

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  025025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Centennial Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  9100 Centennial Drive Anchorage, AK 99504	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42377</b></p> <p>Based on record review, interview and observation, the facility failed to protect the resident's right to be free from deprivation of goods and services by facility staff. Specifically, the facility failed to ensure an anticonvulsant medication was available and administered per physician's order for one resident (#1) out of three sampled residents.</p> <p>This failed practice of deprivation of goods and services resulted in Resident #1 not receiving medication causing the resident to endure multiple seizure episodes, decorticate posturing [a reflex pose that's a symptom of damage to or disruptions in brain activity. It causes your legs to become rigid and straight, while your arms flex upward and hold tensely to your chest.] with nonresponsiveness for several hours, and subsequent hospitalization . This failed practice resulted in a negative outcome that compromised the resident's ability to maintain and/or reach his/her highest practicable physical wellbeing, as a consequence of subtherapeutic levels of anticonvulsant medication and caused actual harm to the resident.</p> <p>Findings:</p> <p>Record review on 1/21-22/25, revealed Resident #1 was admitted to the facility with diagnoses that included hemiplegia (weakness or paralysis of one side of the body) and hemiparesis (partial paralysis of one side of the body), anoxic brain damage (lack of oxygen to the brain resulting in cognitive, physical and neurological impairments) and general epilepsy (seizures that involve both halves of the brain) and epileptic syndrome (seizures that are characterized based on symptoms, location or origin, and diagnostic tests). Further review revealed Resident #1 had a PEG-Tube (a surgically inserted feeding tube into the stomach bypassing the mouth and esophagus).</p> <p>Omitted Medication:</p> <p>Review of the Physician's order, dated 11/14/24, revealed: Valproic Acid Oral Solution 250 MG/5ML (Valproate Sodium) [medication for seizures] Give 20 ml via PEG-Tube two times a day for Anoxic Brain Injury.</p> <p>Review of the Medication Administration Record Report dated 12/1-31/24, revealed valproic acid oral solution 250 mg/5ml was not administered on 12/23/24 at 3:00 PM, 12/24/24 at 7:00 AM and 12/24/24 at 3:00 PM. Dates of unadministered valproic acid oral solution were coded as 9 for Other/See Nurses Notes.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing notes section eMAR (electronic medication administration record) Medication Administration Note, dated 12/23/24 at 4:20 PM, revealed: Valproic Acid Oral Solution 250 MG/ 5 ML Give 20 ml via PEG-Tube two times a day for anoxic Brain Injury awaiting pharmacy to deliver.</p> <p>Review of the nursing notes section eMAR Medication Administration Note, dated 12/24/24 at 10:09 AM, revealed: Valproic Acid Oral Solution 250 MG/5 ML . waiting for delivery.</p> <p>Review of the nursing notes section eMAR Medication Administration Note, dated 12/24/24 at 4:57 PM, revealed: Valproic Acid Oral Solution .medication not available.</p> <p>Record review on 1/21/25 of Resident #1's EHR (electronic health record), dated 12/23/24 through 12/24/24, revealed no evidence that the nurses contacted the physician or the pharmacist about the unavailability of valproic acid oral solution.</p> <p>During an interview on 1/21/25 at 12:52 PM, when asked what the procedure was when a medication was not available, the Director of Nursing (DON) stated the nurse would call the provider if the medication was not available in the Cubex (the facility's medication storage system).</p> <p>Review of the Progress notes Health Status Note, dated 12/25/24 at 1:48 AM, revealed: Note Text: Resident [#1] had seizure like activity lasting approximately between one to two minutes.On-call provider called regarding situation and was given the approval to send resident [#1] to ER [emergency room ].Paramedics arrived 10 minutes later.transferred to .PROV [Providence Alaska Medical Center] ER at 0120. Family notified of transfer.</p> <p>Review of the Providence Alaska Medical Center (PAMC) Admission History &amp; Physical, dated 12/25/24 at 7:33 AM, revealed:</p> <p>[Resident #1] presented with 2 witnessed generalized tonic-clonic seizures [an event that causes a loss of consciousness and violent muscle contractions]. 1 witnessed by [emergency room ] staff which was aborted with IV [intravenous] Ativan [a benzodiazepine medication used to treat active seizures] administration.</p> <p>[He/She] has had ongoing decorticate posturing and nonresponsiveness for several hours. Decorticate posturing improved with additional dose of IV Ativan.</p> <p>Reports from [Resident #1's] [facility] say that [he/she] was not receiving [his/her] Depakote [brand name of valproic acid] for about the last 48 hours due to running out of it, however [his/her] Depakote level was undetectable today, per discussion with pharmacy given the half-life of Depakote this likely means that [he/she] has been off of it for longer than 2 days.</p> <p>Review of Resident #1's PAMC emergency room medical record, dated 12/25/24, revealed a lab result, dated 12/25/24 at 2:33 am, for valproic acid in the Resident's blood was at &lt; [less than] 3.0. The record indicated that a therapeutic range for valproic acid was between 50 and 100 ug/mL (microgram per milliliter).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Providence Alaska Medical Center Discharge Summary, dated 12/27/24 at 11:00 AM, revealed: COURSE IN HOSPITAL .Patient had been without [his/her] home Depakote for the past 48 hours prior to admission, subsequently leading to seizures .Depakote bolus initiated, levels subtherapeutic .I have significant concerns that patient ran out of [his/her] seizure medicine at skilled nursing. Case management and social worker are aware and will be further investigating. Family is also very concerned about patient care at this facility and I understand their concerns .PLAN FOR FOLLOW -UP .3. It is imperative that this patient not run out of [his/her] antiseizure medications, as this is what led to this hospitalization .</p> <p>Review of the SKILLED NURSING FACILITY TRANSFER ORDERS, dated 12/27/24 at 11:36 AM, revealed Resident #1 was admitted to the hospital on 12/25/24 and discharged on [DATE] with a principal problem of Breakthrough seizure. The medication orders section revealed valproic acid 250mg/5 ml liquid was included in the list. Further review of the medication orders section, revealed a handwritten note which read: Please do not run off seizure meds[medicine] again.</p> <p>Review of Progress notes Alert Notes on 12/27/24 at 7:51 PM revealed: Resident [sibling] came in around 19:30 [7:30 pm] this evening .This writer respectfully answered the [sibling] that the only person we can give [information] regarding the resident will be [his/her] POA [Power of Attorney]. As of this time, if you will be asking an in depth regarding resident cares and medications, it's better if you could talk to the POA or if management will be here. This [sibling] adamantly asking what medications are you giving at night and at days and they said to us in the hospital that my resident was neglected with [his/her] medications! This writer even verbalized as of this time, I cannot give you an in depth [information] about that. However, if you have concerns, just wait and talk to our Nursing management during office hours.</p> <p>Review of the Provider's Progress Notes, dated 12/29/24, revealed: .Chief Complaint: return from hospital. HPI [history of present illness]: [Resident #1's name] .seems to have breakthrough seizures related to not receiving [his/her] seizure meds[medications]. Valproic acid undetectable in ED [Emergency Department] Received a loading dose of Depakote and was admitted overnight.</p> <p>Review of the facility's Drug Record Book, dated 1/21/25 at 4:46 PM revealed: Valproic Acid Oral Solution 250 MG/5ML . Re/Ordered Date: 12/09/2024 .12/30/2024 .</p> <p>Review of the medication delivery Packing Slip, dated 12/9/24, from PharMerica [the facility's contracted pharmacy] revealed: . 473.00 [ML] VALPROIC ACD SOL 250/5ML for Resident #1 was delivered. The facility received the medication on 12/10/24.</p> <p>Review of another Packing Slip, dated 12/30/24, revealed valproic acid was delivered to the facility and received on 12/31/24.</p> <p>There was no other valproic acid solution for Resident #1 delivered between 12/9/24 and 12/30/24.</p> <p>During an interview on 1/21/25 at 4:24 PM, the Administrator stated the facility did not have inventory of valproic acid. She stated Resident #1's valproic acid was a G-tube medication (medications administered through a gastrostomy tube). She added that PharMerica would deliver the valproic acid two weeks at a time. She further stated when the medication ran-out on 12/23/24, that would have been the end of the two weeks.