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	02/11/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to ensure residents were informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, or treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred. Specifically, the facility failed to obtain informed consent (a process where a patient or their representative was provided with the necessary information to make an informed decision about the use of medications. This includes understanding the potential benefits, risks, and alternatives associated with the medication, as well as the right to withdraw consent at any time) prior to administering psychotropic medications (medications in the class of either antipsychotics, antianxiety, or antidepressants that would have affected behavior, mood, thoughts, or perception) for 4 residents (#'s 1, 3, 4 and 5), out of 6 sampled residents. This failed practice violated the residents', or resident representatives' right to be informed of, and participate in, the residents' treatment. Findings: Resident #1Record review on 2/9-11/26 revealed Resident #1 was admitted to the facility with diagnoses that included severe dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking) with psychotic disturbance (where individuals lose touch with reality such as hallucinations, delusions, and disorganized thinking), anxiety disorder (intense, excessive and persistent worry and fear about everyday situations), and depressive disorder (a persistent feeling of sadness and loss of interest). Further review revealed Resident #1 had an Office of Public Advocacy (OPA) Guardian who made medical decisions for him/her. Review of Resident #1's Minimum Data Set (MDS - a federally required nursing assessment) admission assessment, dated 11/12/25 revealed, . Antipsychotic Medication Review. A. Did the resident receive antipsychotic medication since admission/entry or reentry or the prior OBRA [Omnibus Budget Reconciliation Act, a federal nursing home reform act] assessment, whichever is more recent? Yes- Antipsychotics were given on a routine and PRN [as needed] basis. Medication administration Review of Resident #1's medical record revealed the following psychotropic medications were ordered between 11/5/25 through 12/12/25 and that 288 separate administrations of these medications were given in this 37-day time period: Divalproex (Depakote - a mood stabilizer medication)39 administrations between 11/11-24/25 of divalproex 250 mg (milligrams) three times daily, oral. Ordered 11/10/25;22 administrations between 11/24/25-12/10/25 of divalproex, 500 mg three times daily, oral. Ordered 11/24/25; and33 administrations between 12/1-10/25 of divalproex 500 mg four times daily, oral. Ordered 12/1/25. Lorazepam (Ativan - an anti-anxiety medication) 5 administrations between 12/9-12/25 of lorazepam liquid 2 mg every 6 hours, as needed, oral. Ordered 12/9/25. Olanzapine Zydis (Zyprexa - a dissolvable tablet anti-psychotic medication)9 administrations between 12/1-9/25 of olanzapine zydis, 5 mg daily in the evening, oral. Ordered 12/1/25; 7 administrations between 11/10-30/25 of olanzapine zydis, 5 mg nightly, as needed, oral. Ordered 11/5/25. Quetiapine (Seroquel - an anti-psychotic medication)6 administrations between 12/8-10/25 of (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	quetiapine, 100 mg four times daily, oral. Ordered 12/8/25; and 98 administrations between 11/5/25 - 12/8/25 of quetiapine 75 mg three times daily, oral. Ordered 11/5/25. Sertraline (Zoloft - an antidepressant medication)35 administrations between 11/6/25 - 12/10/25 of sertraline 100 mg daily, oral. Ordered 11/5/25. Trazodone (Desyrel - an antidepressant medication)34 administrations between 11/5/25 - 12/9/25 of trazodone 100 mg nightly, oral. Ordered 11/5/25. Further review of Resident #1's medical record revealed no documented informed consents for any of these psychotropic medications administered. Review of Resident #1's IDT [Interdisciplinary Team] Care Conference note, dated 11/5/25 and effective from 11/5/25 to 11/19/25, revealed: Nursing Assessment: MD [medical doctor] visits. 11/10 [November 10, 2025]: [spouse] requesting something else for [his/her] anxiety and agitation. Depakote ordered 250 mg three times a day. Resident #1's spouse was not his/her decision maker and there was no proof in the medical record the OPA Guardian was contacted to give approval for the Depakote administration. During the course of this survey, the facility was asked to provide proof that informed consent was obtained for Resident #1's psychotropic medications. The facility only provided two emails: 1. Email #1: Subject line: Mt Haven #secure#, between the MDS coordinator and the resident's OPA Guardian, dated 11/13/25 at 12:15 PM, revealed: [Provider] saw [Resident #1] 11/11 [November 11, 2025] and ordered Depakote. [He/she] is impulsive and high risk for falls. [He/she] is taking Depakote 250mg 3 times a day. [Provider] will be seeing [him/her] every 2 weeks at this time as [he/she] is taking a PRN antipsychotic and a scheduled antipsychotic. I did not see specific documentation you were notified about the Depakote. if you were and this was a duplicate I apologize. Further review of the email revealed the guardian was not informed of the risks and benefits of Depakote, treatment alternatives, or other options, nor was the guardian given the opportunity to choose a preferred option on behalf of the resident. 