STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025024	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Seward Mountain Haven	2203 Oak Street Seward, AK 99664

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42377 43792 50031 50078 Based on interview and record review, the facility failed to ensure final investigation results were reported to the State Agency for five Facility Reported Incidents (FRIs -AK 4446, 4485, 4486, 4487, and 4498) out of six FRIs within the mandatory reporting period. This failed practice had the potential to place all residents (based on a census of 39) at risk of abuse or neglect, and harm. Findings: Resident #5 Record review on 9/9-13/24 revealed Resident #5 was admitted to the facility with a diagnosis that included Alzheimer's disease (a progressive mental deterioration, due to generalized degeneration of the brain) with late onset. During an interview on 9/13/24 at 9:28 AM, the Director of Nursing (DON) stated LN #34 struggled with completing initial and final reports in a timely fashion. Review of the Adult Protective Services Intake Report (APS), dated 11/3/23 at 6:14 PM, revealed an initial report sent to the State of an incident that occurred on 10/31/23 at 5:30 PM. This report was completed by Licensed Nurse (LN) #34. According to this report, Resident #5 was assisted to the floor by CNA (Certified Nursing Assistant) #44. There was no injury reported at this time. On 11/1/23, a new bruise was noticed on the Resident's knuckle, and the Resident reported left hip pain at this time also. On 11/2/23, the Resident had a bruise on the left hand and wrist. On 11/3/23, it was reported from LN #71 that Resident #5's left leg was shorter than the right and there was significant pain. LN #73 reported this to the physician. On 11/3/23, the physician assessed the Resident and then diagnosed a left femur fracture and sent the Resident to the emergency room for evaluation. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Initial Report to the State dated 11/3/23 at 6:41 PM and completed by LN #34 revealed a witnessed fall on 10/31/23 at 5:00 PM which resulted in CNA #44 assisting the Resident to the floor upon difficulty with the Resident's ambulation due to weakness. The report revealed that the knuckle on left hand was bruised on 11/1/23, bruising occurred on 11/2/23 to the left wrist, and then on 11/3/23, bruising was seen on the left hip with left leg shortening and inner rotation and left hip swelling occurring. The Resident was sent to the emergency room for evaluation and then sent to an Anchorage hospital for a left leg fracture repair. Review of the facility's Final Report for Resident #5, dated 12/6/23 for date and time of the incident, was completed by LN #34 on 12/11/23. This report revealed the Resident was found to have an unopened left heel blister measuring 4 cm x 4 cm. Also included on this report were details about the 10/31/23 fall which resulted in a left femur fracture which required a hospitalization and surgery. This final report was completed after the five-day final reporting requirement since it was completed 1 month and 3 days after the incident occurred. Resident # 19 Record review from 9/9-13/24 revealed Resident #19 was admitted to the facility with diagnosis of anoxic (lack of oxygen) brain damage. Record review of the FRI, incident happened on 12/15/23, and revealed the Facility Administrator found Resident #19 outside of the Raven lodge (where resident resided) screaming .in a wheelchair, feet out with [a] blanket on his/her lap, covered with snow . Review of the Final Report, dated 3/5/24, revealed the facility investigated the incident and found out that . [Resident #19] prefers to be outside to cool down from a hot flash. The Resident was left outside unattended without direct supervision and was not provided with a way to alert the staff for assistance. The final investigation further revealed . The event did not cause any injury; however, staff were interviewed, and education to staff provided on direct supervision when residents are outside and providing proper tools for the Resident to communicate with the staff for safety concerns. The final investigation was reported to the State on 3/5/24, 3 months after the incident occurred. Resident #22 Record review on 9/9-13/24 revealed Resident #22 was admitted to the facility with a diagnosis of Alzheimer's disease (a progressive mental deterioration, due to generalized degeneration of the brain) with late onset. During an interview on 9/13/24 at 10:00 AM, the DON stated LN #34's incident reports were not completed in a timely manner. Review of the facility's Initial Report, for Resident #22, date of report 12/13/23 with unknown time, was completed by LN #34. This report revealed an incident occurred on 12/10/23 at 7:21 PM. This report was sent to the State on 12/13/23. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of this document for initial reporting of the incident on 12/10/23 at 7:21 PM revealed: Issue: Multiple Stage II Pressure injuries noted on the sacrum measures approximately 0.6 x 1.5 cm. There are two other wounds on the buttocks, one is about 1 x 1 cm, and the other is approximately 2.5 x 0.7 cm. The inferior on the buttocks appeared to be shallow skin tears. Patient also has some mild erythema (skin redness) of the mid thoracic spine are in the midline of the spinous process (bony projection that extends from the back of each vertebra). Description of the event: 12/10/23 at 7:21 PM, completed by LN #72, revealed: I have examined the Elder's skin from head to toe and have noticed the following skin concerns . has open lesion(s) present in past 7 days. Elder has a new open area on [his/her] lumbar spine. Area is cleansed with wound cleanser. Mepilex[wound dressing] applied. Elder is placed on [his/her] side to offload area. Review of the facility's Final Report, for Resident's incident on 12/10/23 at 6:09 PM of skin concerns regarding the lumbar spine with red areas and an open area revealed this report was completed late. The final report was completed on 3/4/24 at 3:00 PM. This final report was to be completed 5 days after the incident, however this report was not completed until 2 months and 3 weeks past the original incident time and date. The wound had healed, and ongoing follow-up action completed showed the Resident was on an air mattress, the caregivers were educated on prevention of