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 1/21/25 at 3:15 PM revealed Resident #1's Valproic Acid Oral Solution USP bottle was 473 ml in size.</p> <p>During an interview with Licensed Nurse (LN) #2 on 1/21/25 at 3:15 PM, he/she stated the way he/she knew when to reorder Resident #1's valproic acid bottle was to look at the bottle and reorder another bottle if it looked like the bottle was getting close to being empty.</p> <p>During an interview with the Pharmacist on 1/22/24 at 8:00 AM, he/she stated based off Resident #1's medication order, Resident #1 would receive only 11 full days of valproic acid from a 473 ml bottle.</p> <p>During an interview with the Director of Nursing (DON) on 1/21/25 at 2:15 PM, DON stated the investigation for Resident #1's missed doses of valproic acid and subsequent hospitalization was ongoing and had not been completed. DON further stated that he was waiting to interview one nurse that was assigned to Resident #1 on the day Resident #1 did not receive scheduled valproic acid. DON stated he does not know the cause of valproic acid being unavailable. DON stated he opened the investigation the day after Resident #1 came back from the facility. When asked if missed medication was the reason for hospitalization, DON stated possibly, don't know for sure, the hospital paperwork isn't saying that.</p> <p>Review of the Providence Alaska Medical Center Discharge Summary, dated 12/27/24 at 11:00 AM, revealed: COURSE IN HOSPITAL .Patient had been without [his/her] home Depakote for the past 48 hours prior to admission, subsequently leading to seizures .PLAN FOR FOLLOW -UP .3. It is imperative that this patient not run out of [his/her] antiseizure medications, as this is what led to this hospitalization .</p> <p>During an interview on 1/21/25 at 4:24 PM, when asked when the facility requested delivery of valproic acid on 12/23-24/24, the Administrator stated she was out at that time, she learned about the missed medication today [1/21/25]. When asked if the missed medication was discussed during the stand-up meeting [daily staff meeting], she stated there was no leadership team during Christmas so there was no stand-up meeting that day [12/25/24]. She further stated that Resident #1 being in the hospital was discussed during the stand-up meeting the day after [12/26/24] and that the stand up was led by the DON. She stated, It got missed, she further stated it should have been reported to the State.</p> <p>During an interview on 1/21/25 at 5:04 PM with the Administrator, she confirmed that PharMerica did not receive a refill order for valproic acid solution from a nurse during the time when the medication was not available in the facility.</p> <p>Review of the stand up meeting minutes, dated 12/26/24 at 10:16 AM, revealed: Hospital .[Resident #1]-seizures .</p> <p>Review of the Incident Report, Medication Error, unknown creation date, revealed, [Resident #1] had a seizure at 0148 hours on 12/25/2024. After the seizure it was noted that the resident did not receive [his/her] Depakote medication on 12/23/24 at 100 hours, and both doses on 12/24/2024 .The resident was assessed by the unit nurse, the on-call provider was notified and the resident was sent to the emergency room for evaluation .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy Medication Administration General Guidelines, dated 1/2023, revealed: . Documentation .2. If a dose of regularly scheduled medication is withheld .the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN [as needed] documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified .</p> <p>Review of the Food and Drug Administration (FDA) Medication Guide for Valproic Acid, accessed on 1/29/25 at <a href="https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/018081s070,018082s053lbl.pdf#page=41">https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/018081s070,018082s053lbl.pdf#page=41</a> revealed: Stopping Depakote or Depakene suddenly can cause serious problems.</p> <p>Review of the facility provided document Medication Guide Valproic Acid Oral Solution on 1/21/25, revealed: Do not stop Valproic Acid Oral Solution, USP . Stopping Valproic Acid Oral Solution, USP suddenly can cause serious problems. Stopping a seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop (status epilepticus).</p> <p>Review of the facility's policy Unusual Occurrence Reporting, undated, revealed: As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents . 1. Our facility will report the following events to appropriate agencies: Allegations of abuse, neglect . and . Other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents . Unusual occurrences shall be reported via telephone to appropriate agencies are required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations .</p> <p>Review of the facility's Abuse-Screening, Training, Identification, Investigation, Reporting, and Protection policy, revised 1/2023 revealed: .6. Facility utilizes Incident/Accident Investigation policy and procedure to investigate concerns and incidents . All alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown sources . must be thoroughly investigated. The investigation is done to determine, as far as possible: i. What occurred; and ii. To make necessary changes to the provision of care and services to prevent reoccurrence. b. A thorough investigation is completed through a systemic collection and review of evidence/information that describes and explains an event or series of events. It seeks to determine if abuse, neglect . and how to prevent further occurrences . 14. All staff members are considered mandatory reporters and as such are obligated to report using the state reporting mechanism 16 .If the allegation involves neglect . that does not involve abuse or serious injury, the incident is reported within 24 hours to local law enforcement and the state survey agency, as required . DEFINITIONS OF ABUSE: . Neglect: is the failure of the facility, its employees or service providers to provide goods or services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42377</p> <p>.</p> <p>Based on record review and interview, the facility failed to ensure an incident of multiple missed doses of anticonvulsant medication that resulted in multiple seizure episodes and subsequent hospitalization for one resident (#1) out of three sampled residents was reported to the appropriate officials in accordance with State law, including the facility's Administrator and the State Survey Agency, within timeframes specified by the 42 CFR S483.12(c)(1). Specifically, the facility failed to notify the facility's Administrator and the State Survey Agency immediately, but not later than 2 hours, or not later than 24 hours of the incident. This failed practice had the potential to cause future harm to the resident and a delay of necessary actions.</p> <p>Findings:</p> <p>Record review on 1/21-22/25, revealed Resident #1 was admitted to the facility with diagnoses that included hemiplegia (weakness or paralysis of one side of the body) and hemiparesis (partial paralysis of one side of the body), anoxic brain damage (lack of oxygen to the brain resulting in cognitive, physical and neurological impairments) and general epilepsy (seizures that involve both halves of the brain) and epileptic syndrome (seizures that are characterized based on symptoms, location or origin, and diagnostic tests). Further review revealed Resident #1 had a PEG-Tube (a surgically inserted feeding tube into the stomach bypassing the mouth and esophagus).</p> <p>Omitted Medication:</p> <p>Review of the Physician's order, dated 11/14/24, revealed: Valproic Acid Oral Solution [medication for seizures] 250 MG/5ML (Valproate Sodium) Give 20 ml via PEG-Tube two times a day for Anoxic Brain Injury.</p> <p>Review of the Medication Administration Record Report dated 12/1-31/24, revealed valproic acid oral solution 250 mg/5ml was not administered on 12/23/24 at 3:00 PM, 12/24/24 at 7:00 AM and 12/24/24 at 3:00 PM. Dates of unadministered valproic acid oral solution were coded as 9 for Other/See Nurses Notes.</p> <p>Review of the nursing notes section eMAR (electronic medication administration record) Medication Administration Note, dated 12/23/24 at 4:20 PM, revealed: Valproic Acid Oral Solution 250 MG/ 5 ML Give 20 ml via PEG-Tube two times a day for anoxic Brain Injury awaiting pharmacy to deliver.</p> <p>Review of the nursing notes section eMAR Medication Administration Note, dated 12/24/24 at 10:09 AM, revealed: Valproic Acid Oral Solution 250 MG/ 5 ML . waiting for delivery.</p> <p>Review of the nursing notes section eMAR Medication Administration Note, dated 12/24/24 at 4:57 PM, revealed: Valproic Acid Oral Solution .medication not available.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review on 1/21/25 of Resident #1's EHR (electronic health record), dated 12/23/24 through 12/24/24, revealed no evidence that the nurses contacted the physician or the pharmacist about the unavailability of valproic acid oral solution.