

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Heritage Place		STREET ADDRESS, CITY, STATE, ZIP CODE 232 Rockwell Avenue Soldotna, AK 99669	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40259 47929</p> <p>Based on record review, interview, and observation, the facility failed to ensure: 1) a properly sized sling was used in transfers for 1 resident (#195), out of 12 sampled residents; and 2) neurological (or neuro) checks (assessments to determine if any neurological symptoms arose from potential head injuries) were performed after unwitnessed falls for 2 residents (#'s 18 and 20), out of 4 sampled residents for falls. These failed practices had the potential to: 1) cause pain and distress to the resident; and 2) delay treatment if the resident had a change in neurological status.</p> <p>Findings:</p> <p>Transfer Sling</p> <p>Record review from 5/13-17/24 revealed Resident #195 was admitted to the facility with diagnoses that included lung cancer, chronic obstructive pulmonary disease (COPD, a disease making breathing difficult, which involves impaired gas exchange in the lungs), peripheral vascular disease (a condition that cause blood vessels to narrow, block or spasm), and atrial fibrillation (an abnormal heart rhythm characterized by rapid and irregular beating of the atrial chambers of the heart).</p> <p>Review of Resident #195's progress note, dated 5/14/24 at 6:03 PM, revealed: . [Resident #195] stayed in bed all shift. [He/she] requested a shower today but stated [he/she] is 'petrified to get out of the bed using the lift', several attempts made to help [him/her] shower and reassurance given about getting up using the lift but [he/she] refused every offer, will attempt shower tomorrow.</p> <p>Review of Resident #195's progress notes, dated 5/15/24 at 4:43 PM, revealed: . [Resident #195] expressed anxiety [with] transferring using the lift again this morning, MD [physician] notified and PRN [as needed] Ativan order received.</p> <p>During an interview 5/15/24 at 11:29 AM, Resident #195 stated he/she had to work on getting used to how the staff transferred him/her. When he/she first arrived, the staff used a lift to assist with getting him/her out of bed that hurt his/her breasts. The resident stated, It was an awful experience.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and concurrent interview on 5/15/24 at 3:19 PM, Licensed Nurse (LN) #2 and Resident Assistant (RA) #2 used a Sara3000 (sit to stand lift) to transfer Resident #195 from the resident's bed to his/her wheelchair. From a sitting position on the edge of the bed, LN #2 and RA #2 placed a light blue sling with a green border (the green border indicated the sling size was large) around the torso of Resident #195. The staff placed the resident closer to edge of bed, where his/her lower legs were buckled to the standing platform on the lift. The staff then attached the sling to the lift with clips built into the sling. With the resident holding onto the handles, RA #2 advised the resident to lean forward, as the lift assisted the resident into a standing position. In doing so, the sling pulled up the resident's shirt, exposing the entire midsection of the resident and bunched up the shirt in the underarm area. While being lifted, Resident #195 said, Ouch. While LN #2 handled the oxygen tubing, the resident was turned around to align with his/her wheelchair and was lowered down into the wheelchair's seat. The resident was unbuckled, and the sling was removed. When asked how they knew what sling to use, RA#2 stated they use the sling compatible with the lift, which was placed in the room.</p> <p>During an interview on 5/15/24 at 3:44 PM, RA Supervisor #1 stated the RA Supervisors would choose an appropriate lift sling for residents after physical therapy evaluated the residents for the type of lift to be used. The facility had two different types of lifts, the full body lift (called a Hoyer) and the sit to stand lifts. RA Supervisors #1 and #2 would choose the sling size based on the resident's weight as soon as possible after admission, however, the sling sizes were not documented in the medical record. Staff would use what was placed in the room. When asked if a resident weighed 143.6 lbs. (pounds) which sit to stand sling would be selected, RA Supervisor #1 stated a yellow sling should be utilized, according to the sizing guide.</p> <p>Review of the facility's Sling Color Guide, no date, revealed: .Clip style hoyer and [NAME] sling sizes. Trim Color . M [medium] .Yellow . 121-165 lbs (55-75 kg [kilograms]) . L [large] . [NAME] . 154-264 lbs (75-120 kg)</p> <p>Record review from 5/13-17/24 revealed Resident #195's weight on 5/14/24 (date of admission) was 143.6 lbs.</p> <p>During an interview on 5/16/24 at 12:35 PM, the Director of Nursing (DON) stated it was the expectation of the RA Supervisors to size residents for lift slings when they were admitted . If the resident did not like the sling, staff would work with the resident to find something that would work. The DON further stated that Resident #195 developed anxiety over lifts when he/she was in the hospital, and it continued here at the facility. The DON stated that the reason a sit to stand sling bunched up into Resident #195's armpits was because the resident was not engaging his/her legs.</p> <p>Review of Lippincott procedures - Transfer with a mechanical lift, long-term care, revised 5/21/23, revealed: . Preparation of Equipment .Check the size of the sling before applying it to the resident because improper sizing could result in injury.</p> <p>Neuro Checks</p> <p>Resident #18</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review from 5/13-17/24 revealed Resident #18 was admitted to the facility with diagnoses that included cerebral infarction (a brain lesion in which a cluster of brain cells die when they don't get enough blood flow), aphasia (impaired speech due to damage in the brain), atrial fibrillation, and unspecified symptoms and signs involving cognitive functions and awareness.