skin breakdown, keeping the skin areas clean and dry, and the Resident repositioned frequently, for the Resident's daily care. The final investigation was reported to the State on 3/4/24, 3 months after the incident had occurred. Resident #27 Record review from 9/9-13/24 revealed Resident #27 was admitted to the facility with diagnoses that included seizure disorder (epilepsy condition) and schizophrenia (mental disorder). During an interview on 9/12/24 at 10:00 AM, the Quality Improvement Coordinator and the DON both stated that the report was sent late, due to staff not fulfilling the duties of their position: the person doing the job wasn't actually doing it, so he/she stepped down and March of 2024 was when we finally got caught up with all the things, [he/she] didn't do. The DON also provided the internal investigation for this FRI: conclusion: no harm to the Resident was found during the investigation. CNA #6 was notified that he/she was to return to work as the investigation concluded, the caregiver resigned from her position. Per DON the resignation happened on 1/25/24, confirmed by the review of staff's schedule provided. Review of the Initial Report, date of report 3/4/24 was completed by LN #71. However, this allegation occurred on 1/17/24. This report was sent to the State on 3/7/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Final Report, dated 3/4/24, revealed resident complained about . a CNA being rough with him/her during cares . Resident's representative was notified, and CNA #6 taken off the schedule and placed on administrative leave immediately. All caregivers working at the time of the report were interviewed, the resident was interviewed by nursing management, and other residents in the lodge were interviewed as well. The resident requires assistance from one caregiver to ambulate safely with a gait belt and walker. During interviews, the resident reported that he/she felt like he/she was being rushed by CNA #6 and felt like he/she was being challenged during exercises to complete them correctly. Specifically, the resident recalled a time he/she went to walk forward, and CNA #6 told him/her to try to take bigger steps instead of shuffling his/her feet, and the resident endorsed that he/she felt rushed because he/she made the same comment several times, and that his/her tone of voice was rough. The resident denied any harm, threats, or mistreatment by the caregiver and no harm was found during the investigation for reported possible mistreatment. The caregiver resigned from their position and did not return to work, although no harm was found during the investigation, and he/she was released from administrative leave. Although no harm was found during the investigation, education on prevention and reporting of Abuse, Neglect and Exploitation was provided to caregivers. The Resident was educated on where to locate and how to request the Resident complaint/grievance forms and provided the ombudsman contact information for reference. The final investigation was reported to the State on 3/7/24, 2 months after the incident occurred. Resident #32 Record review from 9/9-13/24 revealed Resident #32 was admitted to the facility with diagnoses that included impaired mobility (movement) and cerebrovascular accident (stroke). During an interview on 9/11/24 at 9:50 AM, CNA #8 responded to Resident #32's call light on 9/29/23. Resident #32 reported that CNA #43 was rough and hurt him/her when he/she was wiped with a washcloth up in his/her anus and felt violated. CNA #8 stated he/she informed LN #58, and the nurse manager. LN #71 contacted the [NAME] Police Department. CNA #8 stated he/she provided a report to the police. During a simultaneous interview conducted, on 9/11/24 at 11:00 AM, with the DON, the Administrator, and LN #11, the DON stated on 9/29/23, CNA #43 was immediately removed from the care areas and placed on administrative leave. The Resident's guardian was notified and arrived at the facility to remain with the Resident. The facilities medical director was also notified of the incident. [NAME] Police Department arrived on site on 9/29/23 to investigate the allegation. DON stated: [NAME] Police Department interviewed all caregivers, Resident, and Resident's guardian separately. The Resident was transported to Providence [NAME] Medical Center for an evaluation. CNA #43 remained on administrative leave until police investigation was completed. The Administrator stated the final investigation report should have been sent in 5 days, as per the five-day final reporting requirement. The DON further stated he/she received notification from [NAME] Police Department later the night of 9/29/23 or early on 9/30/23, regarding the investigation that no evidence was found, and no charges would be filed. On 10/3/23 CNA #43 returned to work and was assigned to a different lodge (Eagle Lodge). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of APS Report, dated 9/29/23 at 6:42 PM, revealed an allegation of physical abuse. Resident #32 reported that CNA #43 was rough and hurt him/her when he/she was wiped with a washcloth up in his/her anus and felt violated. The facility reported the incident occurred on 9/29/23 at 5:40 PM. LN #58 assessed the Resident. CNA #43 was removed from Resident care. LN #71 reported to DON, who contacted the [NAME] Police Department. This APS report was submitted by LN #71. Review of Providence [NAME] Medical Center, Emergency Department (ED), Provider Notes dated 9/29/23, revealed: Resident #32 was with frail skin and poor rectal tone. Provider explained with poor rectal tone, when someone was wiped over the anus it would feel like someone was pushing. The provider determined no signs on injury or trauma on exam. Review of Provider Notes, dated 10/2/23, during provider assessment, revealed: Resident #32 denied feeling being sexually assaulted and agreed with the ED provider's conclusion. The final investigation report was received on 10/12/23, 13 days after the incident. Review of facility's PSMH Abuse Prevention and Protection, last revised 12/2023, revealed: . b. Caregiver to resident abuse . The provider, state agency, family and/or resident representative, nursing administration, and the police will be notified as appropriate within 2 hours of the incident . f. Report the results of all investigations to nursing administration and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident .