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	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centennial Post Acute	9100 Centennial Drive Anchorage, AK 99504

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50031 Based on record review, observation and interview, the facility failed to ensure two residents out of 22 sampled residents, and one resident out of 6 unsampled residents were provided care in a manner that promoted dignity and respect. Specifically, the facility failed to: 1) provide covering of the urinary catheter bags (a tube inserted through the urinary tract into the bladder, connected to a drainage bag) for 2 residents (#1 and #96); and 2) provide unsampled resident #40 a dignified dining experience. This failed practice placed the residents at risk of poor self-esteem and/or self-worth and a potential for poor quality of life. Findings: Resident #1 Record review on 12/8-12/24 revealed Resident #1 was admitted to the facility with diagnoses that included type 2 diabetes mellitus with chronic kidney disease, urinary tract infection, unspecified dementia and recurrent major depressive disorder (a mood disorder characterized by depressed mood and loss of interest and/or pleasure in activities). An observation on 12/11/24 at 11:35 AM, revealed that Resident #1 was being wheeled by Certified Nursing Assistant (CNA) #4 from the shower room through the court dining space into Resident #1's room with his/her uncovered urinary catheter bag attached to his/her shower chair. During an interview on 12/11/24 at 11:40 AM, Licensed Nurse (LN) #10 stated that the urinary bag should be covered when a resident is in a public space. Record review of the facility's policy, In-dwelling Urinary Catheter, last revised 2/2019 revealed: .preserving resident dignity . as a guideline when caring for a resident with a urinary catheter . Resident #96 Record review from 12/8-12/24 revealed Resident #96 was admitted to the facility with a diagnosis that included benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, and bladder-neck obstruction. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 12/8/24 at 10:00 AM, revealed Resident #96 ambulating in the community space of the unit with his/her uncovered urinary catheter bag attached to his/her walker. In the presence of Resident #96 were tw other residents, and two unidentified staff members. During an interview on 12/12/24 at 8:19 AM, when asked how the facility ensures a resident's right to dignity when ambulating with a foley catheter, LN #11 stated, .the urinary catheter should have a privacy bag. Record review of the facility's policy, In-dwelling Urinary Catheter, revised on 2/2019, revealed: .preserving resident dignity . as a guideline when caring for a resident with a urinary catheter . Review of Resident #96's Care Plan, dated 11/27/24, revealed: .Privacy cover to catheter bag as indicated to promote dignity . Resident #40 Record review on 12/11/24 revealed Resident #40 was admitted to the facility with diagnoses that included acquired absence of other specified parts of digestive tract, vascular dementia (dementia resulting from impaired blood flow to the brain), unspecified severity, with psychotic disturbance, adult failure to thrive (weight loss of more than 5%, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction and low cholesterol), and schizophrenia (mental disorder characterized by symptoms of hallucinations, delusions and cognitive challenges). During continuous observation on 12/11/24 from 12:31 PM - 1:10 PM, of the Cedar Court dining area, of which three other residents were present, the following occurred: -12:31 PM, CNA #4 brought Resident #40 his/her lunch. CNA #4 set the plate, dessert cup, drinking cup, and silverware on a bedside table by Resident #40. CNA #4 returned to passing meal trays to residents' rooms. -12:33 PM, Resident #40 poured the red liquid from his/her cup into the garbage can next to his/her recliner. Resident #40 scooped out brown pudding-like food from a dessert cup into the garbage with his/her spoon. Resident #40 tapped the spoon on the side of the garbage can, then used a tissue to wipe off the spoon. CNA #4 walked by Resident #40 and stated I thought you were hungry. -12:35 PM, CNA #4 was standing by the meal cart and stated you should eat something [while looking towards Resident #40]. Resident #40 banged a spoon on the side of the garbage can and placed tissues in the garbage. Maintenance Staff (MS) #2 walked onto the unit and looked towards Resident #40 and CNA #4. Resident #40 looked at his/her hands and the spoon. MS #2 walked over to CNA #4 and stated [Resident #40] needs a new spoon. CNA #4 took Resident #40 a clean spoon. In a raised voice, Resident #40 told CNA #4 he/she did not want to eat the food provided. CNA #4 stated I should have moved the garbage can. Resident #40 continued to put his/her hands in the garbage can. While looking at his/her hands, he/she then wiped his/her fingers on his/her blanket. Resident #40 picked up his/her dinner plate and dumped the remaining food into the garbage can. Resident #40 wiped the plate and spoon with tissues, then set them on the bedside table. -12:40 PM, CNA #4 removed all dishes from Resident #40's table. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #40 was not offered any alternative foods and did not receive additional food or drink during the observation period. Record review on 12/8-12/24 of Resident #40's Care Plan revealed, . Eating- 1-person limited assist . Monitor/document/report . Refusing to eat . Provide and serve supplements as ordered: prefers Ensure . Encourage good nutrition and hydration . offer supplements/alternate with intake <50% . Record review of the facility's policy, Activities of Daily Living (ADL), Supporting, last revised on 3/2018, revealed: . Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition (s) demonstrate that diminishing ADLs are avoidable . he or she has been offered alternative interventions to minimize further decline . Appropriate care and services will be provided for residents d. dining (meals and snacks) .

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 50031 Based on observation, interview and record review the facility failed to ensure self-administration of medication evaluation was completed for three residents (#s 14, 83, and 87) out of three residents reviewed. This failed practice placed the residents at risk of adverse effects of the medications. Findings: Resident #14 Record review from 12/8-12/24, revealed Resident #14 was admitted to the facility with diagnoses that included myocardial infarction and diabetes mellitus. An observation on 12/8/24 at 10:41 AM, revealed ear drops carbamide peroxide 6.5% was on top of Resident #14's bedside table. Resident #14 stated he/she had administered it on his/her own for two days now. Review on 12/10/24 at 11:50 AM, of active physician's order for Resident #14, revealed no physician's order for ear drops Carbamide peroxide 6.5%. During an interview on 12/11/24 at 12:14 PM, Licensed Nurse (LN) #1, stated there was no order in the electronic health record (EHR). Resident #83 Record review from 12/8-12/24, revealed Resident #83 was admitted to the facility with diagnoses that included hemiplegia (a condition that causes one sided paralysis) and hemiparesis (one sided muscle weakness). An observation on 12/8/24 at 10:59 AM, revealed clobetasol propionate ointment 0.05 % was on Resident #83's bedside table. Resident #83 stated he/she applied ointment on his/her neck because he/she had rashes. Review of the physician's order, dated 11/7/24, revealed clobetasol propionate external Cream 0.05 % apply to neck topically every morning and at bedtime for Altered Skin Integrity until 11/14/24 23:59 Apply thin film for 7 days. During an interview on 12/11/24 at 12:14 PM, LN #1 stated the nurses had been applying the medication to Resident #83 before (LN #1 could not recall the date) but now Resident #83 wanted to apply the ointment on his/her own. Resident #87 (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review from 12/8-12/24, revealed Resident #87 was admitted to the facility with diagnoses that included infection and an inflammatory reaction due to an internal fixation device of the spine, and asthma. An observation on 12/8/24 at 10:23 AM, revealed albuterol inhaler and artificial tears hypromellose dropper bottle were on Resident #87's bedside table. The Resident stated he/she had administered those medications on his/her own. Review of the physician's order dated 10/1/24, revealed: Albuterol Sulphate HFA Inhalation Aerosol Solution 108, 2 puffs inhale orally every 4 hours as needed for wheezing/SOB (shortness of breath), and Refresh Celluvisc Opthalmic gel 1%, Instill 2 drop[s] every 1 hours as needed for Dry eyes. Review of the electronic Medication Administration Record (eMAR) from October to December 2024, revealed both medications mentioned above were not administered by the LNs. During an interview on 12/11/24 at 12:14 PM, LN #1 confirmed that Resident #87 had the above medications in the resident's room. LN #1 stated the resident preferred to self- administer the medications. During an interview on 12/11/24 at 1:51 PM, the Administrator stated there were no self-administration of medication evaluations and no interdisciplinary team notes that Residents #14, 83, and 87 were evaluated for self- administration of medication.