

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  06/13/2025
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>.</p> <p>Based on record review, observation, and interview the facility failed to ensure comprehensive care plans were revised to meet the changing needs of 3 residents (#s 26, 31, and 33), out of 12 sampled residents. Specifically, the facility failed to revise care plans to reflect: 1) the use of a foot cradle for Resident #26; 2) a change in cognition and activities of daily living (ADLs) for Resident #31, and; 3) the use of enhanced barrier precautions (EBP) for Resident #33. This failed practice placed the residents at risk for less than the highest practicable mental, physical, and psychosocial well-being.</p> <p>Findings:</p> <p>Resident #26</p> <p>Record review on 6/9-13/25 revealed Resident #26 was admitted to the facility with diagnoses that included vascular dementia (reduced blood flow to the brain affecting cognition and brain function), major depressive disorder, delusional disorder (a condition in which a person has one or more fixed persistent beliefs that are not based on reality), and disorders of bone density and structure.</p> <p>Random observations on 6/9-11/25 revealed Resident #26's feet were in a foot cradle (frame installed at the end of the bed to keep sheets/ blankets off the legs/feet), covered with a blanket.</p> <p>Review of Resident #26's Care Plan, revised on 5/13/25, revealed: [Resident #26] has an arterial ulcer of the Left middle Toe r/[related to] poor circulation . Interventions Monitor/document/report PRN [as needed] any s/sx[signs and symptoms] of infection . The use of the foot cradle was not in the care plan.</p> <p>During an interview on 6/9/25 at 2:25 PM, Resident #26 stated he/she had hammertoes [a foot condition where an imbalance of the muscles and ligaments around the toe joint causes the toes to bend in a downward position], the foot cradle was protecting his/her toes from touching the blanket.</p> <p>During an interview on 6/11/25 at 1:44 PM, Certified Nursing Assistant (CNA) #1 stated the foot cradle was in place for at least three weeks to protect Resident #26's left toes from touching the blanket.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/13/25 at 11:26 AM, the Director of Nursing (DON) stated there was no need for a physician's order for the use of the foot cradle because that was a nursing intervention. When asked if the use of foot cradle should be care planned, she stated it should be.</p> <p>Resident #31</p> <p>Record review on 6/9-13/25 revealed Resident #31 was admitted to the facility with diagnoses that included dementia (a decline in cognitive function), congestive heart failure (a long term condition where the heart is unable to pump blood efficiently), and ischemic cardiomyopathy (a condition where the heart muscle is weakened as a result of a heart attack or coronary artery disease).</p> <p>During a joint interview with Resident #31 and Resident #31's Resident Representative (RR) on 6/9/25 at 2:25 PM, Resident #31 would begin to speak but would stop mid-sentence. The RR stated Resident #31 had experienced a decline in cognition and ability to perform activities of daily living (ADLs) beginning around 5/26/25. The RR further stated the change had affected Resident #31's dexterity, eating, and mobility which resulted in increased dependence on staff to perform oral hygiene, feeding, dressing, amongst other ADLs. The RR added Resident #31 had used a walker but was not able to since his/her decline. The RR stated he/she was concerned Resident #31 was not receiving oral care on a regular basis.</p> <p>Review of Resident #31's care plan, focus last revised on 11/12/24, revealed, . [Resident #31 is independent for meeting emotional, intellectual, physical, and social needs . is independent for most activities of daily living . There were no interventions listed on the care plan regarding the resident's oral hygiene needs, or the resident's new needs for additional assistance with cognition or ADLs.</p> <p>Review of the MDS (Minimum Data Set, a federally required nursing assessment), dated 5/9/25, revealed the resident used a walker or a manual wheelchair for mobility. Further review of the assessment revealed:</p> <p>-</p> <p>. Eating .Setup or clean-up [staff] assistance .resident completes the activity .;</p> <p>-</p> <p>. Oral Hygiene . Setup or clean-up [staff] assistance .resident completes the activity .;</p> <p>-</p> <p>. Toileting Hygiene . Partial/moderate [staff] assistance .Helper does LESS THAN HALF the effort .;</p> <p>-</p> <p>. Upper body dressing . [staff] provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity .;</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation and concurrent interview on 6/9/25 at 12:53 PM, revealed Resident #33 had his/her name on the outside of his/her room with a small square picture of fireworks underneath. CNA #5 stated the fireworks meant the resident was on enhanced barrier precautions (EBP), meaning that staff would need to put on a gown and gloves if they were going to come in direct contact with the resident or the resident's body fluids.