</p> <p>During an interview on 1/21/25 at 12:52 PM, when asked what the procedure was when a medication was not available, the Director of Nursing (DON) stated the nurse would call the provider if the medication was not available in the Cubex (the facility's medication storage system).</p> <p>Review of the Progress notes Health Status Note, dated 12/25/24 at 1:48 AM, revealed: Note Text: Resident [#1] had seizure like activity lasting approximately between one to two minutes. On-call provider called regarding situation and was given the approval to send resident [#1] to ER [emergency room]. Paramedics arrived 10 minutes later. transferred to .PROV [Providence Alaska Medical Center] ER at 0120 [1:20 AM]. Family. notified of transfer.</p> <p>Review of the Providence Alaska Medical Center Admission History &amp; Physical, dated 12/25/24 at 7:33 AM, revealed:</p> <p>[Resident #1] presented with 2 witnessed generalized tonic-clonic seizures [an event that causes a loss of consciousness and violent muscle contractions]. 1 witnessed by [emergency room] staff which was aborted with IV [intravenous] Ativan [a benzodiazepine medication used to treat active seizures] administration.</p> <p>[He/She] has had ongoing decorticate [a reflex pose that's a symptom of damage to or disruptions in brain activity. It causes your legs to become rigid and straight, while your arms flex upward and hold tensely to your chest.] posturing and nonresponsiveness for several hours. Decorticate posturing improved with additional dose of IV Ativan.</p> <p>Reports from [Resident #1's] [facility] say that [he/she] was not receiving [his/her] Depakote [brand name of valproic acid] for the about the last 48 hours due to running out of it, however [his/her] Depakote level was undetectable today, per discussion with pharmacy given the half-life of Depakote this likely means that [he/she] has been off of it for longer than 2 days. Review of Resident #1's PAMC emergency room medical record, dated 12/25/24, revealed a lab result, dated 12/25/24 at 2:33 am, for valproic acid in the Resident's blood was at &lt; [less than] 3.0. The record indicated that a therapeutic range for valproic acid was between 50 and 100 ug/mL (microgram per milliliter).</p> <p>Review of the Providence Alaska Medical Center Discharge Summary, dated 12/27/24 at 11:00 AM, revealed: COURSE IN HOSPITAL .Patient had been without [his/her] home Depakote for the past 48 hours prior to admission, subsequently leading to seizures .Depakote bolus initiated, levels subtherapeutic .I have significant concerns that patient ran out of [his/her] seizure medicine at skilled nursing. Case management and social worker are aware and will be further investigating. Family is also very concerned about patient care at this facility and I understand their concerns .PLAN FOR FOLLOW -UP .3. It is imperative that this patient not run out of [his/her] antiseizure medications, as this is what led to this hospitalization .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the SKILLED NURSING FACILITY TRANSFER ORDERS, dated 12/27/24 at 11:36 AM, revealed Resident #1 was admitted to the hospital on 12/25/24 and discharged on [DATE] with a principal problem of Breakthrough seizure. The medication orders section revealed valproic acid 250mg/5 ml liquid was included in the list. Further review of the medication orders section, revealed a handwritten note which read: Please do not run off seizure meds[medicine] again.</p> <p>Review of the facility provided document Medication Guide Valproic Acid Oral Solution on 1/21/25, reveal Do not stop Valproic Acid Oral Solution, USP . Stopping Valproic Acid Oral Solution, USP suddenly can cause serious problems. Stopping a seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop (status epilepticus).</p> <p>Review of the Food and Drug Administration (FDA) Medication Guide for Valproic Acid, accessed on 1/29/25 at <a href="https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/018081s070,018082s053lbl.pdf#page=41">https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/018081s070,018082s053lbl.pdf#page=41</a> revealed: Stopping Depakote or Depakene suddenly can cause serious problems.</p> <p>Review of the Provider's Progress Notes, dated 12/29/24, revealed: .Chief Complaint: return from hospital. HPI [history of present illness]: [Resident #1's name] .seems to have breakthrough seizures related to not receiving [his/her] seizure meds [medications]. Valproic acid undetectable in ED [Emergency Department] Received a loading dose of Depakote and was admitted overnight.</p> <p>Review of Progress notes Alert Notes on 12/27/24 at 7:51 PM revealed: Resident [sibling] came in around 19:30 [7:30 pm] this evening .This writer respectfully answered the [sibling] that the only person we can give [information] regarding the resident will be [his/her] POA [Power of Attorney]. As of this time, if you will be asking an in depth regarding resident cares and medications, it's better if you could talk to the POA or if management will be here. This [sibling] adamantly asking what medications are you giving at night and at days and they said to us in the hospital that my resident was neglected with [his/her] medications! This writer even verbalized as of this time, I cannot give you an in depth [information] about that. However, if you have concerns, just wait and talk to our Nursing management during office hours.</p> <p>Review of the facility's Drug Record Book, dated 1/21/25 at 4:46 PM revealed: Valproic Acid Oral Solution 250 MG/5ML . Re/Ordered Date: 12/09/2024 . 12/30/2024 .</p> <p>Review of the medication delivery Packing Slip, dated 12/9/24, from PharMerica [the facility's contracted pharmacy] revealed: . 473.00 [ML] VALPROIC ACD SOL 250/5ML for Resident #1 was delivered. The facility received the medication on 12/10/24. Due to the medication being received on 12/10/24, this would only allowed the Resident to have enough medication through 12/21/24 if no additional medication was available.</p> <p>Review of another Packing Slip, dated 12/30/24, revealed valproic acid was delivered to the facility and received on 12/31/24.</p> <p>There was no other valproic acid solution for Resident #1 delivered between 12/9/24 and 12/30/24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/21/25 at 4:24 PM, the Administrator stated the facility did not have inventory of valproic acid. She stated Resident #1's valproic acid was a G-tube medication (medications administered through a gastrostomy tube). She added that PharMerica would deliver the valproic acid two weeks at a time. She further stated when the medication ran-out on 12/23/24, that would have been the end of the two weeks.</p> <p>An observation on 1/21/25 at 3:15 PM revealed Resident #1's Valproic Acid Oral Solution USP bottle was 473 ml in size.</p> <p>During an interview with Licensed Nurse (LN) #2 on 1/21/25 at 3:15 PM, he/she stated the way he/she knew when to reorder Resident #1's valproic acid bottle was to look at the bottle and reorder another bottle if it looked like the bottle was getting close to being empty.</p> <p>During an interview with the Pharmacist on 1/22/24 at 8:00 AM, he/she stated based off Resident #1's medication order, Resident #1 would receive only 11 full days of valproic acid from a 473 ml bottle.</p> <p>During an interview on 1/21/25 at 5:04 PM with the Administrator, she confirmed that PharMerica did not receive a refill order for valproic acid solution from a nurse during the time when the medication was not available in the facility.</p> <p>Reporting Event:</p> <p>During an interview with the DON on 1/21/25 at 2:15 PM, DON stated the investigation for Resident #1's missed doses of valproic acid and subsequent hospitalization was ongoing and had not been completed. DON further stated that he was waiting to interview one nurse that was assigned to Resident #1 on the day Resident #1 did not receive scheduled valproic acid. DON stated he does not know the cause of valproic acid being unavailable. DON stated he opened the investigation the day after Resident #1 came back from the facility. When asked if missed medication was the reason for hospitalization, DON stated possibly, don't know for sure, the hospital paperwork isn't saying that.</p> <p>Review of the Providence Alaska Medical Center Discharge Summary, dated 12/27/24 at 11:00 AM, revealed: COURSE IN HOSPITAL .Patient had been without [his/her] home Depakote for the past 48 hours prior to admission, subsequently leading to seizures .PLAN FOR FOLLOW -UP .3. It is imperative that this patient not run out of [his/her] antiseizure medications, as this is what led to this hospitalization .</p> <p>During an interview on 1/21/25 at 4:24 PM, when asked when the facility requested delivery of valproic acid on 12/23-24/24, the Administrator stated she was out at that time, she learned about the missed medication today [1/21/25]. When asked if the missed medication was discussed during the stand-up meeting [daily staff meeting], she stated there was no leadership team during Christmas so there was no stand-up meeting that day [12/25/24]. She further stated that Resident #1 being in the hospital was discussed during the stand-up meeting the day after [12/26/24] and that the stand up was led by the DON.