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 40259 Based on observation and interview, the facility failed to ensure a homelike environment was maintained in resident rooms for 3 unsampled residents (#s 34, 47, and 251), out of 6 unsampled residents reviewed. This failed practice denied the residents a functional, maintained, and homelike environment. Findings: Resident #34 An observation on 12/11/24 at 3:40 PM, Resident #34's room, on Birch Court, revealed six large cardboard boxes in the resident's bathroom. Further observation revealed one box was designated for the Birch Court's artificial Christmas tree's display in the common area, and the other five boxes were stored decorations for Birch Court's Halloween and Christmas holidays. During an interview on 12/11/24 at 3:40 PM, the Director of Business Development (DBD) stated the boxes should not have been stored in the resident's bathroom. Resident #47 An observation on 12/11/24 at 12:46 PM, of Resident #47's room, revealed the face plate to the cable outlet was cracked. The DBD acknowledged these findings upon discovery. Resident #251 An observation on 12/11/24 at 4:04 PM, of Resident #251's room, revealed the face plate to the cable outlet was not secured to the wall. Further observation of the face plate revealed it was loosely hanging, supported by the cable attached to the outlet. The DBD acknowledged these findings upon discovery.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50031 Based on record review, interview and observation, the facility failed to ensure the MDS (Minimum Data Set - a federally required assessment for long term care residents) accurately represented two residents (#37 and #97) out of 22 sampled residents. This failed practice placed the residents at risk for inadequate care planning and services to achieve their highest practicable and functional well-being. Findings: Resident #37 Record review from 12/8-12/24 revealed Resident #37 was admitted with diagnoses that included diabetes mellitus and multiple myeloma (bone marrow cancer). Review of Resident #37's MDS Quarterly review assessment, dated 11/16/24, revealed: Section O .K1. Hospice care .b. While a resident. was checked indicating the resident was on hospice. During an interview on 12/12/24 at 1:30 PM, Nurse Practitioner (NP) #1, Licensed Nurse (LN) #2 and LN#5, when asked if Resident #37 was currently on hospice services, stated Resident #37 was no longer on hospice services. Further record review included a hospice discharge summary, dated 9/13/24, revealed, Patient will be transferred to Centennial PCP [Primary Care Physician]. Report given to [NP #1] at SNF [Skilled Nursing Facility]. During an interview on 12/12/24 at 1:35 PM, after reviewing the MDS quarterly assessment, dated 11/16/24, the MDS nurse stated the resident was not on hospice. Resident #97 Record review from 12/8-12/24, revealed Resident #97 was admitted with a diagnosis that included fracture of right femur. Review of Resident #97's admission MDS, dated [DATE], revealed: Section L - Oral .B. No Natural Teeth . During observation and interview with Resident #97 on 12/8/24 at 1:30 PM, it was revealed that the resident has all natural teeth. During an interview on 12/11/24 at 2:13 PM, the MDS nurse stated that she obtained the dental assessment for Resident #97 from a previously charted assessment in the resident's medical record. She also stated that after learning of the incorrect dental MDS assessment, she corrected the assessment during the survey. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Certifying Accuracy of the Resident Assessment, dated 11/2019 revealed, Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of the assessment .The information captured on the assessment reflects the status of the resident during the observation [look-back] period for that assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50031 Based on record review, interview, and observation and the facility failed to implement care plans for two residents (#41 and #43) based on a sample of 22 residents. These failed practices placed residents at risk for not receiving the necessary and/or appropriate care and services for optimal outcomes. Findings: Resident #41 Record review on 12/8-12/24 revealed Resident #41 was admitted to the facility with a diagnosis that included end stage renal disease (a condition where the kidney reaches advanced state of loss of function. This causes changes in urination, fatigue, swelling of feet, high blood pressure, and loss of appetite). The resident also had a right arm AV (arteriovenous) fistula (a connection made between an artery and vein that is used for dialysis access). Record review of Resident #41's blood pressure readings between the dates of 12/13/23 - 12/17/24, revealed staff measured the blood pressure on the right arm 140 times. Review of Resident #41's care plan, revised on 4/24/23, revealed a nursing intervention, Do not draw blood or take B/P [blood pressure] in arm with graft right arm . During an interview on 12/11/24 at 11:00 AM, when asked how he/she would know where to take Resident #41's blood pressure, Certified Nurse Assistant (CNA) #5 stated .we can get information about the patient on the Kardex [medical record system used by CNAs] . we can print it every shift and it will have the information from the care plan . During an interview with the Director of Nursing (DON) on 12/10/24 at 2:45 PM, when asked if CNAs were supposed to use Resident #41's right arm to obtain blood pressure readings, based on the care plan, he answered No. Hypertension (high blood pressure): Review of Resident #41's Care Plan dated 11/18/19, target date 11/28/24, revealed: Give anti-hypertensive medications as ordered. Review of Resident #41's medication order, with a start date of 3/17/24, revealed, Hydralazine [medication used to decrease blood pressure] . Give 1 tablet by mouth every 6 hours as needed for Elevated b/p [blood pressure] Give for SBP [systolic blood pressure]>[greater than] 150 or DBP [diastolic blood pressure] > 90 on NON-DIALYSIS DAYS ONLY. Review of Resident #41's blood pressure results, dated 3/17/24-12/10/24 revealed 116 missed opportunities for the administration of Hydralazine. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #43 Record review on 12/8-12/24 revealed Resident #43 was admitted to the facility with diagnosis of primary lateral sclerosis (motor neuron disorder), acute respiratory failure with hypoxia (severe oxygen shortage), moderate protein-calorie malnutrition (insufficient nutrition intake), dysphagia (swallowing difficulty), cellulitis (skin infection) of the left toe, retention of urine, neuromuscular dysfunction of the bladder (bladder control loss). During random observations on 12/8-12/24, revealed Resident #43 was bedbound and did not leave his/her bedroom area. Record review of the Interdisciplinary Functional Abilities Collaboration, dated 9/17/24, revealed resident is dependent in all aspect[s] of ADL's [Activities of Daily Living]. Record review of the care plan dated 11/4/24 revealed, .Interventions/tasks PT/OT [Physical Therapy/ Occupational therapy] evaluation and treatment as needed - date initiated 3/26/20 [no date available for last revision]; Resident needs to be up on his/her wheelchair during lunchtime, everyday - date initiated 12/30/21 - last revision on 8/21/24. During an interview on 12/11/24 at 1:30 PM, CNA #6 stated: once in a blue moon Resident #43 will be out on [his/her] chair but it's really only happening when [he/she] has an appointment and sometimes in the summertime because [he/she] likes to get vitamin D. Added that the nurse is usually who decides when [he/she] gets out of bed and that they only do so, when told [he/she] needs to go somewhere per nursing. During an interview on 12/11/24 at 1:40 PM, CNA #8 stated, I only got [him/her] up one time that I can remember, which was last week for [his/her] doctor appointment. When asked who decides to get Resident #43 out of bed, CNA #8 stated, I think it might be the Resident Care Manager (RCM), but I will find out some more because I really don't know. During an interview on 12/12/24 at 2:04 PM, Restorative Aide (RA) #2 stated [He/she] [Resident #43] doesn't get out of bed much, other than when [he/she] goes on appointments out of the facility. During an interview on 12/12/24 at 3:18 PM, RA #3 also stated he/she doesn't get out bed much . we [RAs] are the ones that work the upper body one day, lower body the next day . we also do ADLs like shaving, brushing teeth, dressing. CNAs should be the ones responsible for getting [him/her] in and out of bed and DON [Director of Nursing] is responsible for the CNAs. During an interview on 12/11/24 at 1:46 PM, LN #7 stated, [He/she] just got cleared by PT [Physical Therapy] to get in [his/her] chair recently because [he/she] has not been out of bed for months. During an interview with the Administrator on 12/11/24 at 2:30 PM, she noted that Resident #43 does not have any physical therapy documentation available and is not currently being seen or assessed by PT. During an interview on 12/11/24 at 1:40 PM, CNA #8 stated, The Kardex does not reflect that the resident needs to be up on [his/her] wheelchair during lunchtime, every day. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 12/10/24 at 3:30 PM revealed he was aware of the care plan described above, he stated, I have just read that but have no idea why this is not happening or why is it even on the care plan to begin with .I've been here since 2022 and I have always seen Resident #43 being bed bound . Resident #43 has no schedule for getting up, only for showers and appointments. The DON further confirmed that the Kardex was used by the CNAs on Resident #43 does not accommodate the care plan intervention/task of Resident #43 being up on his/her wheelchair during lunchtime every day. When asked about who developed the care plan and is responsible for the Kardex update he/she stated: we all do, us and the RCM's. Review of the facility policy and procedure titled Care Plan - Baseline Plan of Care/Kardex, last revised on 1/24/24, It is the policy of this facility that direct care givers have accurate information available to them to properly care for their residents. Further review of the same policy revealed . 2. Problem areas and interventions related to the resident's safety/fall risk, transfers, bed mobility, locomotion, toileting, dressing, skin care, grooming, hygiene, bathing preferences, nutrition, dining care, behavior management, cognition, communication, pain management, daily routine/activity preferences, special instructions, restorative nursing is provided on the Kardex . 7. Staff are responsible to give care per the Kardex interventions . staff are responsible to report this to the charge nurse for review or revision.

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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. 50031 Based on record review, observation, and interview the facility failed to revise care plans to reflect the current level of care and services for two residents (#1 and #18) based on a sample of 22 residents. This failed practice placed residents at risk for not receiving the necessary and/or appropriate care and services for optimal outcomes. Findings: Resident #1 Record review from 12/8-12/24 revealed Resident #1 was admitted with diagnoses that included Type 2 Diabetes Mellitus with Chronic Kidney Disease (non-insulin-dependent diabetes with kidney complications), and Urinary Tract Infection (infection in any part of the urinary system, which includes the kidneys, ureters, bladder, and urethra). An observation on 12/8/24 at 3:30 PM, revealed Resident #1 lying in bed with a foley catheter (a tube inserted through the urinary tract into the bladder, connected to a drainage bag), with the bag secured to the left side of the bed. Record review of the care plan, last reviewed on 10/18/24, revealed no care planning for the foley catheter. During an interview with the Director of Nursing (DON) on 12/10/24 at 3:50 PM, when asked about Resident #1's catheter and cares, he was unaware that the resident had a foley catheter. The care plan was updated the following day. During an interview with Resident Case Manager (RCM) #1 on 12/11/24 at 2:45 PM, he/she stated that RCMs oversee and/or update care plans as needed when a resident's status changes. RCM #1 stated urinary catheters should have been included in the care plan and nurses are able to update care plans as well. During an Interview with Nurse Practitioner (NP) #1 on 12/12/24 at 11:22 AM, he/she stated that urinary catheters should be addressed under the care plan and discontinued as soon as possible. Review of the facility's policy, In-dwelling Urinary Catheter, last revised on 02/2019, revealed, .If an indwelling catheter is present, this will be documented . Comprehensive Care Plan . will be developed for indwelling urinary catheter .Care plan development addressing the catheter use may include: management of catheter, bag, and tubing changes, prevention of drag on the catheter tubing, maintenance of the catheter bag below the level of the resident's pelvis, routine catheter care, fluid intake, preserving resident dignity and monitoring for signs of complications . Resident #18 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centennial Post Acute	9100 Centennial Drive Anchorage, AK 99504

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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	Record review on 12/8-12/24 revealed Resident #18 was admitted to the facility with diagnoses that included Parkinson's Disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), diabetes, and congestive heart failure (a chronic condition that results when the heart muscle is unable to pump blood efficiently). Review of Resident #18's care plan, last revised on 12/2/23, revealed a focused problem of: At risk for constipation, ileus or impaction related to the use of morphine. Further review revealed this focus problem was started on 11/10/22. Review of Resident #18's current electronic Medication Administration Record (eMAR) revealed Resident #18 had no active order for Morphine. Review of Resident #18's physician orders on 12/12/24 at 2:00 PM, revealed Resident #18's last Morphine order was on 8/7/23 and was discontinued on 8/14/23 (110 days before Resident #18's care plan for morphine was last revised). During an interview on 12/12/24 at 2:25 PM, the DON stated Resident #18's care plan was inaccurate and should have been updated. Review of the facility's policy Care Plan - Baseline Plan of Care/Kardex, last revised 1/24/24, revealed: . The Resident Care Manager is responsible to review the Kardex quarterly in conjunction with the quarterly MDS review. Revisions are made as needed .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50031 Based on interview, observation, and record review, the facility failed to communicate effectively with one resident (Resident #12) out of 22 sampled residents. This failed practice had the potential to negatively impact the resident's quality of life and overall activities of daily living (ADL's) due to communication barriers. Findings: Resident #12 was admitted to the facility on [DATE] for diagnoses that included intraspinal abscess (pus-filled infection in the spinal canal that can compress the spinal cord or nerves), osteoarthritis (degenerative joint disease), incomplete paraplegia (partial damage to the spinal cord causing impaired function of the lower half of the body while retaining some degree of movement or sensory perception), and dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking). During an interview on 12/9/24 at 8:30 AM, with Resident #12, using the facility's interpreting service, the resident stated he/she like to read the bible and only communicated through his/her family members when they visited. During an interview with Resident #12's representative (RR) on 12/10/24 at 1:00 PM, he/she stated Resident #12 can read Korean only and loves reading. The RR further stated Resident #12 would like to have papers and the activities calendar in Korean. The representative did not remember any instances where the interpretative services were used, and further stated it would be helpful. An observation on 12/9/24 at 8:30 AM, revealed Resident #12's room did not have communication cards or boards to help staff communicate with Resident #12. The activities calendar was also posted in the room in English. During the same observation, Resident #12 was unable to communicate with surveyors. During an interview on 12/8/24 at 9:16 AM, LN #13 stated he/she did not know how to access the interpretative service, if needed, he/she would use the translation application on his/her personal cell phone to communicate with Resident #12. LN #13 stated he/she would find out how to access the interpreting service. Shortly after the interview, the Administrator was observed handing out a document titled PROPIO to staff, which contained information on how to use the interpreting service. During a follow up interview on 12/8/24 at 11:00 AM, LN #13 stated he/she had never used the interpreter service to communicate with Resident #12. During an interview with the MDS Nurse (Minimum Data Set, a federally required nursing assessment) on 12/11/24 at 2:14 PM, she stated documentation written in the resident's language, was not provided. The MDS nurse further stated that if it was needed, she would get an interpreter or staff who spoke the language. If the MDS nurse needed to give the resident or the RR paperwork, she would reach out to the activities staff or to the social worker for assistance. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/24 at 10:30 AM, the Admission Coordinator (AC) stated, We can have the paperwork be provided in a different language. We would contact Propio [interpreter service] and they would send us a translated copy to the requested language if we know what the language is ahead of time. The AC did not recall the last time these services were used. During a joint interview with Activity Coordinator (AC) and Activities Director (AD) on 12/11/24 at 11:30 AM, when asked if Resident #12 understood the activities calendar in his/her room, the AD stated, I'm not sure if Resident #12 understands it, but if [he/she] wants it in Korean we can make it work. Record review of Resident #12's care plan, last reviewed on 10/28/24, revealed Resident requests an interpreter Language: Korean. Review of the Resident's Rights, unknown date, revealed: Each resident and legal representative, as appropriate, has the right: 2. To be fully informed, orally and in writing in a language the resident understands as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing resident conduct and responsibilities. Review of the facility policy and procedure titled Interpreter Services, last reviewed on 3/19, revealed: The facility will take reasonable steps to ensure that persons whose primary language is not English have meaningful access and an opportunity to participate in our services, activities, programs and other benefits . 2. If primary language of the resident's representative is not English, the facility will provide access to the same interpretive services to ensure comprehensive care coordination. 