</p> <p>Review of Resident' #33's care plan, dated 4/7/25, revealed the EBP were not included in the care plan.</p> <p>During an interview on 6/12/25 at 2:23 PM, the Assistant Director of Nursing (ADON) stated EBP was active in Resident #33's electronic medical record. The ADON further stated EBP was not reflected in the care plan but should have been.</p> <p>Review of the facility's policy, Care Plans - Comprehensive Person-Centered [CPCCP], reviewed on 5/2025, revealed: The CPCCP will: . describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing . Incorporate identified problem areas . Assessments of residents are ongoing and care plans are revised as information about the resident and residents' condition change .</p> <p>.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>.</p> <p>Based on record review, interview, and observation, the facility failed to ensure consistent oral care was provided to 1 resident (# 31), out of 12 residents sampled. This failed practice had the potential to place the resident at risk of poor oral health outcomes.</p> <p>Findings:</p> <p>Record review on 6/9-13/25 revealed Resident #31 was admitted to the facility with diagnoses that included dementia (a decline in cognitive function), congestive heart failure (a long term condition where the heart is unable to pump blood efficiently), and ischemic cardiomyopathy (a condition where the heart muscle is weakened as a result of a heart attack or coronary artery disease).</p> <p>During an interview and concurrent observation on 6/9/25 at 2:25 PM, Resident #31's Resident Representative (RR) stated he/she was concerned Resident #31 was not receiving oral care on a regular basis. The RR also stated Resident #31 had experienced a health decline during the last two weeks, which affected the resident's cognition and activities of daily living, such as his/her dexterity. The change had resulted in the resident relying on staff to perform oral hygiene amongst other regular daily activities. During the interview, it was noted that Resident #31 had bad breath that was very notable.</p> <p>Review of Resident #31's Task Description list, undated, revealed: . Oral Hygiene . Frequency . Every Shift [twice a day] .</p> <p>Review of Resident #31's Oral Hygiene Task sheet, dated 5/15/25 through 6/12/25 (28 days), revealed Resident #31 only received oral care once daily on ten occasions (out of 56 opportunities per orders of twice daily).</p> <p>Review of Resident #31's Kardex sheet (a summary of a resident's care plan used by certified nursing assistants to provide care), dated 6/12/25, revealed no instructions regarding assistance with oral hygiene.</p> <p>Review of Resident #31's care plan, last revised on 11/12/24, revealed there were no interventions listed on the care plan regarding the resident's oral hygiene needs.</p> <p>During an interview on 6/13/25 at 10:52 AM, the Director of Nursing (DON) stated oral care was to be performed at least once per 12-hour shift and as needed. The care plan should have been updated to reflect Resident #31's current needs.</p> <p>.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>.</p> <p>Based on interview and record review, the facility failed to ensure the designated Director of Nursing (DON) worked 40 hours a week. This failed practice had the potential to place all residents (based on a census of 44) at risk of not receiving quality nursing services due to a lack of oversight.</p> <p>Findings:</p> <p>During the entrance conference interview on 6/9/25 at 10:45 AM, the DON stated she was designated as the DON and Administrator of the facility. She further stated she worked 35 hours per week as the DON and 5 hours per week as the Administrator.</p> <p>During a follow-up interview on 6/11/25 at 2:03 PM, the DON stated she did not complete a timecard because she was not required to clock-in. She stated she used Monday mornings to perform Administrator duties and the rest of the hours for DON time.</p> <p>During an interview on 6/13/25 at 9:30 AM, the DON stated she assumed the Administrator role since October 2024 after the previous Administrator retired.</p> <p>Record review on 6/11/25 at 2:35 PM, of the POSITION DESCRIPTION [PD], version 2024.04 Title: Administrative/Director, Heritage Place, revealed: POSITION SUMMARY: The Administrator/Director of Clinical Services provides leadership, and oversight to ensure the planning, organizing, and management of all aspects of the nursing home. Supervises and evaluates the care provided to residents to ensure the highest possible quality and compliance with state and federal regulations. In compliance with Long Term Care regulation F354, this position must include a minimum of 35 hours a week to be spent performing Director of Nursing (i.e., Director of Nursing duties).