</p> <p>Further review of the Resident #18's medical record revealed the resident had seven falls in the facility since 10/29/23. Four of these falls were unwitnessed, dated 11/7/23; 12/9/23; 1/4/24; and 1/7/24.</p> <p>Review of Resident #18's Minimum Data Set (MDS - a federally mandated nursing assessment) assessment, an admission assessment dated [DATE] (and prior to any unwitnessed falls), revealed Resident #18 was not able to verbally speak, rarely or never made self understood, and rarely or never understood others.</p> <p>Fall Incident on 11/7/23</p> <p>A review of Resident #18's Incident Audit Report, dated 11/7/23 at 11:30 PM, revealed: Staff alerted this nurse to resident being noted on floor laying flat on back with [his/her] [wheelchair] behind [him/her]. [He/she] was laying in doorway of double doors leading out into hallway from Town Square. Doors were closed previously. This nurse assessed. no injuries noted nor indicated from resident. Does not appear to have hit [his/her] head as no injuries were noted there either.</p> <p>A review of Resident #18's #683 Un-witnessed Fall Incident report, dated 11/7/23 at 11:30 PM, revealed: Resident Description: Resident Unable to give Description.</p> <p>A review of Resident #18's Post Fall Charting, dated 11/8/23 at 12:19 AM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 11/8/23 at 3:21 PM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 11/9/23 at 12:28 PM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>Further review of the medical record revealed no neuro checks were documented for this unwitnessed fall.</p> <p>Fall Incident on 12/9/23</p> <p>A review of Resident #18's Incident Audit Report, dated 12/9/23 at 9:05 AM, revealed: At approximately [9:05 AM] [Resident #18] was found on the floor near the far end of Sunset; we examined [him/her]; took [his/her] vitals, and lifted [him/her] back into [his/her] wheelchair; [he/she] has a small skin tear on [his/her] left hand and a minor abrasion on [his/her] right knee. Factors. Cognitively impaired; [he/she] must have either tried to walk or leaned forward and fell .</p> <p>A review of Resident #18's #694 Un-witnessed Fall Incident report, dated 12/9/23, revealed: the Resident Description section of the report was left blank.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #18's Post Fall Charting, dated 12/9/23 at 12:56 PM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 12/10/23 at 3:29 AM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 12/11/23 at 5:22 PM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>Further review of the medical record revealed no neuro checks were documented for this unwitnessed fall.</p> <p>Review of Resident #18's MDS assessment, a quarterly assessment dated [DATE], revealed Resident #18 was not able to verbally speak, rarely or never made self understood, and sometimes understood others.</p> <p>Fall Incident on 1/4/24</p> <p>A review of Resident #18's Incident Audit Report, dated 1/4/24 at 9:33 AM, revealed: The RA [Resident Assistant] found [Resident #18] on the floor next to [his/her] bed looking toward the door with [his/her] feet straight out in front of [him/her].</p> <p>A review of Resident #18's #705 Un-witnessed Fall Incident report, dated 1/4/24, revealed: Resident Description: Resident Unable to give Description.</p> <p>Review of Resident #18's Progress Note, dated 1/4/24 at 9:47 AM, revealed: [Resident #18] was found on the floor sitting with [his/her] back at [his/her] bed and feet stretched out in front of [him/her]. No demonstration of pain noted with active and passive ROM [range of motion]. [He/she] is resistant to care and combative during skin check, [morning] care, and toileting. No new bruise, redness, or apparent injury is found.</p> <p>A review of Resident #18's Post Fall Charting, dated 1/4/24 at 10:06 AM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 1/5/24 at 4:00 AM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 1/5/24 at 10:08 AM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>Further review of the medical record revealed no neuro checks were documented for this unwitnessed fall.</p> <p>Fall Incident on 1/7/24</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #18's Incident Audit Report, dated 1/7/24 at 2:48 AM, revealed: Resident was noted to be sitting on buttocks [with] legs spread out in front of [him/her]. [He/she] was assessed but no injuries nor [signs/symptoms] of pain/discomfort noted. Head was not hit. [Wheelchair] was not far behind [him/her].</p> <p>A review of Resident #18's #706 Un-witnessed Fall Incident report, dated 1/7/24 at 2:48 AM, revealed: Resident Description: Resident Unable to give Description.</p> <p>A review of Resident #18's Post Fall Charting, dated 1/7/24 at 2:54 AM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 1/7/24 at 12:42 PM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 1/8/24 at 3:36 AM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 1/8/24 at 3:11 PM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 1/9/24 at 3:08 AM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 1/9/24 at 3:51 PM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>Further review of the medical record revealed no neuro checks were documented for this unwitnessed fall.</p> <p>Review of Resident #18's care plan revealed an identified focus of ADL [Activities of Daily Living] Function/Risk for Falls, dated 9/6/23. Further review of the interventions for this identified problem revealed no intervention to follow fall protocols.</p> <p>During an interview on 5/17/24 at 8:52 AM, when asked what he/she would do if a resident was rarely or never understood, and there was a fall, LN #4 stated he/she would ask what happened, assess the resident for injuries, and for unwitnessed falls he/she would do neuro checks because you didn't know if the person could even remember if they hit their head.