free Granulated Chicken Bouillon - single serving packets- half full box, no used by date or expiration date; -One box Monarch Non-Dairy Creamer open box [full box quantity 2000] ,d+[DATE] full-2.5-gram packet, no best used by date or expiration date; During an interview on [DATE] at 10:57 AM, the Culinary Director (CD) stated after the food arrived the products were taken through the hospital kitchen for processing. He stated that the food products were dated with a sticker gun and to be used within 6 months from the received date. When asked about food products that were not dated, and products that did not have a best used by date or expiration date, the CD did not provide an answer. 2) Fireweed Cafe Dining Refrigerator: -One- expired Chobani Blueberry Greek Yogurt individual container-4 ounces, with manufacture expiration date [DATE]; -One plastic container labeled G. Macaroni, no best used by date or expiration date; -One-plastic container labeled P. Macaroni, no best used by date or expiration date; -Two-disposable containers, labeled apple containing light yellow liquid with the sliced apples, no best used by date or expiration date; During an interview on [DATE] at 11:33 AM, Nutrition Service (NS) #3 stated the macaroni containers contained ground and pureed macaroni salad. NS #3 stated they were not dated since they were prepared to be used that day. NS #3 further stated the liquid in apples was apple juice and were going to be used later that day. An observation during the hospital kitchen [a kitchen that stored food and prepared meals for residents in the long-term care] tour, on [DATE] at 9:30 AM, revealed: 3) Walk-in Freezer: -One- open box Plant-Based Smashed Patty in open plastic bag- ,d+[DATE] full- 2.6-ounce patty, no best used by date or expiration date; -One- clear plastic bag, food not identified [appeared to be large shell pasta noodles], not labeled, no best used by date or expiration date; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-One- clear plastic bag, food not identified [appeared to be hotdog buns], 11 buns, not labeled, no best used by date or expiration date; -One- clear plastic bag, food not identified [appeared to be biscuits], quantity unknown, not labeled, no best used by date or expiration date; -Two- clear plastic bags, food not identified [appeared to be angel food cake], both containing ,d+[DATE] cake, not labeled, no best used by date or expiration date; -One- open box Hilltop Hearth Blueberry Muffins, 5 muffins, no best used by date or expiration date; -One- open box [NAME] Blueberry, in open plastic bag- ,d+[DATE] full, no best used by date or expiration date; -One- metal cart with three shelves- containing metal trays appeared to be chicken strips, French fries, and chicken wings not covered, not labeled, no best used by date or expiration date; -One-open box Grimmway Farms Carrots individual packets- 1.6 ounce- best if used by [DATE]; -One-open box US Foods Cheese loaf of white cheese wrapped in plastic, no best used by date or expiration date; -One-open box Cubed Cheese -5-pound packages- 2 opened bags, wrapped in plastic, both ,d+[DATE] full, no open date, no best used by date or expiration date. 4) Main Kitchen Food Preparation: -One- open box Quacker Quick Creamy Wheat-28-ounce box, contents not sealed opened to air; -One- open box [NAME] Enriched Hominy Quick Grits-20-ounce box, contents not sealed opened to air; -One- ,d+[DATE] loaf [NAME] Wheat Sandwich Bread- 24-ounce bag, with manufacture best by date [DATE]; -One- clear plastic bag [NAME] English Muffin -6 muffins, no best used by date or expiration date; -One- clear plastic bag [NAME] Bagel -6 bagels, no best used by date or expiration date; -One-clear plastic bag [NAME] bread -full bag, appears unopened, no label, no best used by date or expiration date. During a simultaneous interview on [DATE] at 9:40 AM, reviewed items found in the walk-in freezer and food preparation area of the kitchen, CD stated food products were not dated in the freezer since it is frozen and safe, only the quality goes down. NS #4 stated the carrots are good as long as they are kept frozen, we take out what we need and use, they can last for years. NS #4 further stated as products come in we just rotate the food, use older stuff first, we go through it quick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5) Food Preparation and Plating Observation: An observation on [DATE] at 6:30 AM, food was prepared in the hospital kitchen and placed in metal containers with plastic wrap over the containers. Containers were placed in a warming cart for transport to the LTC. An observation on [DATE] at 7:00 AM, NS #2 placed metal containers in the steam table with gloved hands. Using the same gloved hands, NS #2 then made pancakes and French toast, placed the food in a metal container and moved it into the steam table. Continuing the observation on [DATE] at 7:25 AM, NS #2, still using the same gloved hands, measured the food temperatures for all food on the steam table. An observation on [DATE] at 7:43 AM, NS #1 was wearing gloves, while preparing supplemental shakes, pureed bananas, and was going in and out of the refrigerators. NS #1 changed his/her gloves without performing hand hygiene. During an interview on [DATE] at 7:43 AM, the CD stated staff was to perform hand hygiene between glove changes. An observation on [DATE] at 7:51 AM, NS #1 removed his/her gloves in