</p> <p>Further review revealed a handwritten note attached to the PD that read: no appoint [appointment] letters available. Org [organization] doesn't use. Another note attached read: 8-4:30 MF [Monday to Friday] 35 hours- wk [week] Focus on DON role 5 hr per wk focusing on Admin [administrator] role.</p> <p>.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .</b></p> <p>Based on observation and interview, the facility failed to ensure medical supplies were labeled appropriately and removed from storage if expired. These failed practices placed all residents (based on a census of 44) 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 on [DATE] at 10:05 AM, of the central medical supply room, revealed the following expired medical supplies:</p> <p>1 - Bard 16 french (diameter size) 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>2 - Bard 24 french urethral catheter, expired on [DATE].</p> <p>Further observation revealed the following sterile suction catheters without documented expiration dates:</p> <p>4 - AirLife Tri Flo 5/6 french suction catheters, with no expiration date; and</p> <p>1 - AirLife Tri-Flo 14 french suction catheter, with no expiration date.</p> <p>During an interview on [DATE] at 12:30 PM, the Support Services Manager (SSM) stated he ordered and stocked the central supply room and that some medical supplies were sourced from the hospital. When asked what the process was for ensuring medical supplies had not expired, the SSM stated the expiration dates were checked once a week and medical supplies from the hospital were stocked weekly. When asked about the products lacking expiration dates, the SSM acknowledged there was no facility process for verifying expiration dates on supplies without a visible date and stated that lot numbers could be used as a reference.</p> <p>During a follow-up interview on [DATE] at 1:38 PM, the SSM stated the expired foley catheters and the suction catheters without expiration dates were stocked by the hospital. The SSM stated there was not a good process in place to verify expiration dates.</p> <p>During an interview on [DATE] at 10:25 AM, Licensed Nurse (LN) #1 stated if nurses found an expired item, they were expected to dispose of the item. LN#1 further stated if he/she found a product with no expiration date, he/she would notify the nurse manager.</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 - Many</p>	<p>Review of the facility's policy Monitoring Supply Dates, last reviewed on 11/2024, revealed: Procedure .4. 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] .5. During spot checks, items which will expire before next check are removed from inventory.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>.</p> <p>Based on record review, observation, and interview the facility failed to ensure pureed food was prepared to the appropriate consistency to meet 3 resident's (#6, #15, and #19 ) individual needs out of 3 residents on a pureed diet. This failed practice had the potential to place the residents at risk for aspiration and compromised nutritional intake.</p> <p>Findings:</p> <p>Record review on 6/9-13/25 revealed Resident #6 was admitted to the facility with diagnoses that included multiple sclerosis (a disease of the central nervous system marked by numbness, weakness, loss of muscle coordination, and problems with vision, speech, and bladder control), Alzheimer's disease (progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain), and dysphagia (difficulty swallowing). Further review revealed Resident #6 was on a pureed/level four texture diet (foods that are blended to a smooth, thick consistency without lumps, making them safe and easy to swallow for individuals with chewing or swallowing difficulties).</p> <p>Record review on 6/9-13/25 revealed Resident #15 was admitted to the facility with diagnoses that included dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking) and anxiety. Further review revealed Resident #15 was on a pureed/level four texture diet.</p> <p>Record review on 6/9-13/25 revealed Resident #19 was admitted to the facility with diagnoses that included dementia, depression and dysphagia. Further review revealed Resident #19 was on a pureed/level four texture gluten free diet.</p> <p>An observation and concurrent interview in the main kitchen on 6/11/25 at 3:05 PM, [NAME] #2 prepared pureed ham and pureed tomato soup. [NAME] #2 blended diced ham with an unmeasured amount of chicken broth in a blender and stated the mixture was pureed ham. The ham had a runny, pourable consistency; when a serving spoon was inserted and stirred, the mixture ran off the spoon like a thin sauce. [NAME] #2 then blended an unmeasured amount of tomato soup with mashed potatoes and stated the mixture was pureed tomato soup. The tomato soup also exhibited a runny, pourable consistency, running off the spoon like a thin sauce. When asked how he/she determined if the correct puree consistency had been achieved, [NAME] #2 stated he/she eyeballs the mixture and did not use any tests or tools to ensure proper puree consistency.