</p> <p>During the same interview the Administrator stated, It got missed, she further stated it should have been reported to the State.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the stand up meeting minutes, dated 12/26/24 at 10:16 AM, revealed: Hospital .[Resident #1]-seizures .</p> <p>Review of the Incident Report, Medication Error, unknown creation date, revealed, [Resident #1] had a seizure at 0148 hours on 12/25/2024. After the seizure it was noted that the resident did not receive [his/her] Depakote medication on 12/23/24 at 100 hours, and both doses on 12/24/2024 .The resident was assessed by the unit nurse, the on-call provider was notified and the resident was sent to the emergency room for evaluation .</p> <p>Review of the facility's policy Medication Administration General Guidelines, dated 1/2023, revealed: . Documentation .2. If a dose of regularly scheduled medication is withheld .the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN [as needed] documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified .</p> <p>Review of the facility policy Unusual Occurrence Reporting, undated, revealed: As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents . 1. Our facility will report the following events to appropriate agencies: Allegations of abuse, neglect . and . Other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents . Unusual occurrences shall be reported via telephone to appropriate agencies are required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations .</p> <p>Review of the facility's Abuse-Screening, Training, Identification, Investigation, Reporting, and Protection policy, revised 1/2023 revealed: .6. Facility utilizes Incident/Accident Investigation policy and procedure to investigate concerns and incidents . All alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown sources . must be thoroughly investigated. The investigation is done to determine, as far as possible: i. What occurred; and ii. To make necessary changes to the provision of care and services to prevent reoccurrence. b. A thorough investigation is completed through a systemic collection and review of evidence/information that describes and explains an event or series of events. It seeks to determine if abuse, neglect . and how to prevent further occurrences .14. All staff members are considered mandatory reporters and as such are obligated to report using the state reporting mechanism 16 .If the allegation involves neglect . that does not involve abuse or serious injury, the incident is reported within 24 hours to local law enforcement and the state survey agency, as required . DEFINITIONS OF ABUSE: . Neglect: is the failure of the facility, its employees or service providers to provide goods or services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42377</b></p> <p>Based on record review and interview, the facility failed to ensure an incident of multiple missed anticonvulsant medications that resulted to multiple seizure episodes and subsequent hospitalization for one resident (#1) out of three sampled residents was thoroughly investigated and the results were reported to the State Survey Agency within 5 working days as specified by the 42 CFR S483.12(c).</p> <p>Specifically, the facility failed to investigate neglectful deprivation of goods and services by facility staff and report results within 5 working days of the incident to the facility's Administrator or his/her designated representative and the State Survey Agency. Additionally, staff interviews, and record reviews and subsequently corrective actions had not been completed. The failure to timely report and fully investigate Resident #1's hospitalization and unavailability of medications, and report to the State Survey Agency, placed the resident at risk for further potential harm or neglect.</p> <p>Findings:</p> <p>Record review on 1/21-22/25, revealed Resident #1 was admitted to the facility with diagnoses that included hemiplegia (weakness or paralysis of one side of the body) and hemiparesis (partial paralysis of one side of the body), anoxic brain damage (lack of oxygen to the brain resulting in cognitive, physical and neurological impairments) and general epilepsy (seizures that involve both halves of the brain) and epileptic syndrome (seizures that are characterized based on symptoms, location or origin, and diagnostic tests). Further review revealed Resident #1 had a PEG-Tube (a surgically inserted feeding tube into the stomach bypassing the mouth and esophagus).</p> <p>Omitted Medication:</p> <p>Review of the Physician's order, dated 11/14/24, revealed: Valproic Acid Oral Solution [medication for seizures] 250 MG/5ML (Valproate Sodium) Give 20 ml via PEG-Tube two times a day for Anoxic Brain Injury.</p> <p>Review of the Medication Administration Record Report dated 12/1-31/24, revealed valproic acid oral solution 250 mg/5ml was not administered on 12/23/24 at 3:00 PM, 12/24/24 at 7:00 AM and 12/24/24 at 3:00 PM. Dates of unadministered valproic acid oral solution were coded as 9 for Other/See Nurses Notes.</p> <p>Review of the nursing notes section eMAR (electronic medication administration record) Medication Administration Note, dated 12/23/24 at 4:20 PM, revealed: Valproic Acid Oral Solution 250 MG/ 5 ML Give 20 ml via PEG-Tube two times a day for anoxic Brain Injury awaiting pharmacy to deliver.</p> <p>Review of the nursing notes section eMAR Medication Administration Note, dated 12/24/24 at 10:09 AM, revealed: Valproic Acid Oral Solution 250 MG/ 5 ML . waiting for delivery.</p> <p>Review of the nursing notes section eMAR Medication Administration Note, dated 12/24/24 at 4:57 PM, revealed: Valproic Acid Oral Solution .medication not available.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review on 1/21/25 of Resident #1's EHR (electronic health record), dated 12/23/24 through 12/24/24, revealed no evidence that the nurses contacted the physician or the pharmacist about the unavailability of valproic acid oral solution.</p> <p>During an interview on 1/21/25 at 12:52 PM, when asked what the procedure was when a medication was not available, the Director of Nursing (DON) stated the nurse would call the provider if the medication was not available in the Cubex (the facility's medication storage system).</p> <p>Review of the Progress notes Health Status Note, dated 12/25/24 at 1:48 AM, revealed: Note Text: Resident [#1] had seizure like activity lasting approximately between one to two minutes. On-call provider called regarding situation and was given the approval to send resident [#1] to ER [emergency room]. Paramedics arrived 10 minutes later. transferred to .PROV [Providence Alaska Medical Center] ER at 0120 [1:20 AM]. Family. notified of transfer.</p> <p>Review of the Providence Alaska Medical Center (PAMC) Admission History &amp; Physical, dated 12/25/24 at 7:33 AM, revealed:</p> <p>[Resident #1] presented with 2 witnessed generalized tonic-clonic seizures [an event that causes a loss of consciousness and violent muscle contractions]. 1 witnessed by [emergency room] staff which was aborted with IV [intravenous] Ativan [a benzodiazepine medication used to treat active seizures] administration.</p> <p>[He/She] has had ongoing decorticate [a reflex pose that's a symptom of damage to or disruptions in brain activity. It causes your legs to become rigid and straight, while your arms flex upward and hold tensely to your chest.] posturing and nonresponsiveness for several hours. Decorticate posturing improved with additional dose of IV Ativan.</p> <p>Reports from [Resident #1's] [facility] say that [he/she] was not receiving [his/her] Depakote [brand name of valproic acid] for the about the last 48 hours due to running out of it, however [his/her] Depakote level was undetectable today, per discussion with pharmacy given the half-life of Depakote this likely means that [he/she] has been off of it for longer than 2 days.</p> <p>Review of Resident #1's PAMC emergency room medical record, dated 12/25/24, revealed a lab result, dated 12/25/24 at 2:33 am, for valproic acid in the Resident's blood was at &lt; [less than] 3.0. The record indicated that a therapeutic range for valproic acid was between 50 and 100 ug/mL (microgram per milliliter).</p> <p>Review of the Providence Alaska Medical Center Discharge Summary, dated 12/27/24 at 11:00 AM, revealed: COURSE IN HOSPITAL .Patient had been without [his/her] home Depakote the past 48 hours prior to admission, subsequently leading to seizures .Depakote bolus initiated, levels subtherapeutic .I have significant concerns that patient ran out of [his/her] seizure medicine at skilled nursing. Case management and social worker are aware and will be further investigating. Family is also very concerned about patient care at this facility and I understand their concerns .PLAN FOR FOLLOW -UP .3. It is imperative that this patient not run out of [his/her] antiseizure medications, as this is what led to this hospitalization .