the main kitchen, walked into Fireweed dining room to retrieve supplies, returned and, without performing hand hygiene, and put on a new pair of gloves. During a continuous observation on [DATE] at 7:53 AM through 9:08 AM, NS #2 cooked and prepared food with gloved hands. NS #2 wiped his/her gloved hands on a towel placed next to steam table. Next, NS #2 cracked raw eggs into a container, then whisked, and then poured the whisked eggs into a pan to cook. Next, NS #2 placed shredded cheddar cheese on top with the same gloved hands and then placed the cooked cheesy eggs onto a resident plate. Next, NS #2 returned to the steam table, which contained sausage gravy, turkey sausage, bacon, scrambled eggs, cream of wheat cereal, oatmeal, hashbrowns, pancakes, blueberry muffins and French toast, and prepped several resident's plates with cooked food from the steam table. While NS #2 prepared another resident plate, he/she touched the cooked eggs and bacon with same gloved hands used to handle raw eggs from earlier in the observation. NS #2 continued creating additional resident plates with food from the steam table while using the same gloved hands. NS #2 did not perform hand hygiene after he/she prepared raw food and served cooked food. During a follow-up observation of the dry storage in Fireweed Cafe on [DATE] at 9:50 AM, revealed: -One expired Kikkoman Less Sodium Soy Sauce-5-ounce bottle-with manufacture best by date of [DATE]; - 30 expired Alpine Spiced Apple Cider Original- single serving packets- with manufacture best by date of [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025020	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denali Center	1510 19th Avenue Fairbanks, AK 99701

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy Food Safety and Sanitization, last reviewed [DATE], revealed: 2) Employees . will hand all foods safely. 4. All staff will wash their hands just before they start to work in the kitchen and when they have used their hands in an unsanitary way.4) Food Storage . 4. Foods are protected from contamination . 8. All leftovers are labeled, covered, and dated when stored . 9. Foods with expiration dates and best by dates are used prior to the date on the package . 10. Canned and dry foods without expiration dates are used within six months of delivery or according to the manufacture's guidelines . Review of the facility's policy Food Preparation, effective date [DATE], revealed: . k. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid manual contact of prepared foods . Review of the facility's Food Service Worker- Job Code: 3304, undated, revealed: . Requires the ability to follow . and maintaining sanitation standard. This position requires the ability to learn and follow established policy and procedures . Must be able to learn food handling regulations . Review of the facility's Cook- Job Code: 3298, undated, revealed: . Must be able to learn and follow established policies and procedures . Must be able to learn food handling regulations . Review of the Food and Drug Administration (FDA) guidelines (Food labeling 2020), accessed at this link: https://www.FDA.gov, revealed: . concerning food storage and labeling, while the FDA does not mandate expiration dates, it encourages to use best by, use by, or sell by dates to indicate peak quality and safety as well as practices of inventory management such as First In, First Out (FIFO), inventory management practice that helps ensuring that older stock is used before newer stock, reducing waste and spoilage.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50078 Based on record review and interview, the facility failed to ensure an accurate medical record was maintained for one resident (#10) out of 20 sampled residents. Specifically, the facility's medical record process failed to ensure medical records were accurate. This failed practice created incomplete medical records which placed the resident at risk for inconsistencies in treatment and care provided. Findings: Record review from 1/6-10/25 revealed Resident #10 was admitted to the facility with diagnoses that include generalized anxiety disorder, heart failure, and chronic kidney disease. Review of the facility's Medical Director's progress note, dated 1/1/25 at 5:16 PM, revealed: [Resident #10] suffers from bi-polar [mental health condition characterized by extreme mood swings including periods of elevated and irritable to low mood and energy levels], hallucinations, anxiety, and depression . Review of the facility's Medical Director's annual history and physical, dated 7/27/24 at 12:08 PM, revealed: [Resident #10] has a history of bipolar disorder with auditory hallucinations. We are following [his/her] mental health issues as well as pain concerns through the BIT/PIT [Behavioral Intervention Treatment/Pain Intervention Treatment] process. Review of the Denali Center Consultation dated 3/27/23, revealed: [Resident #10] has been seen by [Psychiatrist] in 2018 who diagnosed the patient with bipolar disorder type 1 . Review of the MDS (Minimum Data Set, a federally required nursing assessment), dated 10/31/24, revealed in Section I-Active Diagnosis, the response was unmarked for I5900. Bipolar Disorder. Review of the Diagnoses and Problems, on 1/9/25 at 11:43 AM, did not list bipolar disorder in Resident #10's electronic health record (EHR). During an interview with MDS Coordinator #1 on 1/9/25 at 1:07 PM, he/she