2. Email #2: Subject line: Re: PSMH [Providence [NAME] Mountain Haven] Important Update Regarding Resident #secure#, between the LTC Nurse Manager (LTCNM) and the resident's OPA Guardian, dated 12/9/25 at 10:22 AM, revealed medication adjustments were made because of escalating behaviors: . Olanzapine: changed to 5mg scheduled every evening (from as needed). Depakote: increased to 500mg PO [by mouth] four times daily. Quetiapine: increased to 100mg PO [by mouth] four times daily. Further review of the email revealed the guardian was not informed of the risks and benefits of the discussed medications, treatment alternatives, or other options, nor was the guardian given the opportunity to choose a preferred option on behalf of the resident. The facility did not provide any documented informed consents for any psychotropic medications administered to Resident #1. During an interview on 2/10/26 at 2:47 PM, Resident #1's OPA Guardian stated the facility had never reviewed the risks and benefits, treatment alternatives, or other options, or was given the opportunity to choose a preferred option on behalf of the resident for any of the resident's medications. During an email on 2/11/26 at 10:57 AM, the OPA Guardian stated that if the risks and benefits of the medications were provided, it would have guided the decision making. Resident #3Record review on 2/9-11/26 revealed Resident #3 was admitted to the facility with diagnoses that included vascular dementia (dementia from reduced brain blood flow, often due to strokes), and cerebral vascular disease (blood vessel disorders in the brain causing reduced flow or strokes). Further review revealed Resident #3 had an OPA Guardian who made medical decisions for him/her. Review of Resident #3 MDS, quarterly assessments dated 6/3/25, 9/2/25, and an annual assessment dated [DATE], revealed Resident #3 was taking, . High-Risk Drug Classes. K. Anticonvulsant. C. Antidepressants [assessed only on 12/3/25]. Medication Administration Review of Resident #3's medical record revealed the following psychotropic medications were ordered between 7/8/25 through 2/10/26 and that 616 separate administrations of these medications were given in this 217-day time period: Mirtazapine (Remeron - an (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antidepressant medication)28 administrations between 10/16/25 and 11/17/25 of mirtazapine, 7.5 mg tablet, Oral - Frequency: NIGHTLY. Ordered 10/16/25 (Discontinued on 11/18/25);Valproic acid (liquid Depakote, called Depakene - a mood stabilizer medication)585 administrations between 7/8/25 and 2/10/26 of valproic acid, 250 mg/5 mL (milliliters) liquid - Dose: 250 mg, Oral - Frequency: 3 TIMES DAILY AFTER MEALS. Ordered 6/1/25 (date the order was active). Further review of Resident #3's medical record revealed no documented informed consents for any of these psychotropic medications administered. Review of Resident #3's, Progress Note, dated 10/17/25, revealed Licensed Nurse (LN) #2 wrote: Unable to reach Resident #3 representative. Copy of notes including addition of Remeron to med [medication] list sent to Resident's Representative in regular mail. No email option. Further review revealed no other progress notes that documented additional efforts to contact the resident representative to discuss medications. During an email on 2/11/26 at 10:57 AM, the OPA Guardian stated that if the risks and benefits of the medications were provided, it would have guided the decision making. During the course of this survey, the facility was asked to provide proof that informed consent was obtained for Resident #3's psychotropic medications. The facility did not provide any proof. Resident #4Record review on 2/9-11/26 revealed Resident #4 was admitted to the facility with diagnoses that included Parkinson's disease with dyskinesia (involuntary muscle movements), dementia due to Parkinson's disease with behavioral disturbance (cognitive decline with psychiatric features), hallucinations (psychotic symptoms), and moderate Lewy body dementia (a brain disorder characterized by abnormal protein deposits that cause progressive cognitive decline) with psychotic disturbance. Further review revealed Resident #4 had a resident representative who made medical decisions for him/her. Review of Resident #4's MDS quarterly assessment 12/22/25 revealed Resident #4 was taking .High-Risk Drug Classes.A. Antipsychotic.B. Antianxiety.K. Anticonvulsant. Medication Administration Review of Resident #4's medical record revealed the following psychotropic medication was ordered on 11/13/25 through 2/11/26 and that 86 separate administrations of this medication were given in this 90-day time period:Pimavanserin (Nuplazid - an anti-psychotic medication)86 administrations between 11/16/25 and 2/11/26 of pimavanserin 34 mg capsule, Dose: 34 mg, Oral - Frequency: DAILY. Ordered 11/13/25 (Scheduled to start on 11/16/25; order active). Further review of Resident #4's medical record revealed no documented informed consent for this psychotropic medication administered. During the course of this survey, the facility was asked to provide proof that informed consent was obtained for