</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the SKILLED NURSING FACILITY TRANSFER ORDERS, dated 12/27/24 at 11:36 AM, revealed Resident #1 was admitted to the hospital on 12/25/24 and discharged on [DATE] with a principal problem of Breakthrough seizure. The medication orders section revealed valproic acid 250mg/5 ml liquid was included in the list. Further review of the medication orders section, revealed a handwritten note which read: Please do not run off seizure meds[medicine] again.</p> <p>Review of the Food and Drug Administration (FDA) Medication Guide for Valproic Acid, accessed on 1/29/25 at <a href="https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/018081s070,018082s053lbl.pdf#page=41">https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/018081s070,018082s053lbl.pdf#page=41</a> revealed: Stopping Depakote or Depakene suddenly can cause serious problems.</p> <p>Review of the facility provided document Medication Guide Valproic Acid Oral Solution on 1/21/25, revealed: Do not stop Valproic Acid Oral Solution, USP . Stopping Valproic Acid Oral Solution, USP suddenly can cause serious problems. Stopping a seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop (status epilepticus).</p> <p>Review of the Provider's Progress Notes, dated 12/29/24, revealed: .Chief Complaint: return from hospital. HPI [history of present illness]: [Resident #1's name] .seems to have breakthrough seizures related to not receiving [his/her] seizure meds [medications]. Valproic acid undetectable in ED [Emergency Department] Received a loading dose of Depakote and was admitted overnight.</p> <p>Review of Progress notes Alert Notes on 12/27/24 at 7:51 PM revealed : Resident [sibling] came in around 19:30 this evening .This writer respectfully answered the [sibling] that the only person we can give [information] regarding the resident will be [his/her] POA [Power of Attorney]. As of this time, if you will be asking an in depth regarding resident cares and medications, it's better if you could talk to the POA or if management will be here. This [sibling] adamantly asking what medications are you giving at night and at days and they said to us in the hospital that my resident was neglected with [his/her] medications! This writer even verbalized as of this time, I cannot give you an in depth [information] about that. However, if you have concerns, just wait and talk to our Nursing management during office hours.</p> <p>Review of the facility's Drug Record Book, dated 1/21/25 at 4:46 PM revealed: Valproic Acid Oral Solution 250 MG/5ML . Re/Ordered Date: 12/09/2024 . 12/30/2024 .</p> <p>Review of the medication delivery Packing Slip, dated 12/9/24, from PharMerica [the facility's contracted pharmacy] revealed: . 473.00 [ML] VALPROIC ACD SOL 250/5ML for Resident #1 was delivered. The facility received the medication on 12/10/24. Due to the medication being received on 12/10/24, this would only allowed the Resident to have enough medication through 12/21/24 if no additional medication was available.</p> <p>Review of another Packing Slip, dated 12/30/24, revealed valproic acid was delivered to the facility and received on 12/31/24.</p> <p>There was no other valproic acid solution for Resident #1 delivered between 12/9/24 and 12/30/24.During an interview on 1/21/25 at 4:24 PM, the Administrator stated the facility did not have inventory of valproic acid. She stated Resident #1's valproic acid was a G-tube medication (medications administered through a gastrostomy tube). She added that PharMerica would deliver the valproic acid two weeks at a time. She further stated when the medication ran-out on 12/23/24, that would have been the end of the two weeks.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 1/21/25 at 3:15 PM revealed Resident #1's Valproic Acid Oral Solution USP bottle was 473 ml in size.</p> <p>During an interview with Licensed Nurse (LN) #2 on 1/21/25 at 3:15 PM, he/she stated the way he/she knew when to reorder Resident #1's valproic acid bottle was to look at the bottle and reorder another bottle if it looked like the bottle was getting close to being empty.</p> <p>During an interview with the Pharmacist on 1/22/24 at 8:00 AM, he/she stated based off Resident #1's medication order, Resident #1 would receive only 11 full days of valproic acid from a 473 ml bottle.</p> <p>Reporting and Investigation:</p> <p>During an interview with the Director of Nursing (DON) on 1/21/25 at 2:15 PM, DON stated the investigation for Resident #1's missed doses of valproic acid and subsequent hospitalization was ongoing and had not been completed (27 days since hospitalization ).</p> <p>The DON further stated that he was waiting to interview one nurse that was assigned to Resident #1 on the day Resident #1 did not receive scheduled valproic acid. DON stated he does not know the cause of valproic acid being unavailable. DON stated he opened the investigation the day after Resident #1 came back from the facility. When asked if missed medication was the reason for hospitalization , DON stated possibly, don't know for sure, the hospital paperwork isn't saying that.</p> <p>Review of the Providence Alaska Medical Center Discharge Summary, dated 12/27/24 at 11:00 AM, revealed: COURSE IN HOSPITAL .Patient had been without [his/her] home Depakote for the past 48 hours prior to admission, subsequently leading to seizures .PLAN FOR FOLLOW -UP .3. It is imperative that this patient not run out of [his/her] antiseizure medications, as this is what led to this hospitalization .</p> <p>During an interview on 1/21/25 at 4:24 PM, when asked when the facility requested delivery of valproic acid on 12/23-24/24, the Administrator stated she was out at that time, she learned about the missed medication today [1/21/25]. When asked if the missed medication was discussed during the stand-up meeting [daily staff meeting], she stated there was no leadership team during Christmas so there was no stand-up meeting that day [12/25/24]. She further stated that Resident #1 being in the hospital was discussed during the stand-up meeting the day after [12/26/24] and that the stand up was led by the DON.</p> <p>During the same interview the Administrator stated, It got missed, she further stated it should have been reported to the State.</p> <p>During an interview on 1/21/25 at 5:04 PM with the Administrator, she confirmed that PharMerica did not receive a refill order for valproic acid Solution from a nurse during the time when the medication was not available in the facility.</p> <p>Review of the stand up meeting minutes, dated 12/26/24 at 10:16 AM, revealed: Hospital .[Resident #1]-seizures .</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Incident Report, Medication Error, unknown creation date, revealed, [Resident #1] had a seizure at 0148 hours on 12/25/2024. After the seizure it was noted that the resident did not receive [his/her] Depakote medication on 12/23/24 at 100 hours, and both doses on 12/24/2024 .The resident was assessed by the unit nurse, the on-call provider was notified and the resident was sent to the emergency room for evaluation .</p> <p>Review of the facility's policy Medication Administration General Guidelines, dated 1/2023, revealed: . Documentation .2. If a dose of regularly scheduled medication is withheld .the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN [as needed] documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified .</p> <p>Review of the facility's policy Unusual Occurrence Reporting, policy, undated, revealed: As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents . 1. Our facility will report the following events to appropriate agencies: Allegations of abuse, neglect . and . Other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents . Unusual occurrences shall be reported via telephone to appropriate agencies are required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations . Review of the facility's Abuse-Screening, Training, Identification, Investigation, Reporting, and Protection policy, revised 1/2023 revealed: .6. Facility utilizes Incident/Accident Investigation policy and procedure to investigate concerns and incidents . All alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown sources . must be thoroughly investigated. The investigation is done to determine, as far as possible: i. What occurred; and ii. To make necessary changes to the provision of care and services to prevent reoccurrence. b. A thorough investigation is completed through a systemic collection and review of evidence/information that describes and explains an event or series of events. It seeks to determine if abuse, neglect . and how to prevent further occurrences .14. All staff members are considered mandatory reporters and as such are obligated to report using the state reporting mechanism 16 .If the allegation involves neglect . that does not involve abuse or serious injury, the incident is reported within 24 hours to local law enforcement and the state survey agency, as required . DEFINITIONS OF ABUSE: . Neglect: is the failure of the facility, its employees or service providers to provide goods or services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42377</b></p> <p>Based on record review, observation, and interview, the facility failed to: 1) provide multiple doses of routine anticonvulsant medication to Resident #1 per physician's order, and 2) provide accurate acquiring, and receiving of medications for one resident (#1) out of three sampled residents.