

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/24/2025
NAME OF PROVIDER OR SUPPLIER Centennial Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 9100 Centennial Drive Anchorage, AK 99504	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview, observation, and record review, the facility failed to ensure a safe, comfortable and homelike environment was provided for all residents (based on a census of 97). Specifically, the facility failed to ensure: 1) the elevator flooring was properly installed; 2) windows were functional to keep wind and cold from entering resident bedrooms; and 3) room temperature level was within 71 degrees Fahrenheit (F) to 81 degrees F. These failed practices denied all residents the right to have a safe and comfortable homelike environment Findings: Elevator floorDuring random observations from 12/14-18/25, the elevator floor was observed to be composed of approximately 6-inch square sections of linoleum like material curling around the edges. Two of these sections were lifting and had been patched with sections of what appeared to be duct tape, though the sections remained uneven and were not fully adhered to the floor.During an interview on 12/18/25 at 4:11 PM, the Director of Life Safety and Maintenance (DLSM) stated that he had direct oversight of the elevator. The DLSM reported that the elevator floor contained loose pieces, which posed a potential hazard to residents. The DLSM further stated that he planned to purchase a one-piece, medical-grade flooring material to replace the existing flooring rather than continuing repairs using smaller pieces. The DLSM was unable to identify the specific flooring material that was deteriorating. Windows and Resident Room TemperatureDuring an interview on 12/14/25 at 10:22 AM, Resident #68 stated: It's been cold in this room since November [2025]. I have my windows taped up because there's a draft. My roommate's window also has the same issues. The furnace is not really working that well.During an interview on 12/14/25 at 11:31 AM, Resident #1 stated it was cold in here (referring to the bedroom) because the furnace was old. During an interview on 12/14/25 at 11:45 AM, Resident #35 stated, I get really cold easily. It's an old building. My windows are covered with pillows and a blanket to help from the room getting cold, especially since it's been windy. I have a space heater.During an interview and observation on 12/15/25 at 8:54 AM, Resident #40's Resident Representative (RR) stated that Resident #40 complained of his/her room being constantly cold in the winter. An observation of the Resident #40's window revealed it was encircled with multiple layers of black tape, creating a makeshift wind barrier. Further observation revealed three folded blankets placed at the base of Resident #40's window. Resident #40's RR stated that the facility used the blankets to block a cold draft which would enter Resident #40's room through the window, however the RR stated that the draft could still be felt despite this intervention.During an interview on 12/17/25 at 1:48 PM Certified Nursing Assistant (CNA) #1, stated when the residents would complain of their room being cold, he/she would assess the resident first then provide more blankets if it was cold. Then, report the issue to the Maintenance Department through TELS [the facility's maintenance reporting system].During an interview on 12/17/25 at 2:05 PM, the DLSM stated it was difficult to ensure that the temperature of the room was maintained at a comfortable level because of temperature changes. Whether it is cold or hot, it would take three days to bring the temperature to a comfortable level. The DLSM stated the maintenance staff had been checking the residents' room temperature weekly. The DLSM stated they didn't have a policy for checking the room temperature.During the same interview, (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the DLSM further stated that if there were residents' complaints about their room temperature, the staff would report to the DLSM through TELS system. The staff could also report any work order through band app (facility's messaging system), radio, his phone direct line and cellphone. The DLSM stated the maintenance department would response immediately or within 15 minutes even on off hours. The facility would provide heater/fan, and blankets according to residents' needs. When asked if there was a thermostat in the residents' room, he stated he didn't know. During the same interview, the DLSM stated the facility's plan was to replace the boiler in May 2026 and replace 50 windows to cut the drafting. DLSM further stated, comfort is very important to us. Review of the facility's Director of Life Safety and Maintenance room temperature reports, dated January to December 2025, revealed the room temperature standard at Centennial Post Acute was .71-81 degrees Fahrenheit per regulations. temperatures are taken weekly at two rooms per court. Temperatures are taken using an infrared temperature sensor at 3 wall locations in the room, with the average stated in the report. Review of the facility's maintenance department Work Orders, dated 12/1-17/25, revealed:- #11764 two residents complaining of their rooms being too cold that they can't sleep;- #11775 draft from window, could we get it taped please;- #11778 window is letting in air;- #11759 window blew open won't shut;- #11762 Resident stating his/her room is cold.