</p> <p>Resident #20</p> <p>Record review from 5/13-17/24 revealed Resident #20 was admitted to the facility with diagnoses that included dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking).</p> <p>Further review of the Resident #20's medical record revealed the resident had three falls in the facility since 3/30/23. One of these falls was unwitnessed, dated 2/16/24.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #20's MDS assessment, a quarterly assessment dated [DATE] (prior to the unwitnessed fall), revealed Resident #20's speech was unclear, rarely or never made self understood, and rarely or never understood others.</p> <p>Fall Incident on 2/16/24</p> <p>A review of Resident #20's Incident Audit Report, dated 2/16/24 at 2:48 AM, revealed: [Resident #20] had an unwitnessed fall after awakening from [his/her] nap. A loud thud was heard in [his/her] room. [Resident #20] was found sitting quietly on the floor of [his/her] room. [He/she] was wearing grippy socks and there was nothing in the environment that could have caused the fall. [Resident #20] was assisted to [his/her] feet and returned to bed. [He/she] was assessed for pain and injury. A minor abrasion and a 3.9cm [centimeter] [by] 1.8cm contusion was noted on [his/her] right elbow. [He/she] had no complaint of pain and no non-verbal complaint of pain until the contusion was palpated.</p> <p>A review of Resident #20's #721 Un-witnessed Fall Incident report, dated 2/16/24 at 5:42 PM, revealed: Resident Description: Resident Unable to give Description.</p> <p>A review of Resident #20's Post Fall Charting, dated 2/16/24 at 6:19 PM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 2/17/24 at 5:52 PM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 2/18/24 at 4:20 AM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 2/18/24 at 5:57 PM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 2/19/24 at 4:37 AM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>A review of Resident #18's Post Fall Charting, dated 2/19/24 at 5:23 PM, revealed vital signs were taken. Further review revealed: . Did the resident hit their head? Answer, No.</p> <p>Review of Resident #18's care plan revealed an identified focus of Falls. Further review of the interventions revealed follow facility fall protocols.</p> <p>During an interview on 5/16/24 at 3:02 PM, the Assistant Director of Nursing (ADON) stated there were no neuro checks completed with Resident #20's unwitnessed fall on 2/16/24.</p> <p>Fall Protocol</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/15/24 at 2:20 PM, LN #3 stated when a resident falls, there was a risk evaluation, in the occurrence reporting system, that was completed. This would allow the LN to document the details of the incident, including injuries; factors; witnesses; action; notes; and sign off. LN #3 further stated there was a huddle form, located in the main nursing room, that was filled out as well. From this huddle form, a huddle meeting occurred to review the incident and discuss the situation and what could be improved.</p> <p>During an interview on 5/15/24 at 2:40 PM, LN #1 stated there was a checklist in a binder at the main nurses' station to help nurses follow called, PCC [point click care] workflow: Risk Management/Resident Fall. For unwitnessed falls, LN #1 stated nurses would assess the resident, call 911 if needed, call the physician, and completed three days of vitals, neuro checks, and skin checks. LN #1 further stated that an order for neuro checks could be placed in the electronic records as an order.</p> <p>Review of the facility's Fall Action Lesson Learned (Huddle Form) form, undated, revealed this blank form had a section to check off interventions completed due to a fall: Huddle Form, Accident/Injury Report; Fall Risk Assessment; 48[hour]/72[hour] monitoring nurse order; faxed MD; called family; care plan. Further review revealed no neuro check option to select.</p> <p>Review of the facility's PCC [point click care] workflow: Risk Management/Resident Fall, dated 1/29/19, revealed steps taken when a fall occurred: . Under the Clinical tab go to Care Management and choose Risk Management. Click Activate and New. Fill out the incident box-Resident name, date and time, type of incident and incident location. Save. Fill out the information in each tab section across the top of the screen. complete the Morse Fall Scale and initial Post Fall Charting assessment. Review care plan. If serious injury occurred [fracture] or head injury, notify the state. fill out fall huddle form. add order for post fall charting.</p> <p>Further review revealed no guidance for unwitnessed falls, or any time neuro checks would be initiated.</p> <p>Review of the facility's policy Falls Assessment and Intervention, effective September 2023, revealed: . Applies To: Identify residents at risk for falls, establishing the plan of care for those residents and following up on any incidents of falling.Policy: Residents will be assessed for fall risk. Interventions will be used and monitored as appropriate. Evaluation. The Falls Huddle Form will be used within 30 minutes of the fall, whenever possible, to evaluate causes and initiate interventions. Post-Fall Assessment. The incident will be entered into incidents in EMR [electronic medical record] by staff involved. Notification of physician and family will be completed. The Falls Huddle will be held and the completed form will be submitted to the Director of Clinical Services. Orders for follow up assessment will be entered in the EMR. The administrator will be the only one to click the finalize button in the EMR.</p> <p>Further review revealed no guidance for unwitnessed falls, or any time neuro checks would be initiated.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40259</p> <p>Based on record review and interview, the facility failed to adequately monitor the functional status of wander guard tags (a safety assistance device placed on a resident at risk for wandering and possible elopement. This device would trigger an alarm at any exit equipped with a wander guard sensor, alerting staff to a possible elopement attempt).