</p> <p>These failed practices resulted in:</p> <p>1) untimely acquisition and administering of medication for Resident #1;</p> <p>2) Resident #1 enduring multiple seizure episodes, decorticate posturing [a reflex pose that's a symptom of damage to or disruptions in brain activity. It causes your legs to become rigid and straight, while your arms flex upward and hold tensely to your chest.] with nonresponsiveness for several hours, and subsequent hospitalization ; and</p> <p>3) a negative outcome that compromised the resident's ability to maintain and/or reach his/her highest practicable physical wellbeing, as a consequence of subtherapeutic levels of anticonvulsant medication and caused actual harm to the resident.</p> <p>Findings:</p> <p>Record review on 1/21-22/25, revealed Resident #1 was admitted to the facility with diagnoses that included hemiplegia (weakness or paralysis of one side of the body) and hemiparesis (partial paralysis of one side of the body), anoxic brain damage (lack of oxygen to the brain resulting in cognitive, physical and neurological impairments) and general epilepsy (seizures that involve both halves of the brain) and epileptic syndrome (seizures that are characterized based on symptoms, location or origin, and diagnostic tests). Further review revealed Resident #1 had a PEG-Tube (a surgically inserted feeding tube into the stomach bypassing the mouth and esophagus) .</p> <p>Omitted Medication:</p> <p>Review of the Physician's order, dated 11/14/24, revealed: Valproic Acid Oral Solution [medication for seizures] 250 MG/5ML (Valproate Sodium) Give 20 ml via PEG-Tube two times a day for Anoxic Brain Injury.</p> <p>Review of the Medication Administration Record Report dated 12/1-31/24, revealed valproic acid oral solution 250 mg/5ml was not administered on 12/23/24 at 3:00 PM, 12/24/24 at 7:00 AM and 12/24/24 at 3:00 PM. Dates of unadministered valproic acid oral solution were coded as 9 for Other/See Nurses Notes.</p> <p>Review of the nursing notes section eMAR (electronic medication administration record) Medication Administration Note, dated 12/23/24 at 4:20 PM, revealed: Valproic Acid Oral Solution 250 MG/ 5 ML Give 20 ml via PEG-Tube two times a day for anoxic Brain Injury awaiting pharmacy to deliver.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  025025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Centennial Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  9100 Centennial Drive Anchorage, AK 99504	
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F 0755  Level of Harm - Actual harm  Residents Affected - Few	<p>Review of the nursing notes section eMAR Medication Administration Note, dated 12/24/24 at 10:09 AM, revealed: Valproic Acid Oral Solution 250 MG/ 5 ML . waiting for delivery.</p> <p>Review of the nursing notes section eMAR Medication Administration Note, dated 12/24/24 at 4:57 PM, revealed: Valproic Acid Oral Solution .medication not available.</p> <p>Record review on 1/21/25 of Resident #1's EHR (electronic health record), dated 12/23/24 through 12/24/24, revealed no evidence that the nurses contacted the physician or the pharmacist about the unavailability of valproic acid oral solution.</p> <p>During an interview on 1/21/25 at 12:52 PM, when asked what the procedure was when a medication was not available, the Director of Nursing (DON) stated the nurse would call the provider if the medication was not available in the Cubex (the facility's medication storage system).</p> <p>Review of the Progress notes Health Status Note, dated 12/25/24 at 1:48 AM, revealed: Note Text: Resident [#1] had seizure like activity lasting approximately between one to two minutes.On-call provider called regarding situation and was given the approval to send resident [#1] to ER [emergency room ].Paramedics arrived 10 minutes later.transferred to .PROV [Providence Alaska Medical Center] ER at 0120 [1:20 AM]. Family. notified of transfer.</p> <p>Review of the Providence Alaska Medical Center (PAMC) Admission History &amp; Physical, dated 12/25/24 at 7:33 AM, revealed:</p> <p>[Resident #1] presented with 2 witnessed generalized tonic-clonic seizures [an event that causes a loss of consciousness and violent muscle contractions]. 1 witnessed by [emergency room ] staff which was aborted with IV [intravenous] Ativan [a benzodiazepine medication used to treat active seizures] administration.</p> <p>[He/She] has had ongoing decorticate [a reflex pose that's a symptom of damage to or disruptions in brain activity. It causes your legs to become rigid and straight, while your arms flex upward and hold tensely to your chest.] posturing and nonresponsiveness for several hours. Decorticate posturing improved with additional dose of IV Ativan.</p> <p>Reports from [Resident #1's] [facility] say that [he/she] was not receiving [his/her] Depakote [brand name of valproic acid] for the about the last 48 hours due to running out of it, however [his/her] Depakote level was undetectable today, per discussion with pharmacy given the half-life of Depakote this likely means that [he/she] has been off of it for longer than 2 days.</p> <p>Review of Resident #1's PAMC emergency room medical record, dated 12/25/24, revealed a lab result, dated 12/25/24 at 2:33 am, for valproic acid in the Resident's blood was at &lt; [less than] 3.0. The record indicated that a therapeutic range for valproic acid was between 50 and 100 ug/mL (microgram per milliliter).</p> <p>Review of the Providence Alaska Medical Center Discharge Summary, dated 12/27/24 at 11:00 AM, revealed: COURSE IN HOSPITAL .Patient had been without [his/her] home Depakote for the past 48 hours prior to admission, subsequently leading to seizures .Depakote bolus initiated, levels subtherapeutic .PLAN FOR FOLLOW -UP .3. It is imperative that this patient not run out of [his/her] antiseizure medications, as this is what led to this hospitalization .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the SKILLED NURSING FACILITY TRANSFER ORDERS, dated 12/27/24 at 11:36 AM, revealed Resident #1 was admitted to the hospital on 12/25/24 and discharged on [DATE] with a principal problem of Breakthrough seizure. The medication orders section revealed valproic acid 250mg/5 ml liquid was included in the list. Further review of the medication orders section, revealed a handwritten note which read: Please do not run off seizure meds[medicine] again.</p> <p>Review of the Provider's Progress Notes, dated 12/29/24, revealed: .Chief Complaint: return from hospital. HPI [history of present illness]: [Resident #1's name] .seems to have breakthrough seizures related to not receiving [his/her] seizure meds [medications]. Valproic acid undetectable in ED [Emergency Department] Received a loading dose of Depakote and was admitted overnight.</p> <p>Review of the facility's Drug Record Book, dated 1/21/25 at 4:46 PM revealed: Valproic Acid Oral Solution 250 MG/5ML . Re/Ordered Date: 12/09/2024 . 12/30/2024 .</p> <p>Review of the medication delivery Packing Slip, dated 12/9/24, from PharMerica [the facility's contracted pharmacy] revealed: . 473.00 [ML] VALPROIC ACD SOL 250/5ML for Resident #1 was delivered. The facility received the medication on 12/10/24. Due to the medication being received on 12/10/24, this would only allowed the Resident to have enough medication through 12/21/24 if no additional medication was available.</p> <p>Review of another Packing Slip, dated 12/30/24, revealed valproic acid was delivered to the facility and received on 12/31/24.</p> <p>There was no other valproic acid solution for Resident #1 delivered between 12/9/24 and 12/30/24.</p> <p>During an interview on 1/21/25 at 4:24 PM, the Administrator stated the facility did not have inventory of valproic acid. She stated Resident #1's valproic acid was a G-tube medication (medications administered through a gastrostomy tube). She added that PharMerica would deliver the valproic acid two weeks at a time. She further stated when the medication ran-out on 12/23/24, that would have been the end of the two weeks.</p> <p>An observation on 1/21/25 at 3:15 PM revealed Resident #1's Valproic Acid Oral Solution USP bottle was 473 ml in size.</p> <p>During an interview with the Pharmacist on 1/22/24 at 8:00 AM, he/she stated based off Resident #1's medication order of 40 ml per day, Resident #1 would receive only 11 full days of Valproic Acid from a 473 ml bottle.</p> <p>During an interview with Licensed Nurse (LN) #2 on 1/21/25 at 3:15 PM, he/she stated the way he/she knew when to reorder Resident #1's valproic acid bottle was to look at the bottle and reorder another bottle if it looked like the bottle was getting close to being empty.