STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025025	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centennial Post Acute	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. . Based on record review and interview, the facility failed to ensure timely reporting of abuse allegations for two residents (#s 8 and 15) out of 20 sampled residents. Specifically, the facility failed to report the allegations of abuse within 2 hours from the occurrence of the incident to the State Survey Agency. This failed practice placed all residents based on a census of 94 at risk for continued potential abuse. Findings: Resident #8 Record review on 6/11-13/25, revealed Resident #8 was admitted to the facility with diagnoses that included encounter for other orthopedic aftercare, subluxation (misalignment) of L4/L5 lumbar and fusion (surgical procedure that joins two or more vertebra) of spine, lumbar. Record review of the Facility Reported Incident (FRI), Initial Report, dated 5/6/25 at 7:30 AM, revealed, the FRI was reported to the State Agency on 5/6/25 at 11:30 AM by Resident Care Manager (RCM) #1. During an interview and concurrent record review on 6/13/25 at 10:22 AM, the Administrator (ADM) was provided Resident #8's Initial Report of allegation of abuse, dated 5/6/25 at 7:30 AM. When the ADM was asked of the date and time of the initial report of allegation of abuse, she stated 5/6/25 at 7:30 AM. The ADM was further asked how long the facility had to report an abuse allegation, she responded 2 hours. When the ADM was asked if the amount of time they took to report the abuse allegation was appropriate, she answered No. Resident #15 Record review on 6/11-13/25, revealed Resident #15 was admitted to the facility with diagnoses that included, cerebral infarction due to thrombosis of right middle cerebral artery (stroke), type 2 diabetes mellitus, and hypertension. Record review of the FRI, Initial Report, dated 5/6/25 at 8:30 AM, revealed the FRI was reported to the State Agency on 5/6/25 at 11:20 AM by RCM #1. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/25 at 1:52 PM, RCM #1 was asked about the process of abuse reporting, he/she stated the accused staff member would be removed immediately from the care area. The Director of Nursing (DON) and the facility ADM would be notified immediately and contact the proper authorities if deemed necessary. RCM #1 further stated any allegation of abuse must be reported to the State Agency within 2 hours of the incident. During the same interview, RCM #1 stated once the facility obtained the staff statement of the alleged event, the staff member would be placed on administrative leave and would not be allowed to return until after the investigation had been completed. RCM #1 stated the final investigation was to be completed within 5 days. Review of the facility's policy Abuse- Screening, Training, Identification, Investigation, Reporting, and Protection, revised 1/2023, revealed: . b. If with the suspicion of crime, there is abuse or a serious injury the staff member must report the incident within 2 hours of forming the suspicion to . the state survey agency . Abuse: is defined as: a. Abuse is the willful infliction. resulting in physical harm, pain or mental anguish . .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. . Based on record review and interview, the facility failed to ensure 3 Facility Reported Incidents (FRI) for residents (#8, #9 and #15) out of 4 FRIs for allegations of abuse were thoroughly investigated. Specifically, the facility failed to provide evidence of the interventions identified in their investigations. This failed practice placed these residents at risk of having injuries or harm that were not adequately addressed and treated. Findings: Resident #8 Record review on 6/11-13/25, revealed Resident #8 was admitted to the facility with diagnoses that included: encounter for other orthopedic aftercare, subluxation (misalignment) of L4/L5 lumbar vertebra and fusion (surgical procedure that joins two or more vertebra) of spine, lumbar. Record review of the FRI, Final Report, dated 5/6/25, revealed: Interventions: . Resident was placed on Alert Charting. Skin check completed with no new injuries noted. Record review 6/11-13/25 of Resident #8's electronic medical record (EMR), no documentation of skin assessment or alert charting was noted for the interventions identified in Final Report dated 5/6/25. During an interview on 6/13/25 at 10:02 AM, the Administrator was asked if she considered alert charting and skin check as part of the investigation into the allegation of abuse and she responded yes. During an interview on 6/13/25 at 10:21 AM, the Administrator was unable to find alert charting or skin assessment documentation in the Resident #8's chart related to the abuse allegation. Resident #9 Record review on 6/11-13/25 revealed Resident #9 was admitted to the facility with diagnoses including encounter for other orthopedic aftercare [rehabilitation process after orthopedic surgery or injury] and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side [paralysis and weakness on the left side of the body following a stroke]. Record review of the FRI, Initial Report, dated 4/24/25, revealed: Interventions: . The resident was placed on alert charting for psychosocial assessment. Record review of the FRI, Final Report, dated 4/28/25, revealed: Conclusion: . A thorough skin assessment of the resident