</p> <p>During an interview on 6/11/25 at 4:15 PM, the Food Services Supervisor (FSS) stated IDDSI (International Dysphagia Diet Standardization Initiative) guidelines should have been followed when preparing pureed food. The FSS further stated cooks were supposed to follow recipes to make pureed food.</p> <p>Review of the facility's recipe book revealed: P.[Puree]Ham Breakfast .Combine &amp;frac34; Gravy with prepared Meat in blender or food processor. Continue blending until pudding-like consistency is reached. Further review revealed no recipe for pureed tomato soup.</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>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>.</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was stored under proper sanitary conditions in the main kitchen and in the Sitka [NAME] unit. This failed practice placed all residents (based on a census of 44), who received food from both kitchens at risk for foodborne illness and communicable disease.</p> <p>Findings:</p> <p>Main Kitchen</p> <p>An observation, during the initial kitchen tour, on 6/9/25 at 8:09 AM, revealed:</p> <p>1) Dry Storage/Pantry:</p> <ul style="list-style-type: none"> <li>- 1 opened 25 ounce bottle of Traditional Style Rotisserie Seasoning, 3/4 full, received on 11/12/20, no open date;</li> <li>- 1 opened 16 ounce bottle of Whole Celery Seeds, 5/6 full, received on 10/12/20, no open date;</li> <li>- 1 opened 4 ounce bottle of Whole Tarragon Leaves, 3/4 full, received on 10/3/20, no open date, and;</li> <li>- 1 opened 18 ounce bottle of Mild Chili Powder, 5/6 full, received on 10/11/21, no open date.</li> </ul> <p>2) Food Preparation area:</p> <ul style="list-style-type: none"> <li>- 1 opened 25 ounce bottle of Traditional Style Rotisserie Seasoning, 1/2 full, received on 11/12/20, no open date;</li> <li>- 1 opened 5 ounce bottle of Dill Weed, 3/4 full, received on 10/5[no year], no open date;</li> <li>- 1 opened 16 ounce bottle of Whole Celery Seeds, 1/4 full, received on 10/12/20, no open date;</li> <li>- 1 opened 16 ounce bottle of Whole Caraway Seed, 1/4 full, received on 10/5/21, no open date;</li> <li>- 1 opened 12 ounce bottle of Crushed Red Pepper, 1/3 full, received on 9/18/22, no open date;</li> <li>- 1 opened 14 ounce bottle of Whole Fennel Seed, 3/4 full, received date was smudged and unreadable, no open date;</li> <li>- 1 opened 20 ounce bottle of Poppy Seed, 1/3 full, received date was smudged and unreadable, no open date;</li> <li>- 1 opened 18 ounce bottle of Whole Sesame Seeds, 2/3 full, received on 4/7/25, no open date;</li> </ul> <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>- 1 opened 6 ounce bottle of Ground Cloves, received on 1/10/19, no open date;</p> <p>- 1 opened 16 ounce bottle of Ground Nutmeg, 3/4 full, received on 12/21/23, no open date;</p> <p>- 1 opened 16 ounce bottle of Ground Cayenne Pepper, 1/2 full, received on 6/25 [no year], no open date;</p> <p>- 1 opened 15 ounce bottle of Ground Ginger, 1/2 full, received on 2/12[no year], no open date;</p> <p>- 1 opened 14 ounce bottle of Ground Coriander, 1/4 full, received on 9/10/21, no open date;</p> <p>- 1 opened 6 ounce bottle of Rubbed Sage, 1/4 full, received on 10/9[no year] no open date; and,</p> <p>- 1 opened 1 pound box of Corn Starch, 1/2 full, received on 4/1/24, no open date.</p> <p>3) Resident/Family Refrigerator</p> <p>-</p> <p>1 opened 22 ounce bottle of Hershey's Syrup, received on 11/1/24, no open date; and,</p> <p>-</p> <p>A 1/2 loaf of white bread, no open date.</p> <p>During an interview on 6/9/25 at 8:46 AM, the Food Service Supervisor (FSS) stated every container should be labeled with a received date and open date. When asked how staff determined when to replace items without expiration dates, the FSS explained that staff would notify her if the item looked close to being empty.</p> <p>Sitka [NAME] Unit</p> <p>An observation of the Sitka [NAME] unit's kitchenette on 6/9/25 at 2:30 PM, revealed:</p> <p>Refrigerator:</p> <p>- A 1/2 loaf of cinnamon raisin bread, with torn packaging exposing the bread, opened on 6/3/25.</p> <p>Review of the facility's policy Food Labeling and Dating, effective date 11/2024, 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 .</p> <p>Review of the facility's policy Monitoring Supply Dates, effective date 11/2024, revealed: . Food Service 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>(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 policy Shelf Stable Food Safety, effective date 6/2025, revealed: Heritage Place Kitchen follows the USDA [United States Department of Agriculture] recommendations of food storage and recommended shelf life . Spices remain in original manufacturer's container and are clearly labeled with the name of the spice, the receiving date and the opened date to track freshness .