stated active diagnosis were filled out in the MDS based off the diagnosis list in the EHR. He/she further stated he/she did not update the diagnosis list in the EHR. During an interview with [NAME] #2 on 1/9/25 at 2:00 PM, he/she stated coders updated the diagnosis list for residents in the facility and that he/she was the most recent coder assigned to Resident #10. He/she further stated diagnoses were updated based off the most recent physician progress notes, which were checked on Monday, Wednesday and Fridays. When asked if Resident #10 should have had bipolar disorder listed as a diagnosis based off the most recent progress note by the Medical Director on 1/1/25 at 5:16 PM, he/she confirmed Resident #10 should have had bipolar disorder listed as a diagnosis. [NAME] #2 stated, he/she doesn't know why it never got picked up. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident #10's care plan, undated, .Notify Provider if Hallucinations or Delusions are Distressing to Resident as Needed .Evaluate Medications for Desired and Adverse Outcomes .Take Resident to BIT/PIT Quarterly and PRN .Consult BIT/PIT for Evaluation of Causes and Treatment Options . Administer Medications as Ordered . During an interview with the Administrator on 1/9/25 at 4:00 PM, Administrator stated there was no policy and procedures on medical records coding of medical diagnoses.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50031 50078 Based on observation, interview and record review the facility failed to ensure staff followed hand hygiene practices. Specifically, nutrition service staff did not performed hand hygiene and/or glove changes during the cooking and the preparation of the food. This failed practice placed all residents who receive food from the kitchen, based on a census of 70, at risk for cross contamination and spread of infectious disease; Findings: Dietary Hygiene: An observation on 1/9/25 at 7:43 AM, NS #1 was wearing gloves, while preparing supplemental shakes, pureed bananas, and was going in and out of the refrigerators. NS #1 changed his/her gloves without performing hand hygiene. An observation on 1/9/25 at 7:51 AM, NS #1 removed his/her gloves in the main kitchen, walked into the Fireweed dining room to retrieve supplies, returned and, without performing hand hygiene, and put on a new pair of gloves. During a continuous observation on 1/9/25 at 7:53 AM through 9:08 AM, NS #2 cooked and prepared food with gloved hands. NS #2 wiped his/her gloved hands on a towel placed next to steam table. Next, NS #2 cracked raw eggs into a container, then whisked, and then poured the whisked eggs into a pan to cook. Next, NS #2 placed shredded cheddar cheese on top with the same gloved hands and then placed the cooked cheesy eggs onto a resident plate. Next, NS #2 returned to the steam table, which contained sausage gravy, turkey sausage, bacon, scrambled eggs, cream of wheat cereal, oatmeal, hashbrowns, pancakes, blueberry muffins and French toast, and prepped several resident's plates with cooked food from the steam table. While NS #2 prepared another resident plate, he/she touched the cooked eggs and bacon with same gloved hands used to handle raw eggs from earlier in the observation. NS #2 continued creating additional resident plates with food from the steam table while using the same gloved hands. NS #2 did not perform hand hygiene after he/she prepared raw food and served cooked food. During an interview on 1/9/25 at 7:43 AM, the Culinary Director stated staff were to perform hand hygiene between glove changes. Review of the facility's policy, Food Safety and Sanitization, last reviewed 5/28/24, revealed: . 2) Employees . will handle all foods safely. 4. All staff will wash their hands just before they start to work in the kitchen and when they have used their hands in an unsanitary way. Review of the facility's policy, Food Preparation, effective date 10/28/22, revealed: . k. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid manual contact of prepared foods . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Food Service Worker- Job Code: 3304, undated, revealed: . Requires the ability to follow . and maintaining sanitation standard. This position requires the ability to learn and follow established policy and procedures . Must be able to learn food handling regulations . Review of the facility's Cook- Job Code: 3298, undated, revealed: . Must be able to learn and follow established policies and procedures . Must be able to learn food handling regulations . Review of the U.S. Food and Drug Administration (2022) FDA Food Code 2022 (FDA Publication No. 2022) U.S. Department of Health and Human Services, accessed on 1/22/25 at https://www.fda.gov/media/153455/download, revealed 2-301.14 . FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and . (E) After handling soiled EQUIPMENT or UTENSILS . (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks . (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD . (H) Before donning gloves to initiate a task that involves working with FOOD . (I) After engaging in other activities that contaminate the hands. Further review of Review of the U.S. Food and Drug Administration (2022) FDA Food Code 2022 (FDA Publication No. 2022) U.S. Department of Health and Human Services, accessed on 1/22/25 at https://www.fda.gov/media/153455/download, revealed 3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.