3. For any resident whose predominant language is not English we will consider the following protocols to enhance communication between the resident and staff: a. Identify a supportive family member(s) or representative who will be willing to translate resident care needs and issues either in person, via e mail, or over the phone (preferable using conference calling equipment). b. Identify staff member who are conversant in the same language (dialect) as the resident. c. Contract with a language bank organization who can facilitate translation of the resident's care needs and issues. d. Utilize Google Translate either on facility tablet or Workstation .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50031 Based on record review, interview, and observation, the facility failed to provide an ongoing resident-centered activity program for one resident (#43) out of 22 sampled residents. This failed practice placed the resident at risk of boredom, loneliness, and decreased quality of life and enjoyment. Findings: Resident #43 Record review on 12/8-12/24 revealed Resident #43 was admitted to the facility with diagnosis of primary lateral sclerosis (motor neuron disorder), acute respiratory failure with hypoxia (severe oxygen shortage), moderate protein- calorie malnutrition (insufficient nutrition intake), dysphagia (swallowing difficulty), cellulitis (skin infection) of left toe, retention of urine, and neuromuscular dysfunction of bladder (bladder control loss). Record review of the quarterly MDS (Minimum Data Set - A Federally required nursing assessment) dated 9/13/24, revealed, in the communication section: makes self-understood: rarely/never understands .ability to understand others: rarely/never understands. During an interview on 12/08/24 at 1:03 PM, Resident #43's representative stated: Nothing is being done specific to [his/her] condition. The resident representative stated that a previous doctor indicated the resident would benefit from more social stimulation. The resident representative also stated that other family members who attended care planning meetings suggested this in recent meetings, but the family has not seen any improvement in the resident's activities. During an interview on 12/11/24 at 11:30 AM, the Activities Director (AD) stated there were no activity records available for Resident #43 during the months of October, November and December of 2024, as he/she had instructed staff not to document any interactions that were under 30 minutes. During a joint interview on 12/11/24 at 11:30 AM, the Activity Coordinator (AC) and the AD stated activities were being done by the Activities Assistant (AA) one-on-one in the residents' rooms. According to the AC, all other group activities happen outside of the resident rooms. During an observation and concurrent interview on 12/11/2024 at 3:48 PM, revealed the AA and AD walked in Resident #43's room to simulate what an activity would routinely look like. The AA stated that when he/she went into the room, he/she would ask Resident #43 how he/she was doing. The AA stated he/she can usually tell if the resident was interested in engaging or not depending on if he/she was making eye contact. The AA also stated that sometimes he/she would ask the Certified Nurse Assistants (CNAs) if the resident would be interested in a one-on-one ahead of time without going into the room. If the resident kept on staring at the television or grunted, that indicated that he/she was not interested in engaging with an activity and would conclude the one-on-one. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continuing the observation, the AA greeted Resident #43 who was bed bound, nonverbal, and was watching television. The resident did not make eye contact with anyone who entered the room. After a moment of silence, the AA said goodbye to Resident #43 and wished him/her a good day. At no point during this interaction was there an activity offered to the resident. After leaving the room, the AA stated the resident was not interested in activities based on the observation of the resident staring at the television and not making eye contact. The AA then charted, Check-In on the resident's electronic chart. During an interview with LN #7 on 12/11/24 at 1:35 PM, he/she stated: there are no activities being done one-on-one with [Resident #43], they [activity staff] just come around and drop off the daily chronicles with the nurses, but other than restorative [therapy], [he/she Resident #43] does not do any activities. LN #7 further stated the activity staff did not come by often and added he/she did not usually see the activities staff visiting Resident #43's room or the resident attending group activities. During an interview on 12/11/24 at 1:30 PM, when asked if Resident #43 received one-on-one activity sessions or visits from the activities staff, CNA #6 stated the resident was visited by restorative rehab staff but had not seen the activity staff with the resident. CNA #6 stated he/she worked yesterday and did not see the activities staff visiting Resident #43. CNA #7 did not recall any visits from the activities staff also. Both, CNA #6 and CNA #7, stated, Resident #43 only grunts or stares and was non-verbal. Both CNAs stated that it would be inappropriate for Resident #43 to attend group activities such as Bingo or being social, and eating treats, since he/she was on a tube feeding. During an interview on 12/12/24 at 2:04 PM, Restorative Aide (RA) #2 stated [He/she, Resident #43] doesn't get out of bed much, other than when [he/she] goes on appointments out of the facility. RA #2 further stated that he/she had never seen the resident participating in activities or had seen the activities staff in the resident's room providing one-on-one activities. During an interview on 12/12/24 at 3:18 PM, RA#3 stated he/she doesn't get out bed much and [he/she] does not participate in group or one-on-one activities. Review of the care plan dated 11/4/24, revealed: Focus: I enjoy being around others . I will confirm satisfaction with my activity participation by my re-evaluation date . preferred activities pet therapy, watching tv, newspaper cartoons, listening to country and rock music, family visits, being social, news and views, Minnesota sports teams and hockey . Staff will transport resident to activities [he/she] wishes to attend. Record review of the quarterly Activity assessment dated [DATE] revealed: Attendance and participation summary . resident is able to acknowledge [his/her] likes and dislikes regarding activities .favorite activities . pet therapy, watching tv, newspaper cartoons, listening to country and rock music, family visits, being social, news and views, Minnesota sports teams and hockey . goals were met. Record review of the quarterly Activity assessment dated [DATE] revealed: Resident is independent in [his/her] activity choices. [He/she] is able to acknowledge [his/her] likes and dislikes to activities staff . goals were not met but resident progress was achieved. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/24 at 11:30 AM, the AD was unsure on how this information was obtained, and since the resident was non-verbal, the AD assumed this information was extracted from the 3/3/20 admission paperwork that was provided by the family, since the resident was not independent. The AD further stated she started this position in September of this year, and these were done by a previous AD who no longer worked at the facility. Review of the facility policy and procedure titled Activity Programs revised on 6/18, revealed: . 3. the activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities . 5. our activity programs are designed to encourage maximum individual participation and are geared to the individual resident needs. 6. Activities are scheduled 7 (seven) days a week and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup and critique of the programs . 10. activities participation for each resident is approved by the attending physician based on information in the resident's comprehensive assessment. Review of the facility policy and procedure titled Activity Programs - Staffing revised on 2/23, revealed: . 2. The activity director/coordinator's responsibilities include: a. completing or delegating the completion of the activities component of the comprehensive assessment; b. ensuring that the activity goals and approaches reflected in the resident's care plans are individualized to match the skills, abilities and interests/preferences of each resident; c. monitoring and evaluating the residents' responses to activities and revising the approaches as appropriate; and d. developing, implementing, supervising and evaluating the activity programs at least quarterly.