was completed. Record review 6/11-13/25 of Resident #9's EMR, no documentation of alert charting was noted for the interventions identified in Initial Report, dated 4/24/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review 6/11-13/25 of Resident #9's EMR, no documentation of skin assessment was noted for the FRI identified in Final Report, dated 4/28/25. During an interview on 6/13/25 at 10:02 AM the Administrator was asked if she considered alert charting and skin check a part of the investigation into the allegation of abuse and she responded yes. During an interview on 6/13/25 at 10:21 AM, the Administrator was unable to find alert charting or skin assessment documentation in the resident's chart related to the abuse allegation. Resident #15 Record review on 6/11-13/25, revealed Resident #15 was admitted to the facility with diagnoses that included, cerebral infarction due to thrombosis of right middle cerebral artery (stroke), type 2 diabetes mellitus, hypertension, foot drop left foot, foot drop right foot and retention of urine. During an interview on 6/12/25 at 1:52 PM, RCM #1 stated Resident #15 was assessed with a thorough skin check and assessment for any injuries. RCM #1 further stated Resident #15 was placed on alert charting for one week. Record review of the incident, Final Report, dated 5/6/25, revealed: Interventions: . Resident was placed on Alert Charting. Skin check completed with no new injuries notes [d]. Record review 6/11-13/25 of Resident 15#'s EMR, no documentation of alert charting or a skin assessment was noted for the interventions identified in Final Report, dated 5/6/25. Review of the facility's policy Abuse- Screening, Training, Identification, Investigation, Reporting, and Protection, revised 1/2023, revealed: Policy. 3. Prevent and prohibit all types of abuse. 5. Investigate allegations of abuse. 7. Protect out resident from abuse. a. All alleged incidents of abuse. must be thoroughly investigated. .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. . Based on interview and record review, the facility failed to update and revise the care plan for 1 resident (Resident #21) out of 1 resident reviewed for care plan. Specifically, the facility failed to update and revise the care plan to reflect new interventions and/or monitoring to address aggressive or escalating behaviors. This failed practice placed the resident at risk for not receiving appropriate and/or accurate care and services. Findings: Review on 6/11-13/25 revealed Resident #21 was admitted to the facility with diagnoses that included unspecified dementia (cognitive decline), aphasia (impaired ability to understand or express speech), and parkinsonism (a group of movement abnormalities such as tremor, stiffness, and slowed movement). During an interview on 6/12/25 at 11:00 AM, Resident #3 allegedly stated during a verbal altercation with Resident #21 on 4/25/25, he/she was struck in the face by Resident #21. Resident #3 then retreated to his/her room, called the police and reported the assault. Review of Resident #21's Nursing notes, dated 4/25/25, revealed: . Behavior note . Resident was reported to be walking in the dining area with only a shirt on. Another resident mentioned to him to be respectful to the ladies and put on some clothing. Resident [#3] in room . reports that is when the resident hit him in the face. During an interview on 5/21/25 at 3:15 PM, the Director of Nursing (DON) was asked if Resident #21's care plan should have been reviewed or revised following the altercation, then replied, Yes. The DON further stated that there are care plan review processes in place for residents with escalating behavioral issues. The DON also stated, We bring all reportable events to QAPI [Quality Assurance and Performance Improvement - a systematic, data-driven program designed to improve the quality of care and services in the facility through ongoing monitoring, review, and correction of system issues], this event was brought to the QAPI meeting. Review of Resident #21's Comprehensive care plan, initiated 4/18/25, revealed no interventions or monitoring for escalating behaviors or potential for aggression following the incident. Review of the facility's policy, Safety and Supervision of Residents, revised 7/2017, revealed: 1. Our individualized, resident-centered approach to safety addresses safety .for individual residents .2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific hazards or risk for individual residents .3. The care team shall target interventions to reduce individual risk 4. Implementing interventions to reduce risk and hazards .5. Monitoring the effectiveness of interventions . Review of the facility's policy, Care Plans, Comprehensive Person-Centered, revised 3/2022, revealed: . The interdisciplinary team should review and update the care plan: . when there has been a significant change in the resident's condition . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure provision of necessary care and services for one resident (#1) out of 20 sampled residents.Specifically, the facility failed to:1) monitor and evaluate the resident's response to the IV fluid bolus ordered on [DATE];2) educate and inform the resident of the risks and benefits after he/she declined vital sign measurements while in a life threatening condition;3) notify the attending provider of the resident's refusal of care, sustained hypotension and continued altered mental status; and4) ensure the resident was transferred to the emergency room for a higher level of care. These failed practices prevented Resident #1 from receiving care and services necessary to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and placed the resident at risk for serious harm and death due to unaddressed changes in condition. The resident passed away on [DATE]. A determination was made that the facility's noncompliance with one or more requirements of participation placed Resident #1 in immediate jeopardy beginning on [DATE]. This situation was brought to the attention of the facility's administration on [DATE] at 3:35 PM, at which time the facility was notified of the identified immediate jeopardy.The State Agency verified onsite on [DATE] at 12:35 PM that the immediacy was removed on [DATE] at 10:45 PM. The facility removed the immediacy by reviewing all current residents for any changes in conditions within the previous 48 hours. Any identified residents were assessed by the Director of Nursing or nursing manager and notified physicians of change in condition. Change of condition education was to be provided to licensed nurses and certified nurse aides. Following the removal of the immediacy, noncompliance remained at a scope and severity of D, no actual harm with potential for more than minimal harm that is not immediate jeopardy.Findings:Review on 6/11-13/25 revealed Resident #1 was admitted to the facility with diagnoses that included severe sepsis with septic shock (a life-threatening condition caused by the body's response to infection, leading to dangerously low blood pressure and organ dysfunction), essential hypertension, and atrial fibrillation (an irregular heart rhythm).Assessment of Resident #1's HypotensionReview of Resident #1's SBAR (Situation, Background, Assessment, Recommendation - a standardized communication tool used by healthcare staff to clearly and concisely report a resident's condition and facilitate physician notification), dated [DATE] at 12:00 PM, revealed: . Situation . Hypotensive [abnormally low blood pressure] & tachycardic [abnormally fast heart rate] . Background . 69 y/o [year old] [male/female], DNR [do not resuscitate] . Hx [history of] sepsis with shock . Assessment . 65/46 [mm/Hg (millimeters of mercury)] [BP], 107 [heart rate], increased confusion.During an interview on [DATE] at 12:23 PM, Resident #1's attending physician and Medical Director (MD), stated he was notified on [DATE], via SBAR, that Resident #1 had a critically low blood pressure and tachycardia. He assessed the resident and noted he/she was mildly obtunded (altered mental status characterized by decreased consciousness and responsiveness) with ongoing hypotension and elevated heart rate. He ordered a one-time 1000 mL (milliliter) IV (intravenous) bolus of normal saline for dehydration and hypotension. The MD stated he did not provide instructions or orders for follow-up monitoring, but expected nursing staff to notify him after shift change or upon completion of the fluids if the Resident had not improved.Review of Resident #1's Order Recap Report, revealed an order dated [DATE], Sodium Chloride Solution 0.9% Use 1000 ml IV one time only for dehydration, hypotension. Until [DATE] 23:59 bolus 1 L [liter] normal saline. This order did not include any parameters for reassessment or guidance for notifying the physician based on the resident's response to treatment.Further review revealed: Azithromycin Tablet 250 MG [milligram] Tablet Give 500 mg by mouth one time a day for infection for 1 day -Start Date- [DATE] 1230.Critical Hypotension Event - No Clinical ResponseReview of Resident #1's Progress Notes, dated [DATE] at 12:23 AM, revealed an entry by Licensed Nurse (LN) #5: Patient refused to allow staff to take vitals. Attempted 3 more times and [he/she] still refused. Further review revealed no documentation of physician and/or resident representative notification of the resident's refusal to allow staff to obtain vital signs.Review of Resident #1's Blood Pressure Summary, revealed a blood pressure reading of: . [DATE] 07:41 [AM] . 75/45 [mm/Hg].Record review on 6/11-13/25 revealed no documentation of physician and/or resident representative notification for Resident #1's blood pressure measurement of 75/45 mm/Hg.During an interview on [DATE] at 12:23 PM, the MD stated he was not informed when the resident's blood pressure remained critically low on [DATE]. The MD further stated Resident #1 would have been immediately transferred to the emergency room for possible sepsis had he been advised of Resident #1's condition and/or lack of improvement. The MD stated a blood pressure of