Resident #4's psychotropic medication. The facility did not provide any proof. Resident #5Record review on 2/9-11/26 revealed Resident #5 was admitted to the facility with diagnoses that included dementia with behavioral disturbance and Parkinson's disease. Review of Resident #5's physician orders revealed the provider ordered Seroquel on 1/12/26 at 9:00 PM: . QUEtiapine (SEROquel) tablet 25mg.oral. nightly. Review of Resident #5's medical record revealed this Seroquel medication was first administered to Resident #5 on 1/13/26 at 8:16 PM. Review of Resident #5's Providence [NAME] Mountain Haven Psychotropic Risk/Benefits Verification of Informed Consent, dated 1/14/26 at 1:33 PM, revealed: LIST of Residents current PSYCHOTROPIC MEDICATIONS. Medication: Quetiapine (Seroquel). Dosage: 25 mg [milligrams]. Route: PO [by mouth]. Frequency: Nightly. Diagnosis: Parkinson's disease with dyskinesia and fluctuating manifestations. EXPLANATION OF RISK AND BENEFITS PROVIDED BY [Long Term Care Nurse Manager] on 1/14/2026 to the following: Representative. This informed consent was obtained one day after the medication was already administered to the Resident. Informed Consent Process Interviews During an interview on 2/11/26 at 11:38 AM, LN #4 stated that he/she believed the physician was ultimately responsible for obtaining informed consent for medications from the resident or resident representative. He/she stated, .when there are medication changes, such as dose adjustments, discontinuations, or (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changes from one medication to another, the physician would obtain consent and staff would notify the resident or Power of Attorney of the changes. LN #4 was unsure where the signed medication consents were stored in the resident's medical record. During an interview on 2/11/26 at 11:40 AM, LN #6 was not sure who was responsible for obtaining informed consent, when to obtain an informed consent, or where informed consents were kept in the resident's medical record. LN #6 stated he/she did not know how to verify if an informed consent was present prior to administering a new medication. The LN further stated that only antipsychotics needed consent and if the question came up he/she would call the nursing supervisor and ask. During an interview on 2/11/26 at 11:51 AM, LN #5 stated the resident was responsible for providing consent for medications. If the resident had a representative, then that individual would provide consent on the resident's behalf. Consent was obtained during the admission process, documented in the electronic medical record (EMR), and management handled much of the admission paperwork. LN #5 further stated that he/she assumed that since the physician wrote the medication orders, the physician had obtained informed consent before writing the order. He/she identified psychotropic medications and antipsychotics as requiring informed consent, and that included discussion of risks and benefits. During an interview on 2/10/26 at 4:10 PM, the Director of Nursing (DON) and the LTCNM stated when the doctor placed new orders for medications that needed consent, the LN at the bedside would be notified via the electronic medication administration record (EMAR) that a new medication was ordered. The LNs were trained to obtain informed consent prior to giving the first dose. There was also an online reference for the LNs. The DON further stated that the facility did not obtain informed consent for psychotropic medications if a resident was already taking the same medication when admitted , because the resident was assumed to know the risks and benefits. During an interview on 2/11/26 at 12:33 PM, the LTCNM stated it was the responsibility of the nurse assigned to the resident's cottage to obtain informed consent for psychotropic medications prior to the medication's first administration. The LTCNM further stated that the facility would email resident representatives or guardians for medication consents, however, copies of those emails were not placed in the residents' medical records. The LTCNM further stated she had audited the electronic records for informed consents; however, the audits had not occurred regularly. The gap was recently identified, and the facility had since filled two nurse supervisor positions to assist with consent audits. When a missing informed consent was identified, the facility obtained it immediately. Review of the facility resident rights document As a Resident, you have the Right, Revision 4/2024, revealed: . Further, you have the right to be informed in advance of any change in care or treatment that may affect your well-being. This includes being told of the benefits and reasonable risks of treatment, and about the reasonable available alternatives. Review of the facility policy PSMH Psychopharmacological Drug Use and Gradual Dose Reduction, last revised 3/2024, revealed, . General Provisions: 1. Residents or their representative are advised of potential risks versus benefits of psychotropic medication therapy. PROCEDURE. C. Licensed Nursing staff: 1. Advise the resident or resident's representative of potential benefits and side effects of Psychotropic medication therapy, and document risk/benefit information has been provided on the Psychotropic Risk/Benefit documentation sheet.