</p> <p>Specifically, the facility used an outdated, obsolete tag battery tester, incapable of accurately indicating battery level status, for 1 Resident's (#30) tag device, out of 3 residents reviewed with wander guards, and which resulted in an elopement from the facility. This failed practice placed all residents with wander guard safety precautions (based on a census of 6) at risk for wander guard tag failure and possible elopement.</p> <p>Findings:</p> <p>Resident #30</p> <p>Record review on ,d+[DATE]-,d+[DATE] revealed Resident #30 was admitted to the facility with a diagnosis of dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking).</p> <p>Review of Resident #30's care plan revealed an identified focus for Behavior. [Resident #30] has history of wandering related to dementia, dated [DATE]. Further review revealed interventions that included, [Resident #30] has a wander guard on [his/her] [left] ankle. Ensure the device is in place [every] shift. RA [Resident Aide] supervisor to check function weekly.</p> <p>Review of Resident #30's medical record revealed two separate elopement attempts and two successful elopements:</p> <ul style="list-style-type: none"> - [DATE] at 5:40 PM, Incident Note: [Resident #30] exited out the alarmed sunset door. was immediately escorted back in the same doorway. was wearing [his/her] wander guard during [his/her] elopement. - [DATE] at 6:32 PM, Behavior Note: Resident intended to leave out the front door but the wander guard alarmed and staff was able to redirect [him/her]. - [DATE] at 8:34 PM, Behavior Note: Attempted to lead another resident out the front doors this evening. Alarms alerted staff and was able to redirect without issue. - [DATE] at 6:01 PM, Communication with Physician: [Resident #30] was found to have eloped and was found walking in the parking lot ambulating with wheeled walker by staff member and was easily escorted back into building. Wander guard battery was not working, so door did not alarm. <p>Review of Resident #30's wander guard tag testing log, revealed his/her tag was tested the day prior, on [DATE], and passed the test as being functional.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Heritage Place		STREET ADDRESS, CITY, STATE, ZIP CODE 232 Rockwell Avenue Soldotna, AK 99669	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Incident Audit Report, dated [DATE] through [DATE], revealed: Description of Action Taken: [Resident #30] was helped back into building and [Resident #30's] [wander guard] was in place on [his/her] left ankle. The battery in [his/her] [wander guard] was found to be not working so that is why the front door alarm did not go off. [RA Supervisor #1] said [he/she] had checked the battery on [his/her] [wander guard] yesterday and it was working.</p> <p>Wander Guard Battery Tester</p> <p>During an interview on [DATE] at 3:18 PM, the Assistant Director of Nursing (ADON) stated the wander guard tag batteries were not rechargeable and the whole tag device must be replaced if the battery died . The ADON further stated that RA Supervisors checked the batteries for all wander guard tags weekly to ensure they were functioning.</p> <p>During an interview on [DATE] at 3:21 PM, when asked how the wander guard tag batteries were tested , RA Supervisor #1 stated he/she used an Accutech Tag Activator/Deactivator device to check all wander guard tags weekly every Wednesday. After turning the device on, RA Supervisor #1 held the wander guard tag to the back of the device and pressed a button labeled TAD and waited for the Signal Strength lights to appear. There were two lights under the Signal Strength label, one labeled Tag is very near and one labeled Tag in Area. If the two lights activated, RA Supervisor #1 interpreted the tags as functioning.</p> <p>RA Supervisor #1 further stated he/she also looked for a light labeled Active Band Removal or Low Battery on Tag. If this light activated, RA Supervisor #1 interpreted the tag as having a low battery and replaced it.</p> <p>Record review on [DATE] at 4:08 PM, revealed the facility used an Accutech wander guard system. Further review revealed the device to check the wander guard tag batteries was an Accutech Tag Activator/Deactivator, FCC ID: JM7-IGWT-6660021.</p> <p>During an interview on [DATE] at 9:02 AM, Accutech Representative #1 stated the Accutech Tag Activator/Deactivator model the facility was using was [AGE] years old and obsolete. It was not recommended to be used anymore, as there had been 3 or 4 revisions since that particular model was in use. Accutech Representative #1 further stated that the model the facility was using was limited and would not give an accurate determination of the tag's battery status, the device will tell you the light is flashing and currently working but does not tell you how low the battery currently is. If the tag is weak or close to shutting down due to low battery, the device won't tell you that. It will tell you it is functioning, but the tag [could] shut down an hour later. Accutech Representative #1 further stated, when the tag goes weak it may not accurately trip the wander guard system at the door.</p> <p>During an interview on [DATE] at 10:10 AM, the Support Services Manager stated the wander guard system in the facility was about [AGE] years old and it was very expensive to update.</p> <p>Review of the facility's policy Resident Elopement Prevention, effective [DATE], revealed: . Proper functioning of the device is checked weekly and the results are recorded. Maintenance is notified of the need for any repair/replacement of the device.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47929</p> <p>Based on observation, interview, and record review, the facility failed to ensure expired medical products were removed from the medical supply storage areas. This failed practice placed all residents (based on a census of 43) at risk for adverse effects or complications from use of the expired products.