</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>.</p> <p>Based on record review and interview, the facility failed to ensure medical records were complete for 1 sampled resident (#33), out of 12 sampled residents. Specifically, physician signatures on written orders were not dated. This failed practice created incomplete medical records which placed the resident at risk for inconsistencies in treatment and care provided.</p> <p>Findings:</p> <p>Record review on 6/9-13/25 revealed Resident #33 was admitted to the facility with diagnoses that included cellulitis (a bacterial infection of the skin and soft tissues underneath), peripheral vascular disease (a condition where blood circulation is reduced to body parts outside of the brain and heart), and was under palliative care (a treatment approach for individuals living with a life-limiting illness).</p> <p>Review of Resident #33's physician telephone/verbal order sheets, from 1/3/25 to 5/8/25, revealed the following:</p> <p>A telephone/verbal order slip, dated 1/3/25, was written to: Hold KCl [potassium chloride - a mineral supplement] Repeat BMP [lab work: basic metabolic panel] in 1 wk [week] . The handwritten orders contained a physician's signature with no date or time associated with the signature;</p> <p>A telephone/verbal order slip, dated 1/6/25, was written to: Stop: Hydromorphone [an opioid medication used to treat pain] 2mg Tablet . Start: Hydromorphone 4mg Tablet . The handwritten orders contained a physician's signature with no date or time associated with the signature;</p> <p>A telephone/verbal order slip, dated 1/6/25, was written for the following: Prognosis [less than or equal to] 6 months to live . The handwritten order contained a physician's signature with no date or time associated with the signature;</p> <p>A telephone/verbal order slip, dated 1/13/25, was written to: Stop: Potassium. The handwritten order contained a physician's signature with no date or time associated with the signature;</p> <p>A telephone/verbal order slip, dated 4/9/25, was written to: Stop: lactulose [a medication used to treat constipation] 15 ml [milliliters] .; miralax [a medication used to treat constipation] .; sertraline [an antidepressant] 100 mg .; tizanidine [a muscle relaxer] 2mg .; torsemide [a diuretic medication used to treat edema] 20mg . The handwritten orders contained a physician's signature with no date or time associated with the signature; and</p> <p>A telephone/verbal order slip, dated 5/8/25, revealed two medication orders for: Cephalexin [an antibiotic] 1gram . [and] Doxycycline [an antibiotic] 100 mg [milligrams] . The handwritten orders contained a physician's signature with no date or time associated with the signature.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #33's electronic orders revealed all the above orders were entered into the resident's electronic medical record (EMR) by the facility's Resident Care Coordinator (RCC). The different ordering physicians for all the above orders were Ordered By: GROUP, THE ALASKA HOSPITALIST . There were no individual electronic physician signatures with a designated time or date stamp on any of the orders.</p> <p>During an interview on 6/13/25 at 8:50 AM, the RCC stated when physicians gave verbal orders, she would fill out a telephone/verbal order slip and then enter the order in the EMR. She further stated the physicians signed the telephone order slips when they rotated through for their weekly visits to the facility. The RCC stated that she would check the order slips to ensure completeness after the physician signed the slip.</p> <p>During an interview on 6/13/25 at 11:20 AM, the Director of Nursing (DON) stated all physician signatures on verbal orders should have a date and time. The DON further explained the facility's physicians do not enter orders or physician progress notes directly into the facility's EMR but wrote their notes into another EMR associated with the hospital.</p> <p>Review of The American Health Information Management Association (AHIMA)'s article Ethical Standards of Clinical Documentation Integrity (CDI) Professionals, dated 2020, at <a href="https://www.ahima.org/media/r2gmhlop/ethical-standards-for-clinical-documentation-integrity-cdi-professionals-2020.pdf?oid=301868">https://www.ahima.org/media/r2gmhlop/ethical-standards-for-clinical-documentation-integrity-cdi-professionals-2020.pdf?oid=301868</a> revealed: . Facilitate accurate, complete, and consistent clinical documentation within the health record to demonstrate quality care, support coding, and reporting to high-quality healthcare data used for both individual patients and aggregate reporting .