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. . Based on record review, observation and interview, the facility failed to ensure 1 resident (#5) out of a census of 94, had supervised access to an unauthorized location in the facility. This failed practice had the potential to place the Resident at risk of injury due to inadequate supervision and the lack of security measures posed the possibility of hazard including the potential for elopement through unsecured exits. Findings: Record review from 6/11-13/25 revealed, Resident #5 was admitted to the facility with diagnoses that included hemiplegia and hemiparesis (paralysis on one side), following cerebral infarction (stroke), lack of coordination, abnormalities of gait and mobility, muscle weakness, cognitive communication deficit (impaired thinking/speech), epilepsy unspecified, not intractable without status (recurrent seizures), and depression (low mood). Record review of Resident #5's Minimum Data Set (MDS - a federally required assessment), dated 5/7/25, revealed: Wheel 150 feet: once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space required supervision or touching assistance. Review of Resident #5's, Care Plan Report, last revised on 8/16/22, revealed Resident #5 had impaired cognitive/impaired thought processes related to stroke. Resident will have needs met with assistance from staff as needed, staff will encourage resident to assist as much as tolerated by resident. It is also noted that resident was at risk for falls related to hemiplegia and hemiparesis. Resident #5 was on behavior monitoring due to suicidal statements and actions with focused behaviors such as wandering, exit seeking and sliding off wheelchair when needing assistance. An observation on 6/11/25 at 12:50 PM, revealed the basement on level 0 had one exit through the loading dock, accessible via double doors immediately to the right of the elevator. These doors were unlocked, unmanned, and lacked alarms or monitoring. This area was designated as an unauthorized zone for all residents, with access restricted to authorized staff, such as maintenance personnel or contractors. An observation on 6/11/25 at 1:00 PM, during the tour in the basement, Maintenance Director (MD) pushed the elevator button to go upstairs, and the doors opened and revealed, Resident #5 in a wheelchair on the elevator by himself/herself. Resident #5 appeared to have some difficulty answering basic questions during the encounter. The MD helped Resident to the first floor, then the Medical Records Director (MRD) further assisted Resident #5. During an interview on 6/11/25 at 12:50 PM, the MD discussed elopements and stated, residents don't come down to floor 0, it never happens, since the elevator requires a code to grant access to the floors. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/25 at 10:50 AM, when asked about Resident #5 being found on the elevator on 6/11/25 at 1:00 PM, the MRD stated Resident #5 was headed to a ceramic activity on the 1st floor and somehow got confused so the MRD escorted him/her to the dining room. During an interview on 6/13/25 at 9:30 AM, the Administrator was asked about Resident #5's incident on 6/11/25 at 1:00 PM on the elevator in the basement unsupervised. The Administrator stated Resident #5 was considered low risk for elopement, but the incident raised concerns about how residents with cognitive impairments, particularly those at risk of wandering, were monitored to prevent unsupervised access to areas like the basement. The Administrator further stated the facility was conducting monthly staff training and elopement drills. The Administrator stated Resident #5's unsupervised elevator incident would be reviewed. The Administrator further stated, the elevator's operation required a code to be entered by one person and would allow the elevator to continue to the basement, allowing unsupervised and/or unauthorized access of the residents. The Administrator stated that changing the elevator's functionality was not feasible due to its age, but staff education could be reinforced to ensure residents were not left alone in the elevator. She suggested measures like documenting when codes were used or ensuring staff accompany residents to prevent similar occurrences from reoccurring. When asked if the elevator's functionality had ever been addressed or identified through Quality Assurance and Performance Improvement (QAPI), the Administrator stated No, it never has. During a follow-up interview on 6/13/25 at 12:17 PM, the Administrator stated there was not a specific protocol on elevator usage for the staff, but during orientation, the maintenance department provided verbal education on how to use the elevator code and the procedure to escort a resident back to their court if they came down to the basement. During an interview on 6/13/25 at 2:00 PM, the MD covered several key topics related to the maintenance and safety of the building, particularly its elevator system and resident oversight: He stated, The building, constructed in the mid-1980s, has aging elevators that occasionally break down. He further stated resident safety and wandering behaviors were a significant concern, particularly those with cognitive impairments like Resident #5, wandering into restricted areas such as the basement. The MD noted those incidents were rare (less than monthly) and lack a formal policy, but staff ensured residents were escorted back by authorized personnel. Review of the facility's policy, Safety and Supervision of Residents, last revised 2001, revealed a comprehensive approach to ensure a safe environment for residents, prioritizing accident prevention and supervision as facility-wide goals. It employs a dual strategy: a facility-oriented approach and an individualized, resident-centered approach. The facility-oriented approach involves identifying safety and environmental hazards .The individualized, resident-centered approach focuses on tailoring safety measures to the specific needs of each resident, with the care team analyzing assessment and observation data to identify and address individual accident hazards or risks. This includes implementing adequate supervision and assistive devices. .