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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. 50031 Based on record review and interview, the facility failed to: 1) complete a quarterly smoking assessment for one resident (#19) out of one resident who smoked marijuana. Specifically, the facility failed to complete quarterly or annual smoking safety evaluations for Resident #19 since 7/19/23; and 2) maintain accessibility to a crash cart, for immediate use during a life-saving emergency for one resident unit (Spruce Court), out of 6 units reviewed. These failed practices: 1) had the potential for the facility to be unaware of a change in status with regards to the resident's safety while smoking, placing the resident and others at risk of burns and/or fire; and 2) placed all residents of the Spruce Court, based on a census of 16, at risk of potential delay of life-saving measures during an emergency. Findings: Smoking Assessments Resident #19 Record Review on 12/8-12/24 revealed Resident #19 was admitted to the facility with diagnoses that included concussion (temporary brain injury) of unspecified duration and quadriplegia (complete paralysis of the body from the neck down). Further review of Resident #19's care plan, dated 10/18/24, revealed, The resident was a smoker. The resident will remain safe and follow facility smoking protocols. This was initiated 9/5/19 with a target date of 1/4/25. Further review of the record revealed a smoking safety evaluation, dated 7/19/23. This was the only smoking evaluation found in the record during review. During an interview on 12/9/24 at 9:32 AM, CNA #5 stated the resident goes outside and smoked independently. During an interview on 12/11/24 at 3:15 PM, Resident #19 stated he/she was independent smoking outside the facility safely. Resident #19 stated he/she preferred to smoke at night. During an interview on 12/12/24 at 10:10 AM, the Administrator stated the smoking evaluations were to be completed upon admission, when needed, and quarterly. The Administrator agreed that the smoking evaluation was overdue at this time. The facility's policy titled Medical and Recreational Marijuana Use, reviewed 9/2023 stated, It shall be the policy of this facility to follow federal marijuana laws, but we will recognize a person's right to smoke off premises as set forth by state law .Alaska-Legal for Medical and Recreational. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Smoking Policy and Procedure Independent and Supervised, revised 9/2024 stated, It is the policy of Centennial Post Acute to provide a safe environment for residents, staff and visitors by limiting the use of smoking materials on its grounds. Residents who wish to smoke are evaluated for the ability to smoke safely . Residents who smoke are re-evaluated on a quarterly basis, or more frequently as dictated by any significant changes in the RAI process. This ongoing assessment is to verify that they remain capable of smoking and using smoking materials without presenting a danger to themselves or others. Crash Cart Accessibility An observation on 12/11/24 at 1:05 PM, of the Spruce Court common area, revealed the court's covered crash cart (which contained life-saving measure equipment) was sitting in an alcove between a wall (on the cart's left side) and a small wooden wall that was approximately 2 1/2 feet tall and 4 1/2 feet long (on the cart's right side). The court's Christmas tree was situated on the opposite side of the small wooden wall. Further observation revealed a string of Christmas lights was plugged into an outlet that was in the wall on the left side crash cart and ran across the length of the alcove to be strung on the Christmas tree. Further observation revealed an unoccupied wheelchair was parked in front of the crash cart as well. During an interview on 12/11/24 at 1:05 PM, the Director of Business Development stated the Christmas lights and wheelchair should not have been blocking access to the crash cart. .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 50031 Based on observation, interview and record review, the facility failed to ensure one resident (#41), out of one resident reviewed for dialysis (the process of cleansing the blood by passing it through a special machine, necessary when the kidneys are unable to filter the blood), received the services consistent with professional standards of practice. Specifically, the facility failed to ensure: 1) blood pressure measurements were taken on the appropriate extremity; 2) medications used to treat blood pressure were administered according to the medical provider's orders; and 3) documented assessments were completed before and after dialysis treatments. This failed practice placed the resident at risk for: 1) damage to the right AV (arteriovenous) fistula (connection made between an artery and vein that is used for dialysis access), 2) increased risk of blood clot formation, 3) worsening hypertensive chronic kidney disease (condition that occurs when chronic high blood pressure damages the kidney), 4) worsening ESRD (end stage renal disease) symptoms. Findings: Record review on 12/8-12/24, revealed Resident #41 was admitted to the facility with a diagnosis that included ESRD, and hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease. Right arm AV fistula : Review of Resident #41's care plan, revised on 4/24/23, revealed a nursing intervention, . Do not draw blood or take B/P [blood pressure] in arm with graft right arm . During an interview with the Director of Nursing (DON) on 12/10/24 at 2:45 PM, when asked if nursing aides were to be using Resident #41's right arm to obtain blood pressure readings, based on the care plan, he answered No. Record review on 12/12/24 of the facility's policy titled, Hemodialysis Care, last revised 11/2023, revealed, . No blood pressure readings in access arm . Review of Resident #41's blood pressure measurements revealed staff measuring the blood pressure on the right arm 140 times between the dates of 12/13/23 - 12/17/24. Review of Lippincott procedures, Hemodialysis, arteriovenous access, dated 8/14/24, accessed at: https://procedures.lww.com/lnp/view.do?pId=5967808&disciplineId=12427, revealed .not to allow anyone to use the access arm to measure blood pressure . (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 12/10/24 at 2:45 PM, when asked if Certified Nurse Assistants (CNAs) were supposed to use Resident #41's right arm to obtain blood pressure readings, based on the care plan, he answered No. Hypertension (high blood pressure): Review of Resident #41's Care Plan last reviewed 11/1/24, revealed: Give anti-hypertensive medications as ordered. Review of Resident #41's medication order, with a start date of 3/17/24, revealed, Hydralazine [medication used to decrease blood pressure] . Give 1 tablet by mouth every 6 hours as needed for Elevated b/p Give for SBP [systolic blood pressure]>[greater than] 150 or DBP [diastolic blood pressure] > 90 on NON-DIALYSIS DAYS ONLY. Review of Resident #41's blood pressure results on non-dialysis days, dated 3/17/24-12/10/24 revealed 116 missed opportunities for the administration of Hydralazine. During an interview with the DON on 12/10/24 at 2:40 PM, when asked about the indications for giving hydralazine, he said . I would say if the blood pressure is greater than 150 or diastolic is greater than 90, we should give the medication . Review of Lippincott procedures, Safe medication administration practices, long term-care, dated 9/19/24, accessed at: https://procedures.lww.com/lnp/view.do?pId=5967599&hits=medications,medication,administration&a=false&ad=false&q=MEDICATION%20ADMINISTRATION, revealed . to promote a culture of safety and prevent medication errors . select the right medication, administer the right dose, administer the medication at the right time . Pre/Post Dialysis Assessments: Record review of the dialysis pre/post evaluation forms for Resident #41 revealed missing pre-dialysis evaluation forms for the following dates: 8/24/24 8/13/24 8/6/24 7/23/24 Missing post-dialysis evaluation forms were found for the following dates: 11/30/24 11/16/24 11/9/24 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/21/24 8/31/24 During an interview on 12/11/24 at 11:10 AM, Licensed Nurse (LN)#12 stated, . A pre and post dialysis assessment should be charted in the electronic chart, when they [residents] go [to dialysis] and when they come back . Record review of the facility's Hemodialysis Care policy, revised on 11/2023, revealed, Residents who require hemodialysis are provided ongoing assessment and monitoring of the resident's condition before and after dialysis treatments including monitoring for complications and interventions as part of nursing standard of practice. Review of Lippincott procedures, Hemodialysis, arteriovenous access, dated 8/18/24, access at: https://procedures.lww.com/lnp/view.do?pId=5967808&hits=evaluating,assessment,dialysis, evaluation&a=false&ad=false&q=dialysis%20assessments , revealed . Documentation associated with hemodialysis includes . predialysis assessment . ongoing assessment . response to treatment .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50031 Based on record review and interviews, the facility failed to ensure the drug regimen for one resident (#25), out of 22 sampled residents, was free from unnecessary medication. Specifically, the facility failed to prevent duplicate drug therapy was prescribed. This failed practice placed the resident at risk for potential adverse effects from unnecessary medication administration. Findings: Record review on 12/8-12/24, revealed Resident #25 was originally admitted to the facility on [DATE] for rehabilitation services for diagnoses that include heart failure (inability of the heart to maintain adequate blood circulation), type II diabetes (non-insulin dependent diabetes), and Parkinson's disease (degenerative disorder characterized by tremor and impaired muscular coordination). Record review of Resident #25's Pharmacy Notes and Alert Notes, dated 11/17/2024 revealed the following: 1. Patient has two SGLT [Sodium-Glucose Cotransporter-2 Inhibitors] [a class of drugs that lower blood sugar levels by promoting excretion of excess glucose through the urine] medications on their profile Dapagliflozin 5 mg from 10/19 and a newer order for Empagliflozin 10 mg from 11/12, please discontinue one as this is a therapeutic duplication and not warranted after consulting provider. 2. Monthly Pharmacist Chart Review October 2024 . Patient has two SGLT medications on their profile Dapagliflozin 5 mg from 10/19 and a newer order for Empagliflozin10mg from 11/12, please discontinue one as this is a therapeutic duplication and not warranted. Review of Resident #25's physician orders on 12/8-12/24, revealed the following: 1. Dapagliflozin Propanediol Oral Tablet 5 MG . Give 5 mg by mouth one time a day for DM [Diabetes Mellitus], HF [Heart Failure]. -Start Date- 07/23/2024 . D/C [Discontinue] Date-12/11/2024 . 2. Empagliflozin Oral Tablet 10 MG . Give 10 mg by mouth in the morning for HF; DM. -Start Date-10/19/2024 . D/C Date-12/11/2024 . Further review of the medication administration record revealed that Resident #25 continued to receive both Dapagliflozin and Empagliflozin from 10/20/2024 until 12/11/2024. Further record review of Resident #25's nursing notes, dated 12/11/24 at 11:38 AM, revealed: Hospice provider revised medication regime. LN [Licensed Nurse] altered to d/c the following medications: Dapagliflozin .Empagliflozin . Record review of Resident #25's provider progress notes, dated 11/18/24 at 8:00 PM, revealed .No new pharmacy recommendations . (continued on next page)