</p> <p>During an interview on 1/21/25 at 4:24 PM, when asked when the facility requested delivery of valproic acid on 12/23-24/24, the Administrator stated she was out at that time, she learned about the missed medication today [1/21/25]. When asked if the missed medication was discussed during the stand-up meeting [daily staff meeting], she stated there was no leadership team during Christmas so there was no stand-up meeting that day [12/25/24]. She stated, It got missed, she further stated it should have been reported to the State.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/21/25 at 5:04 PM with the Administrator, she confirmed that PharMerica did not receive a refill order for valproic acid solution from a nurse during the time when the medication was not available in the facility.</p> <p>Review of the facility's policy Medication Administration General Guidelines , dated 1/2023, revealed: . Documentation .2. If a dose of regularly scheduled medication is withheld .the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN [as needed] documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified .</p> <p>Review of the Food and Drug Administration (FDA) Medication Guide for Valproic Acid, accessed on 1/29/25 at <a href="https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/018081s070,018082s053lbl.pdf#page=41">https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/018081s070,018082s053lbl.pdf#page=41</a> revealed: Stopping Depakote or Depakene suddenly can cause serious problems.</p> <p>Review of the facility provided document Medication Guide Valproic Acid Oral Solution on 1/21/25, revealed: Do not stop Valproic Acid Oral Solution, USP . Stopping Valproic Acid Oral Solution, USP suddenly can cause serious problems. Stopping a seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop (status epilepticus).</p> <p>Acquisition and receiving of medications:</p> <p>During an interview on 1/21/25 at 10:51 AM, LN #1 stated residents' medications were in the medication cart. If there was no available medication in the medication cart, the nurse would check the availability of the medication in the Cubex . If there was no available medication in the Cubex, the nurse would request for a refill.</p> <p>Review of the Anchorage Cubex [Medication Inventory] List, on 1/21/25 at 3:57 PM, revealed valproic acid was not listed.</p> <p>When asked about the requisition process, LN #1 stated if the medication was a new medication, then the nurse would have removed a strip from the medication's label and attached the strip to a fax form and send the fax to PharMerica for refill.</p> <p>During the same interview, LN #1 stated PharMerica had an automatic refill process in the pharmacy system for scheduled medications that the residents' had been receiving, so the nurses did not need to fax a refill order.</p> <p>During an interview on 1/21/25 at 12:52 PM, the Director of Nursing (DON) when asked about the expectation for the pharmacy delivery time, he stated if the medication order was placed at 2:00 PM then the medication would be delivered the next day. If the order was placed after 4:00 PM, the medication would be delivered not the next day but the following day. DON further stated if nurses were unable to administer a medication within the hour due to a missing dose, the expectation was to further notify the provider and document in the EHR.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>When asked if PharMerica would notify the facility if the medication was not available, the DON stated PharMerica would not notify the facility of the unavailability of the medication, but they would send a partial refill. He added that if PharMerica could not send the medication, PharMerica would call a satellite pharmacy locally (in Anchorage), then the local pharmacy will deliver the medication to the facility in a few hours.</p> <p>During an interview on 1/22/25 at 8:00 AM, the Pharmacist stated he was not a fulltime employee of the facility. He added that he was a local pharmacist that was hired by PharMerica to provide consultation. His role in the facility was to load medication in the Cubex on Tuesdays and Thursdays and conduct a monthly chart review including psychotropic medication review of all residents in the facility. He stated the nurses and providers could email, call or text him.</p> <p>During the same interview, the Pharmacist stated the Cubex had individual cubies that stored individual medication like tablets or inhalers which were not Resident specific medications. He added that when the medications were delivered, he would stock the Cubex. If the delivered pack contained a whole month supply for a resident , he stated he does not check those medications. He further stated he did not reconcile the medications received for the resident specific medications.</p> <p>The Pharmacist further stated if the medication was running low, or expired, PharMerica would send new supply.</p> <p>When asked if he kept a list of delivered medication for the Cubex, he stated no. He further stated a delivery invoice comes with the package. After loading the medication in the Cubex, he would then throw away the delivery invoice.</p> <p>When asked if he had a list of expired medications that were sent to PharMerica, he stated no, the expired medication was packed and returned to the pharmacy.</p> <p>Review of the Pharmacy Services Agreement, signed by the facility on 7/29/24 and signed by PharMerica on 8/2/24, revealed: .Pharmacy shall provide the services set forth in the agreement to Client and persons in care of the Customer (the 'Residents' or 'Patients') in accordance with the terms and conditions of this Agreement, and any Schedules, Exhibits or policies and procedures of the Manual (collectively, the 'Services'), which are incorporated into this Agreement by reference.OBLIGATIONS OF THE PHARMACY. A. Pharmacy shall provide to Client and deliver to the Customer prescription and non-prescription drugs. In accordance with the orders of the Resident's licensed prescribers as provided to Pharmacy by Customer, and the Customer's own orders.B. Pharmacy shall deliver Products in accordance with Pharmacy's routine delivery schedule. Delivery schedules and cut-off times will be at the sole discretion of Pharmacy. Pharmacy will make three (3) schedule deliveries per day. OBLIGATIONS OF THE CLIENT. Client shall, or require the Customer to, as the case may be.B. Use its reasonable effects to aggregate, organize and plan daily orders to Pharmacy to minimize Stat orders. H. Provide Pharmacy with access to the Customer, as necessary, to enable Pharmacy to carry out its obligations under the Agreement.J. Store and handle all Medications in accordance with Applicable Law. M. return to Pharmacy unused Medications.P. adopt Medication ordering processes that conform to the Pharmacy's dispensing procedures.</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42377</b></p> <p>Based on record review, observation , and interview, the facility failed to ensure one resident (#1) out three sampled residents was free of a significant medication error. Specifically, the facility failed to provide multiple consistent doses of an anticonvulsant medication per physician's order.</p> <p>This failed practice resulted in:</p> <ol style="list-style-type: none"> <li>1) a significant medication error due to the omission of administering multiple doses of anticonvulsant medication for Resident #1;</li> <li>2) Resident #1 enduring multiple seizure episodes, decorticate posturing [a reflex pose that's a symptom of damage to or disruptions in brain activity. It causes your legs to become rigid and straight, while your arms flex upward and hold tensely to your chest.] with nonresponsiveness for several hours, and subsequent hospitalization ; and</li> <li>3) a negative outcome that compromised the resident's ability to maintain and/or reach his/her highest practicable physical wellbeing, as a consequence of subtherapeutic levels of anticonvulsant medication and caused actual harm to the resident.</li> </ol> <p>Findings:</p> <p>Record review on 1/21-22/25, revealed Resident #1 was admitted to the facility with diagnoses that included hemiplegia (weakness or paralysis of one side of the body) and hemiparesis (partial paralysis of one side of the body), anoxic brain damage (lack of oxygen to the brain resulting in cognitive, physical and neurological impairments) and general epilepsy (seizures that involve both halves of the brain) and epileptic syndrome (seizures that are characterized based on symptoms, location or origin, and diagnostic tests). Further review revealed Resident #1 had a PEG-Tube (a surgically inserted feeding tube into the stomach bypassing the mouth and esophagus) .</p> <p>Omitted Medication:</p> <p>Review of the Physician's order, dated 11/14/24, revealed: Valproic Acid Oral Solution [medication for seizures] 250 MG/5ML (Valproate Sodium) Give 20 ml via PEG-Tube two times a day for Anoxic Brain Injury.</p> <p>Review of the Medication Administration Record Report dated 12/1-31/24, revealed valproic acid oral solution 250 mg/5ml was not administered on 12/23/24 at 3:00 PM, 12/24/24 at 7:00 AM and 12/24/24 at 3:00 PM. Dates of unadministered valproic acid oral solution were coded as 9 for Other/See Nurses Notes.</p> <p>Review of the nursing notes section eMAR (electronic medication administration record) Medication Administration Note, dated 12/23/24 at 4:20 PM, revealed: Valproic Acid Oral Solution 250 MG/ 5 ML Give 20 ml via PEG-Tube two times a day for anoxic Brain Injury awaiting pharmacy to deliver.</p> <p>(continued on next page)</p>