</p> <p>Findings:</p> <p>Central Medical Supply Room:</p> <p>An observation and concurrent interview on [DATE] at 9:09 AM, revealed the following expired medical supplies:</p> <p>5 - Bard Urethral Catheterization trays (contains a flexible tube that is inserted through the urethra to help drain urine from the bladder) with preconnected drain bag, 15 french (size of the tube), expired on [DATE];</p> <p>3 - Bard 14 french urethral catheters with a coude tip (meaning, the tip is slightly bent, helping the catheter bypass obstructions within the urethra that would hinder a straight catheter's path), expired on [DATE]; and</p> <p>1 - Bard 14 french urethral catheter with a coude tip, expired on [DATE].</p> <p>Licensed Nurse (LN) #1 stated the maintenance department was responsible for stocking the central supply room, however, the nurses checked the expiration dates as they gathered their supplies to stock the nurses' stations. LN #1 further stated the nurses stocked the main nurses' station/med room and the Sitka [NAME] Unit medication/supply corner. If the nurses found an expired item, they were expected to properly dispose of the item.</p> <p>Sitka [NAME] Unit Medication/Supply Corner:</p> <p>An observation and concurrent interview on [DATE] at 10:10 AM, revealed the following expired medical supplies:</p> <p>1 - BD 5 ml (milliliter) syringe, expired on [DATE]; and</p> <p>1 - Bard Urethral Catheterization tray with preconnected drain bag, 15 french, expired [DATE].</p> <p>LN #3 stated the staff would have checked the expiration date as the supplies were stocked. The supplies were gathered from the central medical supply room.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 9:23 AM, the Support Services Manager (SSM), stated he ordered and stocked the central supply room and staff stocked their work area. When asked what the process was for ensuring products for the facility had not expired, the SSM stated the expiration dates were checked while he ordered the supplies twice a week. When asked about the multiple expired Bard Urethral Catheterization tray with preconnected drain bags, the SSM stated they must have received an expired case.</p> <p>Review of the facility's policy Monitoring Supply Dates, last reviewed on ,d+[DATE], revealed: Procedure .All department manager/supervisors are responsible [for] monitoring supplies stocked in their department. However, the Supports Services Manager will conduct spot inspections of storage areas during the bi-weekly Housekeeping inspection to ensure proper rotation of materials stocked in the Sitka storage area, and the Med-room [medication room] .During spot checks, items which will expire before next check are removed from inventory.</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>40259</p> <p>Based on observation, interview, and record review, the facility failed to ensure appropriate competencies and skills sets were properly established for Resident Aides (RAs), Licensed Nurses (LNs), and Food Service Staff who prepared modified diets for Sitka [NAME] residents. Specifically, the facility failed to ensure: 1) the RAs and LNs, as well as food service staff, were trained to operate a Cuisinart chopper/grinder food processor used on the Sitka [NAME] unit for preparing modified diets; and 2) RAs and LNs had food worker cards to certify they were appropriately trained to prepare modified diets. These failed practices placed 3 unsampled Sitka [NAME] residents (#s 15, 21, and 38) who were on modified diets, and potentially future residents placed on modified diets, at risk for improper food preparation and food borne illnesses.</p> <p>Findings:</p> <p>Food Processor Training and Operation</p> <p>During an interview on 5/13/24 at 11:46 AM, the Dietary Manager stated all personnel in the kitchen preparing food were required to wear a hairnet.</p> <p>An observation on 5/13/24 at 3:32 PM, revealed RA #1 prepared a minced and moist modified diet for Resident #15 on the Sitka [NAME] unit. Further observation revealed RA #1 placed approximately 3/8-inch by 1 1/2-inch round pieces of sausage into a Cuisinart chopper/grinder food processor and started the appliance by pushing a button. After the food processor automatically stopped, RA #1 then opened the processor's lid and pulled out and discarded larger pieces of sausage, that did not chop or grind down, and sausage casein out of the bowl with his/her gloved fingers. RA #1 was not wearing a hair net during this meal preparation. RA #1 then plated the rest of the meal and served the resident.</p> <p>During an interview and simultaneous observation on 5/14/24 at 10:46 AM, RA #1 stated the food processor appliance was used for residents with modified diets. He/she demonstrated the chopper/grinder process by placing one full-link sausage, during the breakfast meal, in the Cuisinart appliance. He/she stated the sausage was for a resident on a modified diet of minced and moist. RA #1 stated the texture of food was determined and gauged by the order and knowing their residents well and what they could handle. Further observation revealed RA #1 was not wearing a hair net during this meal preparation.</p> <p>During an interview on 5/16/24 at 11:03 AM, the Dietician initially stated that modified diets were to be completed by kitchen staff in the kitchen. When told of the observations from 5/13/24 and 5/14/24 of the RAs on Sitka [NAME] preparing minced and moist diets with a Cuisinart food processor, the Dietician stated she had never seen a food processor used on the unit before.</p> <p>The Dietician further stated that the International Dysphagia Diet Standardisation Initiative (IDDSI) training the RAs and LNs received would have prepared them to make modified diets.</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/16/24 at 11:03 AM, the Administrator stated that RAs and LNs were trained on the consistencies of modified diets.