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and record review, the facility failed to ensure infection control procedures were properly implemented in the facility. Specifically, the Certified Nurse Assistants (CNAs) failed to change gloves and perform hand hygiene while providing personal cares, for 2 residents (#s 26 and 35), out of 2 residents observed for personal cares. This failed practice had the potential to place all residents at risk of contamination and transmission of infections.</p> <p>Findings:</p> <p>Resident #26</p> <p>An observation on 6/10/25 at 9:04 AM, revealed both CNAs were wearing gloves. CNA #1 and CNA #2 began to assist the resident put on brief and pants up to Resident #26's lower legs while the resident was on lying position. Next, CNA #1 inserted an absorbent pad liner in between the resident's legs. Then the CNAs helped the resident change into a clean shirt. Next, CNA #1 wiped Resident #26's abdominal skin folds with wet wipes and applied cream on the skin and then inserted dry wipes in between the skin folds. Afterwards, CNA #1 and CNA #2 turned the resident onto his/her right side, then CNA #1 wiped Resident #26's perianal area. Next, CNA #1 pulled out a soiled absorbent pad liner and inserted a Hoyer lift (a mobility tool to assist individuals with limited mobility to safely transfer) sling under the Resident's back.</p> <p>While still wearing the same soiled gloves, CNA #1 and CNA #2, pulled the resident's pants and brief up. Both CNAs repositioned the Resident to the center of the bed, then pulled the brief and pants up more ensuring a good fit. Then CNA #1 and CNA #2 turned the resident onto his/her left side and secured placement of the Hoyer lift sling under the resident and positioned the resident to a lying position. CNA #1 removed his/her soiled gloves, sanitized his/her hands, put on new gloves, then continued to transfer the resident to his/her wheelchair.</p> <p>Resident #35</p> <p>An observation on 6/11/25 at 9:15 AM, revealed CNA #3 provided Resident #35's perineal care. CNA #3 started by sanitizing his/her hands and put on gloves. Resident #35 was lying on bed. Then, while a soiled brief was still on the resident, CNA #3 assisted the resident with putting on his/her socks, placed a new brief around the resident's thighs, and placed clean pants onto the resident lower legs. Next, CNA #3 removed a pillow from resident's right side and placed a clean absorbent pad liner onto the bed. Then, CNA #3 removed Resident #35's soiled absorbent pad liner and wiped Resident #35's peri-area.</p> <p>While still wearing the same soiled gloves, CNA #3 removed Resident #35's eyeglasses and set them aside, repositioned the resident's head, then, repositioned the resident's arms towards his/her body. Afterwards, the CNA turned Resident #35 onto his/her left side, then CNA #3 cleaned Resident #35's anal area, wiped off the zinc oxide from the skin, applied new zinc oxide onto resident's skin, and then removed the soiled bed pad and turned Resident #35 to his/her back.</p> <p>While still wearing the same soiled gloves, CNA #3 placed a new absorbent pad liner over the resident's peri-area and pulled the new brief and pants up. CNA #3 continued to wear the same soiled gloves until Resident #35 was ready to be transferred through a Hoyer lift.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>While still wearing the same soiled gloves, CNA #3 brought the resident's wheelchair over to the bedside. Then the CNA removed his/her soiled gloves, wiped his/her hands with a sanitizing wipe, and continued to transfer the Resident into his/her wheelchair.</p> <p>During a joint interview on 6/12/25 at 1:58 PM, the Resident Care Coordinator (RCC) stated hand hygiene should be performed based on the facility's policy and procedures and Centers for Disease Control and Prevention (CDC). She stated hand hygiene should be performed after contact with the residents, after removal of gloves, and after a task was completed. The Director of Nursing (DON) and RCC were asked if the CNAs were expected to change gloves and wash hands after providing residents perineal care and before touching the resident, both DON and RCC replied, Yes.</p> <p>Review of the facility's policy, Hand Hygiene, dated 11/2024, revealed: . Use alcohol- based hand rub containing at least 62% alcohol.for the following situations.before moving from a contaminated body site to a clean body site during resident care.after contact with a resident's skin.after contact with blood or bodily fluids.</p> <p>Review of CDC's guidelines on clean hands Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, accessed on this link: <a href="https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html">https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html</a>, revealed: . know when to clean your hands . Before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, After contact with blood, body fluids, or contaminated surfaces, immediately after glove removal.</p>		