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	025025	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centennial Post Acute	9100 Centennial Drive Anchorage, AK 99504

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 12/12/24 at 9:00 AM, regarding the process of medication regimen reviews (MRR), with Pharmacist #1, he/she stated that MRRs were conducted monthly and a monthly chart note was entered in each resident's medical record. An email of all recommendations made is then sent to the 3 RNs [registered nurses], supervisor along with 2 individuals at [the Pharmacist #1 company]. For more urgent recommendations he/she would label the note as an Alert. When asked how long he/she expects recommendations to be followed up on, he/she stated about a week. When informed that the medications dapagliflozin and empagliflozin ordered for Resident #25 were not discontinued until 12/11/24 by hospice, he/she acknowledged that had those medications not been discontinued by hospice he/she would not have caught that until the next MMR. He/she further stated that the order not being addressed is longer than what he/she would expect. During an interview with the Director of Nursing (DON) on 12/12/24 at 10:15 AM, regarding the process of monthly MMRs, the DON stated he/she gets an email from the Pharmacist #1 of all recommendations, prints the recommendations off and then physically puts the recommendations in the provider's box located outside their office for them to review. The provider will then sign the recommendations indicating they were acknowledged. The DON was asked for paperwork of provider signoff on pharmacy recommendations for October 2024. Follow up interview with the DON, on 12/12/24 at 12:22 PM, the DON stated he was unable to find paperwork where the provider acknowledged pharmacy recommendations for October 2024. During an interview with NP #1 on 12/12/24 at 10:30 AM, regarding the process for monthly MMRs, the NP #1 confirmed that the DON prints off the monthly MMRs and puts the recommendations in the provider's box to review for he/she to sign off but stated typically I do not usually review those hard charts since they are in [the medical record] anyways. When asked about Resident #25's Dapagliflozin and Empagliflozin order, he/she stated he/she will follow up. Follow up interview with NP #1 on 12/12/24 at 11:22 AM, he/she stated that there was a break in the system and Resident 25's SGLT-2 Inhibitors did not get discontinued because it got missed. Record review of facility's policy Pharmacy Service Agreement Review, undated, revealed . On a monthly basis, during the previously scheduled visit to the Customer, a Consultant Pharmacist shall perform a medication regimen review (MRR) for each Resident on active Customer census on the visit date . Within 48 hours after conducting the MRR, the Pharmacy or Consultant Pharmacist shall provide the MRR report to Client's Administrator/Executive Director and Director of Nursing. When irregularities are noted, the MRR report documenting such irregularities will be provided to Client's Administrator/Executive Director and Director of Nursing. Electronic delivery of the report is an appropriate alternative to hard copy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50031 Based on observation, interview, and record review, the facility failed to ensure medication and/or medical supplies in two medication storage rooms (the main medication storage room and in [NAME] Court), out of five medication storage rooms, and two medication carts (located on the Birch Court and [NAME] Court), out of three medication carts, were unexpired. Specifically, the facility failed to discard expired medications and/or medical supplies. These failed practices placed all residents (based on census of 99) at risk for adverse effects or complications from receiving expired medications and/or medical supplies. Findings: Main Medication Storage Room An observation on 12/10/24 at 8:28 AM, of the facility's main medication storage room revealed the following medications and/or medical supplies on the open shelves were expired: - 4 - 100ml (milliliter) 0.9% Sodium Chloride Injection USP (US Pharmacopeia is a nonprofit organization that sets quality standards for medications to ensure quality and safety), expired on 8/2024; - 2 boxes- EvenCare G2 Glucose Control Solutions Net Contents: 5 mL, expiration dated 2024- 08-17; - 1- 1000ml 5% Dextrose Injection USP, expired on 8/2024; - 1- 1000ml 5% Dextrose Injection USP, expired on 10/2024. During an interview on 12/10/24 at 8:32 AM, the Director of Nursing (DON) stated that the medications and/or medical supplies were expired and should have been removed from the supply shelves. Willow Court Medication Room An observation on 12/10/24 at 9:13 AM, of the facility's [NAME] Court medication room, revealed the following medications and/or medical supplies were expired: -7- eSwab Collection & preservation of Aerobic, Anaerobic & Fastidious Bacteria (type of collection swabs for testing resident wounds for bacterial growth), expired on 5/22/24. During an interview on 12/10/24 at 9:14 AM, the DON stated that the medications and/or supplies were expired and should have been discarded. Birch Court Medication Cart An observation on 12/10/24 at 10:24 AM, concerning the facility's Birch Court medication cart, revealed the following medications and/or medical supplies were expired: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-3 Single Dose Flexible Bags- Vancomycin (an antibiotic intravenous medication) Injection 1.25g[[NAME]] per 250 mL(mililiter), expired on 11/24/24, pharmacy labeled for a resident; During an interview on 12/10/24 at 10:33 AM, LN #1 stated the expired medications should have been returned to the pharmacy. [NAME] Court Medication Cart An observation on 12/10/24 at 11:21 AM, of the facility's [NAME] Court medication cart, revealed the following medications and/or medical supplies were expired: -1 container- GeriCare Zinc 50mg (miligrams), expired on 11/24. During an interview on 12/10/24 at 11:22 AM, LN #6 stated the expired medication should have been returned to the pharmacy. Additional Interviews: During an interview on 12/10/24 at 8:35 AM, the DON stated the nurses were expected to monitor the medication carts to ensure that expired medications were discarded or returned to the pharmacy. During an interview on 12/12/24 at 9:12 AM, Pharmacist #1 confirmed that the facility should have returned the expired medications to the facility's pharmacy provider. Review of the facility's Medication Storage policy, dated 1/2023, revealed: . Outdated . medications . are immediately removed from stock, disposed of according to procedures for medication disposal .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 50031 Based on record review, observation, and interview the facility failed to provide nutritious food substitutions to accommodate the preferences for one unsampled resident (#40) out of a census of 90 residents who received meals from the kitchen. This failed practice had the potential to decrease nutrition and cause unnecessary weight loss. Findings: Record review on 12/11/24 revealed Resident #40 was admitted to the facility with diagnoses that included acquired absence of other specified parts of digestive tract, vascular dementia (dementia resulting from impaired blood flow to the brain), with psychotic disturbance, adult failure to thrive (weight loss of more than 5%, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction and low cholesterol), and schizophrenia (mental disorder characterized by symptoms of hallucinations, delusions and cognitive challenges). During observations of the Cedar Court dining area on 12/11/24 from 11:35 AM to 12:30 PM, Resident #40 sat in a recliner chair in the dining area. Resident #40 stated, I am hungry. Certified Nursing Assistant (CNA) #3 told Resident #40, Food is coming. When Resident #40 yelled, I am hungry. CNA #4 replied, I know. Continuing with the observation, at 12:31 PM, CNA #4 brought Resident #40 his/her lunch. CNA #4 set the plate, dessert cup, drinking cup, and silverware on a bedside table by Resident #40. CNA #4 returned to passing meal trays to residents' rooms. During an observation on 12/11/24 at 12:35 PM, Resident #40 told CNA #4 he/she did not want the food provided. Resident #40 had thrown his/her lunch in the garbage can next to his/her recliner. During an interview on 12/11/24 at 12:54 PM, LN (Licensed Nurse) #10 stated Resident #40 would throw his/her food away. LN #10 stated Resident #40 would commonly say my sister peed in it and would not want the food given. LN #10 further stated Resident #40 would drink Ensure (nutitional supplement drink) and enjoyed culturally relevant foods. Resident #40 was not offered any alternative foods and did not receive additional food, or drink during the observation period. Record review during 12/8-12/24 of Resident #40's care plan revealed, . Refusing to eat . Provide and serve supplements as ordered: prefers Ensure . Encourage good nutrition and hydration . offer supplements/alternate with intake <50% . (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, Activities of Daily Living (ADL), Supporting, last revised 3/2018, revealed: . Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition (s) demonstrate that diminishing ADLs are avoidable . he or she has been offered alternative interventions to minimize further decline . Appropriate care and services will be provided for residents . d. dining (meals and snacks) .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50031 Based on observation, interview, and record review, the facility failed to ensure that food was stored, prepared, and served in accordance with professional standards for food safety. Specifically, the facility failed to ensure: 1) food was stored under proper sanitation and food handling practices in the main kitchen; 2) the kitchen was kept in a clean, sanitary condition. These failed practices had the potential of causing or spreading foodborne illness to all residents, based on a census of 99. Findings: Main Kitchen An observation, during the initial main kitchen tour, on 12/8/24 at 8:20 AM, revealed: 1) Main Kitchen Freezer Unit: - 1 clear plastic bag of chicken nuggets - 3/4 full - not sealed, no label, no date. - 1 clear plastic bag of sausage patties in cardboard box - 3/4 full - not sealed, open to the elements. - Food tray with six small bowls of individual cake-like desserts, covered with clear plastic wrap - No labels, no dates. 2) Main Kitchen Refrigerator Unit: - Metal tray containing sliced fruit - loosely wrapped in clear plastic wrap, leaving some portions of fruit exposed to the elements no label, no date. - Metal square tray containing sliced tomato - loosely wrapped in clear plastic wrap, leaving some portions of tomato exposed to the elements - no label, no date. - Block of orange cheese slices, loosely wrapped in clear plastic wrap, leaving some portions of cheese exposed to the elements. - Unsealed plastic bag containing red grapes - half full - open to elements. - Metal square tray containing sliced black olives - covered with clear plastic wrap - no label, no date. - Metal square tray containing sliced onions - covered with clear plastic wrap - no label, no date. - Metal square tray containing sliced fruit - covered by clear plastic wrap - not sealed, no label, no date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Metal square tray containing lettuce - covered with clear plastic wrap - no label, no date. - Metal square tray containing sliced pickles - covered with clear plastic wrap - no label, no date. - Food tray with 5 premade salads on plates covered with clear plastic wrap - No labels, no dates. - On the food tray with the premade salads were seven different individual-size cups with lids of salad dressings - No labels, no dates. - Metal square kitchen container containing eight whole tomatoes. There were black dented spots over 50% on four tomatoes. There were black dented spots over 20% on four different tomatoes. - Metal cylinder tray labeled vanilla pudding, covered by clear plastic wrap, unsealed. - Metal square tray containing two unsealed clear plastic bags of sliced meat. One bag contained what appeared to be sliced turkey. The other bag contained what appeared to be sliced ham resting in clear gelatinous substance. The ham had a use by date of 11/19/24. During an interview on 12/8/24 at 8:40 AM, when asked about a tray holding premade ham sandwiches, [NAME] #4 stated the sandwiches were made using the ham that was in the fridge. 3) Main Kitchen Large Bin Containers: - 22-quart container labeled rice dated 11/24 - Lid loose sitting askew on the tub, contents open to air. - 22-quart tub labeled sugar dated 7/24 - Plastic round scoop in the container with the sugar. 4) Dry Storage/Pantry area: - Box of fresh whole bananas stored in the pantry with dry goods - Box of fresh whole potatoes stored in the pantry with dry goods 5) Downstairs Walk-In Refrigerator: - 1 Large square plastic tub storing fresh green and purple whole cabbages and 1 large square plastic tub storing fresh green lettuce. Both tubs not covered and open to air, sitting on the bottom shelf of the refrigerator closest to the evaporator coil/fan system. This evaporator coil/fan system was visibly loaded with a large amount dust/dirt-like debris throughout the grill covering the fan blades. The air was blowing directly onto the cabbages and lettuce. 6) Downstairs Walk-In Freezer: - Ice build up was visibly built up on the piping of the evaporator coil/fan system inside the freezer. This build up was also coating the food packages sitting directly below the evaporator coil/fan system. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Food was stacked to the ceiling on the two shelves on either side nearest the freezer's door. During an interview on 12/8/24 at 8:38 AM, [NAME] #4 stated all food items in the unit refrigerator and freezer should be labeled and dated and the rice bin should have been closed. [NAME] #4 further stated all foods found open to the elements should have been closed or covered. [NAME] #4 stated the tomatoes should have been thrown away. 7) Pureed Station: An observation of the kitchen's pureed station, on 12/8/24 at 8:42 AM, revealed this station was in a corner of the kitchen with a 90-degree metal counter with two deep sinks that fit flush into the corner and against the walls, making an L shaped station. Standing in front of the 90-degree corner of the station, the counter with the two sinks was against the right wall of the corner station and the counter space was against the left wall of the corner station. An observation of the left wall counter space section of the pureed station, revealed: - The blender machine base, without the blender pitcher attached, was sitting on the counter visibly soiled with a white, dried, food substance coating the left side of the base. - The blender machine base was sitting on a white kitchen towel. This towel was visibly soiled with food particles and stained. - The counter was visibly soiled with dried food particles and white powder particles scattered on the counter. - On the wall directly in front of the counter were two magnetic strips with hooks secured to the wall approximately 2 feet long each. Seven clean knives were stuck to the magnetic strips by the blades of the knives. The wall was visibly soiled throughout the length of the counter with food particles of varying colors and sizes. The knives were exposed to these particles. - To the right of the blender was a handheld pitcher on a small cooking tray, about 1/8 full of white powder. The pitcher's contents were not covered exposing it to air. Further observation of the pureed station revealed a one shelf directly 2 feet above, and running the length of, the left counter. An observation of the shelf above the left counter, on 12/8/24 at 8:51 AM, revealed a medium size metal square container of several loaves of uncut bread. This container was covered with plastic wrap. There was no label or date on the container. An observation of the right wall counter, with the two large deep sinks, section of the pureed station, revealed: - On the left side of the sink was a large 22-quart square container of a white powdery substance. The container was not labeled or dated. This container was not covered and open to the elements. Further observation revealed this container was sitting approximately 19 1/2 inches from the sink. The counter area between the container and sink had visible pooling of standing water on the counter. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further observations of the pureed station revealed two shelves above, and running the length of, the right counter with the sinks. The first shelf on the right was approximately 1 foot above the counter, the second shelf was approximately 2 feet above the counter. An observation of the shelf above the right counter revealed: - 3 cans of Sysco Mandarin Oranges, 6.61 lbs. cans. 1 can was dented on the rim of the can. - 1 square metal container holding 5 whole onions. A small fly-like insect was observed to be sitting on one onion. When the container was moved the fly flew off into the air. During an interview on 12/8/24 at 9:02 AM, [NAME] #4 stated the pureed station was dirty. [NAME] #4 acknowledged the wall was soiled with food, the blender and the towel under the blender were dirty, the counter was wet, and the bread should have had a label and date. When asked what the white powder in the 22-quart container to the left of the sink was, [NAME] #4 stated the container held powder thickener used during the pureeing process, and it should have been covered with a lid. [NAME] #4 stated the container should have been stored in a dry area. When asked how the cooks determined the amount of thickener to use during the pureed process, as there was no guide chart or book visible in the area, [NAME] #4 stated they just know. Cook #4 further stated the 3 cans of mandarin oranges were to be served to residents during meals. When asked if the can with the dented rim would be served as well, [NAME] #4 stated it would be served to residents. 8) Main Kitchen Plating Area: - The food warmer by the ice machine was visibly soiled throughout the front outer surface area, especially the door of the warmer. The door handle was visibly soiled and sticky to the touch. - The overall condition of the kitchen floor was dirty. Debris build up was observed in every corner throughout the flooring, food particles were observed in all areas of the flooring. Pooled standing water was observed in the entrance to the cook station area. An observation on 12/10/24 at 11:18 AM, of the pureed station in the main kitchen, revealed: - The 22-quart container of powder thickener remained positioned to the left of the sink, still uncovered. The lid to the container sat on vertically stacked cutting boards to the left of the container. To the right of, and approximately 1 inch from the powder thickener container, was a red sanitation bucked of cleaning solution with a white washcloth in the solution. - The wall with the knives stuck to the magnetic strips was still soiled with food particles - The blender used to puree foods was sitting on the left counter. The blender machine base was visibly soiled with white, dry food particles over the left and face of the machine base. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- A pitcher was seated on the blender machine base. This pitcher was dry and had a clean cover sitting within the pitcher. The pitcher appeared to have been washed, however there were dried food particles stuck to the inner surface of the pitcher. These food particles were at the inner top portion of the pitcher, to the left of the upper portion of the handle base of the pitcher. Food Tray Preparation An observation of hot food tray preparation was conducted on 12/11/24 at 4:00 PM. Previously prepared hot food trays were obtained from the hot holding cabinet and were used to replace depleted hot food trays in the steam table. It was noted that during this exchange, food temping (the process of measuring the internal temperature of food to ensure food safety and quality) had not occurred and this untemped food was plated for residents. During an interview on 12/11/24 at 4:26 PM, when asked how often food temperatures should be temperature checked, the Kitchen Manager stated, .after food comes out of the oven, and after food comes out of the warmer, before going to the steam table . Pureed Food Preparation: An observation of pureed food preparation, on 12/12/24 at 10:00 AM, revealed [NAME] #4 was observed pouring previously prepared fish broth into a blender. He/she then added other ingredients along with an unmeasured amount of food thickener. It was noted that during the process of preparing and placing the puree food mixture into bowls to be served to residents, no temperature checks occurred. During an interview with [NAME] #4 on 12/12/24 at 10:15 AM, when asked if the food should have been temperature checked, he/she stated, Yes. Review of the facility's policy Food Preparation and Service, revised 11/2022, revealed: .temperatures of foods held in steam tables are monitored throughout the meal service by food nutrition services staff .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40259 Based on observation, interview, and record review, the facility failed to ensure electrical equipment was maintained in safe operating conditions. Specifically, the facility failed to ensure: 1) All patient care related electrical equipment (PCREE) had regular, routine preventative maintenance (PM) inspections to ensure they were in safe operating condition; 2) All non-patient care related electrical equipment (N-PCREE) was inspected to ensure it was safe for operation in resident care areas and used in a safe manner; and 3) Space heaters used in non-resident care areas were inspected by maintenance and used in a safe manner. These failed practices placed all residents, based on a census of 99, at risk for: 1) receiving inadequate treatment and/or care, from equipment not subjected to routine preventive maintenance monitoring, that could affect the resident's overall physical, mental, and psychosocial well-being; 2) electrical shock and/or exposure to electrical fire. Findings: PCREE An observation on 12/11/24 at 1:25 PM, in resident room [ROOM NUMBER], revealed the following PCREE: 1) one Drive DeVilbiss model 1025DS 10-liter oxygen concentrator (a machine that purifies natural air, into a higher concentration of oxygen, that a resident breaths through a mask or nasal cannula); 2) one Drive Power Nebultra nebulizer (a machine that turns medicine into a mist that a resident can breathe, which helps to opens airways for easier breathing); 3) one Direct Supply DS-ASP Attendant aspirator (or suction) machine; and 4) one Covidien Kangaroo E-pump Enteral Feeding and Flush pump (a machine used for feeding a resident, through a tube inserted into the stomach, when a resident cannot eat food). None of these PCREE had PM stickers. An observation on 12/11/24 at 1:52 PM, in resident room [ROOM NUMBER], revealed one Invacare [NAME] 2 V oxygen concentrator (different brand of machine that purifies natural air). Further observation revealed a PM sticker that indicated the next service was due on [September] 2020. An observation on 12/11/24 at 1:25 PM, in resident room [ROOM NUMBER], revealed the following PCREE: 1) one Covidien Kangaroo E-pump Enteral Feeding and Flush pump currently being used to feed the resident with no PM sticker; 2) one Drive Power Nebultra nebulizer with no PM sticker; and 3) one Direct Supply suction machine with a PM sticker that indicated the next service was due 6/[2020]. An observation on 12/11/24 at 2:36 PM, in resident room [ROOM NUMBER], revealed one Invacare [NAME] 2 V oxygen concentrator. Further observation revealed the concentrator had no PM sticker. An observation on 12/11/24 at 2:38 PM, in resident room [ROOM NUMBER], revealed one Invacare [NAME] 2 V oxygen concentrator. Further observation revealed the concentrator had no PM sticker. (continued on next page)

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	025025	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centennial Post Acute	9100 Centennial Drive Anchorage, AK 99504

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 12/11/24 at 3:34 PM, in resident room [ROOM NUMBER], revealed one Invacare [NAME] 2 V oxygen concentrator. Further observation revealed the concentrator had no PM sticker. An observation on 12/11/24 at 3:40 PM, in resident room [ROOM NUMBER], revealed one Covidien Kangaroo E-pump Enteral Feeding and Flush pump. Further observation revealed the pump had no PM sticker. An observation on 12/11/24 at 3:56 PM, revealed a portable GE Carescape V100 vital sign machine for Birch court had no PM sticker. An observation on 12/11/24 at 3:59 PM, in resident room [ROOM NUMBER], revealed one Invacare [NAME] 2 V oxygen concentrator. Further observation revealed the concentrator had no PM sticker. An observation on 12/11/24 at 4:01 PM, in resident room [ROOM NUMBER], revealed one Invacare [NAME] 2 V oxygen concentrator. Further observation revealed a PM sticker that indicated the next service was due on 6/2020. An observation on 12/11/24 at 4:04 PM, in resident room [ROOM NUMBER], revealed one Drive Power Nebultra nebulizer. Further observation revealed the nebulizer had no PM sticker. An observation on 12/11/24 at 4:11 PM, in resident room [ROOM NUMBER], revealed one Invacare [NAME] 2 V oxygen concentrator. Further observation revealed a PM sticker that indicated the next service was due on [March] 2019. An observation on 12/11/24 at 4:14 PM, in the alcove between resident rooms [ROOM NUMBERS], revealed one Invacare [NAME] 2 V oxygen concentrator. Further observation revealed the concentrator had no PM sticker. An observation on 12/11/24 at 4:30 PM, revealed a portable GE Carescape V100 vital sign machine for [NAME] court had a PM sticker that indicated the next service was due [September] 2020. An observation on 12/11/24 at 4:34 PM, in resident room [ROOM NUMBER], revealed one Drive Power Nebultra nebulizer. Further observation revealed the nebulizer had no PM sticker. An observation on 12/11/24 at 4:51 PM, in resident room [ROOM NUMBER], revealed one Invacare [NAME] 2 V oxygen concentrator. Further observation revealed the concentrator had no PM sticker. An observation on 12/11/24 at 4:52 PM, in resident room [ROOM NUMBER], revealed one Covidien Kangaroo E-pump Enteral Feeding and Flush pump. Further observation revealed the pump had no PM sticker. An observation on 12/11/24 at 4:59 PM, in resident room [ROOM NUMBER], revealed one Covidien Kangaroo E-pump Enteral Feeding and Flush pump. Further observation revealed the pump had no PM sticker. The Director of Business Development acknowledged the PCREE observed either had no PM stickers, or the PM stickers attached were outdated upon discoveries. Oxygen Concentrator Preventative Maintenance Guidelines (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility-provided Category: Oxygen Concentrators In-House Maintenance guide, dated 2024, revealed: . At a minimum, preventative maintenance MUST be performed according to the maintenance record guidelines . Review of the Drive DeVilbiss service manual, dated 2020, revealed the 1025 series models should have preventative maintenance every 3 years. Review of the Invacare [NAME] 2 V service manual, dated 2014, revealed this model had an Invacare SensO2 oxygen sensor. Because of this feature, the maintenance record guidelines recommended that this oxygen concentrator have preventative maintenance every 26,280 hours or 3 years, whichever comes first. Nebulizer Preventative Maintenance Guidelines Review of the Drive Power Nebultra Instruction Guide, dated, revealed: . Nebulizer Cleaning . Filter Change. Filter should be changed every 6 months or sooner if filter discolors . Maintenance. All maintenance must be performed by a qualified Drive provider or authorized service center . Electric shock hazard. Do not remove compressor cabinet. All disassembly and maintenance must be done by a qualified Drive provider . Aspirator Maintenance Guidelines Review of the Direct Supply DS-ASP Attendant aspirator owner's manual, dated 2011, revealed: . Maintenance . Do not attempt to open or remove the suction cabinet. If a service is required then return your suction to an authorized service center . Bacteria Filter Change . Bacteria filter should be replaced as needed. If overflow occurs, change the filter immediately During an interview on 12/26/24 at 9:03 AM, a Direct Supply representative stated the DS-ASP Attendant aspirator's filter should be changed every 2 months. Tube Feeding Maintenance Guidelines Review of the Covidien Kangaroo E-pump Enteral Feeding and Flush pump operation Manual, dated 2012, revealed: . Performance Evaluation. System Performance Tests. A series of tests can be performed to verify pump performance. It is recommended that tests be run at least once every two years, or any time the pump is suspected of having improper performance . Preventative Maintenance. This pump must be periodically tested to assure proper functioning and safety. The recommended service interval is every 2 years . Vital Sign Machine Maintenance Guidelines Review of the GE Carescape V100 vital sign machine service manual, dated 2011, revealed: . Maintenance schedule. To ensure the monitor and its components remain in proper operational and functional order, the following maintenance schedule is recommended . Calibration procedures and tests: every 12 months, or whenever the accuracy of the reading is in doubt . Electrical safety tests: Upon receipt of the equipment, every 12 months thereafter, and each time the unit is serviced . (continued on next page)

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