</p> <p>During an interview on 5/16/24 at 11:49 AM, LN #3 stated 3 residents (#s 15, 21, and 38) had minced and moist diets. LN #3 further stated that staff used a food processor for minced and moist diets and food was ground in the processor till it stopped and staff would add gravy or broth for moisture if needed. When asked how RAs and LNs were trained to use the food processor, LN #3 stated RAs taught each other.</p> <p>Record review of Resident #15's provider diet order, dated 6/14/22, revealed: Resident choice/texture as tolerated diet. Easy to Chew/Level 7 texture. Further review revealed: finger foods. There was no minced and moist diet ordered for Resident #15.</p> <p>Record review of Resident #21's provider diet order, dated 8/19/19, revealed: Minced and Moist/Level 5 texture. Further review revealed: . texture as tolerated ranging mechanical soft to puree.</p> <p>Record review of Resident #38's provider diet order, dated 5/2/24, revealed: Minced and Moist level 5 texture. Further review revealed: . Resident choice/texture as tolerated. Diet is MM5 [minced and moist, level 5]/PU4 [pureed, level 4] depending on [resident's] alertness and abilities.</p> <p>An observation on 5/16/24 at 2:14 PM, of Sitka Rose's Cuisinart chopper/grinder food processor revealed there were two buttons on the processor, one labeled chop and one labeled grind. The opening of the processor bowl was wide, allowing for contact with blades of the processor with fingers.</p> <p>During an interview on 5/16/24 at 2:15 PM, when asked about the Cuisinart food processor and what level of diet the processor made, the Dietary Manager stated level 3 (IDDSI level 3 - liquidized diets). The Dietary Manager stated the staff would add gravy or broth and push the processor's button for 3 to 4 minutes until you reach grind level. When asked if the food processor would make level 5 minced and moist modified diets, the Dietary Manager stated, yes, you would add gravy or broth and process for 10 minutes.</p> <p>Review of the Cuisinart Instruction [and] Recipe Booklet, dated 2015, revealed: .</p> <ul style="list-style-type: none"> - Important Safeguards: When using an electrical appliance, basic safety precautions should always be adhered to. Read all instructions. - Tips for Processing Food. Size. Always cut large pieces of food into smaller pieces for even size - about 1/2 inch. or as specified under Operation/Technique. if you don't start with pieces that are small and uniform, you will not get an even chop. Selecting the Right Operating Control. Use the Chop function for chopping, pureeing and mixing. It is the right choice, for example, for chopping soft, fragile food. Pulse action is best when you are using the Chop function. Two or three pulses are often enough. Use the Grind function for grinding spices, and for chopping hard food. Continuous-hold action is best when you are using Grind function. Never operate the. Chopper/Grinder continuously for longer than 1 minute at a time. - The Cuisinart Elite Collection Chopper/Grinder is intended for HOUSEHOLD USE ONLY. <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Operation/Technique Chart: Meats. Chop. Pulse to chop, or process continuously to puree. Cooked meat. cut up to 8 ounces into 1/2-inch pieces.</p> <p>Review of the facility's policy Safety in Food Service, effective date November 2023, revealed: . Equipment Hazards. Never use machinery you have not been [trained] to use. Food Grinders. Food grinders should be equipped with narrow necks to make it impossible to reach the cutters with the fingers. General Precautions. Keep clean. Wash hands thoroughly before handling food or dishes. Food service personnel must wear hairnets while on duty.</p> <p>Food Worker Cards</p> <p>During an interview on 5/16/24 at 11:03 AM, when asked if RAs and/or LNs who prepared modified diets had food worker cards, the Administrator stated no RAs or LNs had food worker cards.</p> <p>Review of the State of Alaska web site for food worker cards, accessed on 5/16/24 at https://dec.alaska.gov/eh/fss/food-worker-card#about, revealed: . The Alaska Food Code requires food workers to obtain a food worker card. About the Food Worker Card Program. The goal of the Food Worker Card program is to educate food workers in Alaska about safe food practices and verify they have the essential knowledge needed to protect public health in food facilities. Food Worker Card is Required. Any person working with unpackaged food, potentially hazardous food, or food-contact surfaces is considered a food worker and needs a food worker card.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40259</p> <p>Based on observation, interview, and record review, the facility failed to ensure that food was stored, prepared, and served in accordance with professional standards for food safety. Specifically, the facility failed to ensure: 1) food was stored under proper sanitation and food handling practices in the main kitchen; 2) food was stored under proper sanitation and food handling practices on the Sitka [NAME] unit; and 3) the dishwasher water temperature was at appropriate temperature range, prior to washing dishes, for proper sanitation of all dishware and food service equipment. These failed practices had the potential of causing or spreading foodborne illness to all residents, based on a census of 43.</p> <p>Findings:</p> <p>Main Kitchen</p> <p>An observation, during the initial kitchen tour, on 5/13/24 at 11:05 AM, revealed:</p> <p>1) Dry Storage/Pantry area:</p> <ul style="list-style-type: none"> - 4- 28-ounce containers of Danish Orchards Blackberry Fruit Preserves, manufacture expiration date was 4/9/24; - Penne Noodles loose, in Rubbermaid bin, no packaging and no open date on bin; and - Fettuccine Noodles loose, in Rubbermaid bin, no packaging and no open date on bin. <p>2) Refrigerator:</p> <ul style="list-style-type: none"> - 1- 16-ounce container of Roseli Parmesan Cheese - 1/2 full - no open date; - 1- 1 quart container of [NAME] Horseradish - 1/2 full - no open date; - 1- 48-ounce container of Real Lemon Juice - 1/3 full - no open date; - 1- 1-gallon container of Sliced Pepperoncini - 3/4 full - no open date; - 1- 5-pound container of Sour Cream - 1/2 full - no open date; - 1- 4.5-pound container of Minors Sweet and Sour Sauce - 1/2 full - no open date; - 1- 1-gallon container of Monarch 3/16-inch Crinkle Cut Dill Pickles - 1/4 full - no open date; and - 1- 1-gallon container of Monarch Sweet Pickle Relish - 1/4 full - no open date. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3) Freezer:</p> <ul style="list-style-type: none"> - 1- Ziploc bag of one brown meat roast, labeled Roast Beef, dated 3/17; - 1- clear plastic bag with frozen slices of garlic bread labeled Garlic Bread - use first - no open date. <p>3) Central Kitchen area:</p> <ul style="list-style-type: none"> - 1 Large rolling white container with clear lid labeled Peas - contained a mix of open individual bags marked: pearl barley, great northern beans, pinto beans, and navy beans, no open dates. - 1 Large rolling white container with clear lid labeled Pancake Mix - contained a large plastic bag with loose white powder, no packaging, no label, no open date. - 1 Large rolling white container with clear lid that did not close and not labeled - contained a mix of open individual bags marked: powdered sugar, granulated sugar, and cinnamon sugar, no open dates. - 1 Pan of cooked food, set on top of a pan filled with ice, on kitchen prep table. No lid on pan, open to air, filled with contents of orange, white, brown chunks with brownish liquid (gravy like) with spoon in the contents. <p>An observation on 5/13/24 at 11:44 AM, revealed Food Service Assistant (FSA) #1 was preparing food-filled plastic cups labeled egg salad and tuna salad in the kitchen. FSA #1 was not wearing a hairnet.</p> <p>During an interview on 5/13/24 at 11:46 AM, the Dietary Manager stated every container should be labeled with an open date when the container was opened. The Dietary Manger further stated all personnel in the kitchen and preparing food were required to wear a hairnet.</p> <p>Sitka [NAME] Unit</p> <p>An observation of the Sitka [NAME] unit kitchenette on 5/15/24 at 2:10 PM, revealed:</p> <p>1) Cupboards and Countertop:</p> <ul style="list-style-type: none"> - 1- opened box of Pedialyte electrolyte powder (6 individual packets in a box) with a manufacture use by date of 01 [DATE]; - 1- unopened box of Pedialyte electrolyte powder (6 individual packets in a box) with a manufacture use by date of 01 [DATE]; - 1- opened box of [NAME] Microwave Popcorn Movie Theatre Butter (1 package in box) with a manufacture expiration date of 11/30/21; - 1- 5-fluid ounce container of Kikkoman Soy Sauce - 1/2 full - No open date; <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- 1- 12-ounce container of [NAME] Bee Pure Honey Clover - 1/4 full - No open date; and</p> <p>- 1- container of Local Raw Unfiltered Honey - 1/4 full - No open date.</p> <p>2) Refrigerator:</p> <p>- 1- 20-ounce container of ketchup - 1/2 full - no open date;</p> <p>- 1- 13-ounce container of mustard - 3/4 full - no open date;</p> <p>- 1- 20-ounce container of mayonnaise - 1/2 full - open date not readable (smudged);</p> <p>- 1- 12-ounce container of tabasco sauce - 1/4 full - dated 11/10/22.</p> <p>3) Freezer:</p> <p>- 1 Ziploc bag with 13 blueberry muffins - dated 7/10.</p> <p>Review of the facility's policy Food Labeling and Dating, effective date November 2023, revealed: .All food items are dated before they are stored. The manufacturer's date of expiration or use by will be the date to dispose the product. Items opened and stored in their original container. will have the letters OP on them, with the date that the product was opened. Once foods have been cooked to the proper temperature, held, and properly cooled; they may be labeled, dated, and may be frozen.</p> <p>Review of the facility's policy Monitoring Supply Dates, effective date November 2023, revealed: . the food services will monitor all groceries in the dietary department storeroom, cabinets, refrigerators, and freezers (including Sitka Rose). The dietary supervisor will perform weekly inspections of all areas where food is stored to ensure proper rotation and fresh dates are maintained. During spot-checks, items which will expire before next check are removed from inventory.</p> <p>Review of the facility's policy Safety in Food Service, effective date November 2023, revealed: General Precautions. Keep clean. Wash hands thoroughly before handling food or dishes. Food service personnel must wear hairnets while on duty.</p> <p>Dishwasher</p> <p>An observation and concurrent record review on 5/13/24 at 11:45 AM, revealed a May 2024 temperature log posted in the main kitchen near the dishwasher. A review of the log revealed the dishwasher temperatures for each cycle (wash, rinse, and sanitize) were documented for each meal of the day (breakfast, lunch, and dinner). Further review revealed a temperature target range of 120 degrees Fahrenheit (F) was under each cycle name on the log, however many of the temperatures logged for May 2024 were below this target temperature.</p> <p>An observation on 5/15/24 at 9:43 AM, revealed the label on the facility's dishwasher identified it as an American Dish Service dishwasher, model series AFC-3D-S. Further review of the label revealed: wash temperature 120 degree F minimum and rinse temperature 120 degree F minimum.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Heritage Place		STREET ADDRESS, CITY, STATE, ZIP CODE 232 Rockwell Avenue Soldotna, AK 99669	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation on 5/15/24 at 9:44 AM, FSA #4 demonstrated the steps of a dishwasher cycle: rinse off the dishes of any food particles, place dishes in a standard dish rack and put into the dishwasher, and then lower the dishwasher cover which initiated the wash, rinse, and sanitize cycles. Further observation revealed the wash cycle water temperature was 113 degrees F and the rinse cycle was 117 degrees F.