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F 0760  Level of Harm - Actual harm  Residents Affected - Few	<p>Review of the nursing notes section eMAR Medication Administration Note, dated 12/24/24 at 10:09 AM, revealed: Valproic Acid Oral Solution 250 MG/ 5 ML . waiting for delivery.</p> <p>Review of the nursing notes section eMAR Medication Administration Note, dated 12/24/24 at 4:57 PM, revealed: Valproic Acid Oral Solution .medication not available.</p> <p>During an interview on 1/21/25 at 12:52 PM, when asked what the procedure was when a medication was not available, the Director of Nursing (DON) stated the nurse would call the provider if the medication was not available in the Cubex (the facility's medication storage system).</p> <p>During the same interview on 1/21/25 at 12:52 PM, when asked about the expectation for the pharmacy delivery time, the DON stated if the medication order was placed at 2:00 PM then the medication would be delivered the next day. If the order was placed after 4:00 PM, the medication would be delivered not the next day but the following day. DON further stated if nurses were unable to administer a medication within the hour due to a missing dose, the expectation was to further notify the provider and document in the EHR (electronic health record).</p> <p>Record review on 1/21/25 of Resident #1's EHR, dated 12/23/24 through 12/24/24, revealed no evidence that the nurses contacted the physician or the pharmacist about the unavailability of valproic acid oral solution.</p> <p>Review of the Progress notes Health Status Note, dated 12/25/24 at 1:48 AM, revealed: Note Text: Resident [#1] had seizure like activity lasting approximately between one to two minutes.On-call provider called regarding situation and was given the approval to send resident [#1] to ER [emergency room ].Paramedics arrived 10 minutes later.transferred to .PROV [Providence Alaska Medical Center] ER at 0120 [1:20 AM]. Family. notified of transfer.</p> <p>Review of the Providence Alaska Medical Center (PAMC) Admission History &amp; Physical, dated 12/25/24 at 7:33 AM, revealed:</p> <p>[Resident #1] presented with 2 witnessed generalized tonic-clonic seizures [an event that causes a loss of consciousness and violent muscle contractions]. 1 witnessed by [emergency room ] staff which was aborted with IV [intravenous] Ativan [a benzodiazepine medication used to treat active seizures] administration.</p> <p>[He/She] has had ongoing decorticate posturing and nonresponsiveness for several hours. Decorticate posturing improved with additional dose of IV Ativan.</p> <p>Reports from [Resident #1's] [facility] say that [he/she] was not receiving [his/her] Depakote [brand name for valproic acid] for the about the last 48 hours due to running out of it, however [his/her] Depakote level was undetectable today, per discussion with pharmacy given the half-life of Depakote this likely means that [he/she] has been off of it for longer than 2 days.</p> <p>Review of Resident #1's PAMC emergency room medical record, dated 12/25/24, revealed a lab result, dated 12/25/24 at 2:33 am, for valproic acid in the Resident's blood was at &lt; [less than] 3.0. The record indicated that a therapeutic range for valproic acid was between 50 and 100 ug/mL (microgram per milliliter).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Providence Alaska Medical Center Discharge Summary, dated 12/27/24 at 11:00 AM, revealed: COURSE IN HOSPITAL .Patient had been without [his/her] home Depakote for the past 48 hours prior to admission, subsequently leading to seizures .Depakote bolus initiated, levels subtherapeutic .PLAN FOR FOLLOW -UP .3. It is imperative that this patient not run out of [his/her] antiseizure medications, as this is what led to this hospitalization .</p> <p>Review of the SKILLED NURSING FACILITY TRANSFER ORDERS, dated 12/27/24 at 11:36 AM, revealed Resident #1 was admitted to the hospital on 12/25/24 and discharged on [DATE] with a principal problem of Breakthrough seizure. The medication orders section revealed valproic acid 250mg/5 ml liquid was included in the list. Further review of the medication orders section, revealed a handwritten note which read: Please do not run off seizure meds[medicine] again.</p> <p>Review of the Provider's Progress Notes, dated 12/29/24, revealed: .Chief Complaint: return from hospital. HPI [history of present illness]: [Resident #1's name] .seems to have breakthrough seizures related to not receiving [his/her] seizure meds [medications]. Valproic acid undetectable in ED [Emergency Department] Received a loading dose of Depakote and was admitted overnight.</p> <p>Review of the facility's Drug Record Book, dated 1/21/25 at 4:46 PM revealed: Valproic Acid Oral Solution 250 MG/5ML . Re/Ordered Date: 12/09/2024 .12/30/2024 .</p> <p>Review of the medication delivery Packing Slip, dated 12/9/24, from PharMerica [the facility's contracted pharmacy] revealed: . 473.00 [ML] VALPROIC ACD SOL 250/5ML for Resident #1 was delivered. The facility received the medication on 12/10/24. Due to the medication being received on 12/10/24, this would only allow the Resident to have enough medication through 12/21/24 if no additional medication was available.</p> <p>Review of another Packing Slip, dated 12/30/24, revealed valproic acid was delivered to the facility and received on 12/31/24.</p> <p>There was no other valproic acid solution for Resident #1 delivered between 12/9/24 and 12/30/24.</p> <p>During an interview on 1/21/25 at 4:24 PM, the Administrator stated the facility did not have inventory of valproic acid. She stated Resident #1's valproic acid was a G-tube medication (medications administered through a gastrostomy tube). She added that PharMerica would deliver the valproic acid two weeks at a time. She further stated when the medication ran-out on 12/23/24, that would have been the end of the two weeks.</p> <p>An observation on 1/21/25 at 3:15 PM revealed Resident #1's Valproic Acid Oral Solution USP bottle was 473 ml in size.</p> <p>During an interview with the Pharmacist on 1/22/24 at 8:00 AM, he stated based off Resident #1's medication order of 40 ml per day, Resident #1 would receive only 11 full days of valproic acid from a 473 ml bottle.</p> <p>During an interview with Licensed Nurse (LN) #2 on 1/21/25 at 3:15 PM, he/she stated the way he/she knew when to reorder Resident #1's valproic acid bottle was to look at the bottle and reorder another bottle if it looked like the bottle was getting close to being empty.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  025025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Centennial Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  9100 Centennial Drive Anchorage, AK 99504	
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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/21/25 at 4:24 PM, when asked when the facility requested delivery of valproic acid on 12/23-24/24, the Administrator stated she was out at that time, she learned about the missed medication today [1/21/25]. When asked if the missed medication was discussed during the stand-up meeting [daily staff meeting], she stated there was no leadership team during Christmas so there was no stand-up meeting that day [12/25/24]. She stated, It got missed, she further stated it should have been reported to the State.</p> <p>During an interview on 1/21/25 at 5:04 PM with the Administrator, she confirmed that PharMerica did not receive a refill order for valproic acid oral solution from a nurse during the time when the medication was not available in the facility.</p> <p>Review of the facility's policy Medication Administration General Guidelines , dated 1/2023, revealed: . Documentation .2. If a dose of regularly scheduled medication is withheld .the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN [as needed] documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified .</p> <p>Review of the Food and Drug Administration (FDA) Medication Guide for Valproic Acid, accessed on 1/29/25 at <a href="https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/018081s070,018082s053lbl.pdf#page=41">https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/018081s070,018082s053lbl.pdf#page=41</a> revealed: Stopping Depakote or Depakene suddenly can cause serious problems.</p> <p>Review of the facility provided document Medication Guide Valproic Acid Oral Solution on 1/21/25, revealed: Do not stop Valproic Acid Oral Solution, USP . Stopping Valproic Acid Oral Solution, USP suddenly can cause serious problems. Stopping a seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop (status epilepticus).</p>		