</p> <p>During an interview on 5/15/24 at 9:44 AM, when asked if he/she knew the target temperature range for the dishwasher to properly clean and sanitize the dishes, FSA #4 stated he/she did not know what the target temperature should be.</p> <p>Record review of the facility kitchen's temperature logs for the dishwasher, dated 1/1/24 through breakfast of 5/17/24, revealed the number of times a dishwasher cycle was below 120 degrees for each meal:</p> <p>1) January 2024: (93 total opportunities)</p> <p>- Breakfast: Wash cycle - 24 out of 31 times; Rinse cycle - 25 out of 31 times; Sanitization cycle - 15 out of 31 times.</p> <p>- Lunch (three days were not documented): Wash cycle - 22 out of 28 times; Rinse cycle - 20 out of 28 times; Sanitization cycle - 13 out of 28 times.</p> <p>- Dinner: Wash cycle - 16 out of 31 times; Rinse cycle - 16 out of 31 times; Sanitization cycle 8 out of 31 times.</p> <p>2) February 2024 (87 total opportunities):</p> <p>- Breakfast: Wash cycle - 24 out of 29 times; Rinse cycle - 25 out of 29 times; Sanitization cycle - 19 out of 29 times.</p> <p>- Lunch: Wash cycle - 22 out of 29 times; Rinse cycle - 21 out of 29 times; Sanitization cycle - 10 out of 29 times.</p> <p>- Dinner (one day was not documented): Wash cycle - 23 out of 28 times; Rinse cycle - 16 out of 28 times; Sanitization cycle - 6 out of 28 times.</p> <p>3) March 2024 (93 total opportunities):</p> <p>- Breakfast: Wash cycle - 30 out of 31 times; Rinse cycle - 25 out of 31 times; Sanitization cycle - 16 out of 31 times.</p> <p>- Lunch: Wash cycle - 23 out of 31 times; Rinse cycle - 20 out of 31 times; Sanitization cycle - 10 out of 31 times.</p> <p>- Dinner (two days were not documented): Wash cycle - 19 out of 29 times; Rinse cycle - 15 out of 29 times; Sanitization cycle - 6 out of 29 times.</p> <p>4) April 2024 (90 total opportunities):</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Heritage Place		STREET ADDRESS, CITY, STATE, ZIP CODE 232 Rockwell Avenue Soldotna, AK 99669	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- Breakfast: Wash cycle - 27 out of 30 times; Rinse cycle - 30 out of 30 times; Sanitization cycle - 19 out of 30 times.</p> <p>- Lunch (one day was not documented): Wash cycle - 23 out of 29 times; Rinse cycle - 19 out of 29 times; Sanitization cycle - 13 out of 29 times.</p> <p>- Dinner (one day was not documented): Wash cycle - 21 out of 29 times; Rinse cycle - 22 out of 29 times; Sanitization cycle - 5 out of 29 times.</p> <p>5) May 2024 (49 total opportunities):</p> <p>- Breakfast: Wash cycle - 15 out of 17 times; Rinse cycle - 11 out of 17 times; Sanitization cycle - 4 out of 17 times.</p> <p>- Lunch: Wash cycle - 11 out of 16 times; Rinse cycle - 10 out of 16 times; Sanitization cycle - 3 out of 16 times.</p> <p>- Dinner: Wash cycle - 10 out of 16 times; Rinse cycle - 4 out of 16 times; Sanitization cycle - 2 out of 16 times.</p> <p>During an interview and concurrent observation on 5/15/24 at 10:10 AM, the Support Services Manager (SSM) stated the dishwasher was a chemical sanitizing dishwasher machine. An observation revealed the SSM ran the dishwasher and monitored the temperature with a facility maintenance temperature gauge. The first wash cycle revealed the wash temperature to be 112.4 degrees F and the rinse temperature to be 124.4 degrees F. The second wash cycle revealed the wash temperature to be 129 degrees F and the rinse temperature to be 130.2 degrees F. The third wash cycle revealed the wash temperature to be 126.6 degrees F and the rinse temperature to be 132.2 degrees F. The SSM stated he would like to see the dishwasher temperature reach 130 degrees F for proper washing and sanitation of dishes. The SSM further stated the food service staff needed to run the dishwasher a couple of times to get the water temperature up to the target temperature range prior to using it to wash dishes.</p> <p>An observation on 5/15/24 at 3:32 PM, revealed FSA #8 was preparing to wash dishes. FSA #8 ran an empty cycle which revealed a wash temperature of 104 degrees F and a rinse temperature of 113 degrees F. Further observation revealed FSA #8 ran the dishwasher 3 times in a row before preparing to wash a set of dishes. The next cycle with dishes, which was the fourth time the dishwasher was run in a row, revealed a wash temperature of 118 degrees F and a rinse temperature of 122 degrees F.</p> <p>During an interview on 5/15/24 at 4:08 PM, FSA #8 stated, I have to run them [meaning dishes] through multiple times if I step away to get more dishes. If I keep running the dishwasher it holds the temperature, if I stop, it drops.</p> <p>Review of the latest provided, facility dishwasher routine service report from Ecolab, dated 1/9/24, revealed the dishwasher was working well and sanitizing effectively at a documented wash temperature of 130 degrees F.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility's owner's manual for the American Dish Service, Upright Dishwashers. AF/AFC-3DS. , dated 10/1/22, revealed: . General. The chemical sanitizing agent provides comparable germ killing ability in 140 degree rinse water as in the conventional machines with 180 degree rinse. If water temperature gauge has not reached 120 [degrees] F. when the water level is just below overflow, drain water from the machine and continue to fill until proper temperature is attained.</p> <p>Review of the facility's General Operating Instructions for the American Dish Service dishwasher, undated, revealed: . It is recommended that 140 [degrees] water be used. Report to your supervisor if it is lower than 120 [degrees] or higher than 160 [degrees].</p> <p>Review of the facility's policy Dish Room Procedures [and] Sanitation Regulations, effective date November 2023, revealed: . Serving ware and utensils will be sanitized according to the procedures outlines below. Low Temp. Dish Machines minimum requirements: Wash cycle - 120 [degrees] F.</p>		