- #11753 heater needed;- #11734 complaining its cold; and- #11708 window leaking. An observation on 12/18/25, between 9:08 AM to 9:25 AM, of random room temperature checks with the DLSM who took three readings of the room temperature using an infrared sensor, revealed two out of eight rooms checked, had the following average room temperature readings of:- room [ROOM NUMBER] - 67.7 degrees F and- room [ROOM NUMBER] - 69.3 degrees F. An observation on 12/18/25 at 2:00 PM, of the Birch Court rooms revealed room [ROOM NUMBER]'s window was sealed with duct tape. An observation on 12/18/25 at 2:14 PM, of the [NAME] Court rooms revealed there were six rooms where the windows were sealed with duct tape: Rooms 501, 502, 506B, 508, 509, and 510B. An observation on 12/18/25 at 2:36 PM, of [NAME] Court rooms revealed room [ROOM NUMBER] had towels around the base of the window. An observation on 12/18/25 at 2:40 PM, of Cedar Court rooms revealed eight rooms where windows were sealed with duct tape: Rooms 202, 204, 206B, 207, 210A, 210B, 211 (also had blankets around the base of the window), and 212. An observation on 12/18/25 at 3:01 PM, of [NAME] Court rooms revealed five rooms where windows were sealed with duct tape: Rooms 301, 303, 305A, 307, and 310A. room [ROOM NUMBER] had blankets at the base of the window. An observation on 12/18/25 at 3:11 PM, of Spruce Court rooms revealed 7 rooms where windows were sealed with duct tape: Rooms 103, 105, 106 (also had blankets at the base of the window), 108, 109, 111, and 112 (also had blankets at the base of the window). Common Area Temperature Random observations from 12/14-18/25 revealed group activities for all residents were held in the common area. Review of Centennial Activity Calendar, dated 12/16/25, revealed Bingo was held in the common area. Random observation on 12/16/25 revealed Bingo was held in the common area. Review of Centennial Activity Calendar, dated 12/17/25 revealed Craft Circle with Kevin and [NAME] sings were held in the common area. An observation on 12/18/25 at 9:25 AM, revealed the common area on the first floor had an average temperature reading of 66.6 degrees F. During an interview on 12/18/25 at 9:25 AM, DLSM stated the maintenance staff were checking the room temperature in rooms [ROOM NUMBERS] on each court. However, the room temperature in the common area on the first floor was not included in their weekly room temperature check. Review of the Quality Assurance and Performance Improvement (QAPI) minutes of the meeting, dated 10/2025, revealed an email from the Director of Nursing (DON) .QAPI Maintenance.boiler replacement is on track for Spring. Review of the facility's policy Maintenance Service, dated 2001, revealed: .The maintenance department is responsible for maintaining the buildings.maintaining the heat/cooling system.in good working order.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure:1) accurate grievance officer contact information was available to residents and representatives through required postings or individual notice, and2) to provide clear instructions on how to file and submit grievances, since grievance forms and admission information did not include submission instructions and the primary posted notice contained incorrect grievance officer information. These failed practices resulted in residents and resident representatives not having reliable access to the grievance process due to inaccurate grievance officer identification and unclear submission instructions, placing residents at risk for delayed reporting and resolution of concerns, creating a facility-wide system failure that limited residents' ability to access and use the grievance process Findings: During random observations from 12/14-18/25, the grievance procedure notice was observed posted throughout residents' courts. The notice indicated that residents and others could submit complaints or grievances anonymously, either orally or in writing, with grievance forms available in the Social Services Office. The notice stated that all concerns would be addressed within a reasonable timeframe and that the Grievance Officer should be notified immediately of any suspected resident abuse, neglect, misappropriation, or exploitation. The notice identified the designated Grievance Officer as Grievance Officer (GO) #1 and listed the following contact information: 9100 Centennial Circle, Anchorage, AK 99504; email: [name of GO#1]@centennialpa.com; phone number: [PHONE NUMBER]. The notice further stated that a copy of the Grievance Policy or a written grievance decision was available upon request. During an interview on 12/17/25 at 10:00 AM, the Social Services Director (SSD) stated that she currently serves as the facility's Grievance Officer (GO #2), a role she assumed upon starting her position in November 2025. The SSD was unsure of the exact departure date of the previous Grievance Officer (GO #1). She stated that residents were informed about the grievance process through admission packets, grievance forms located on each court and outside of the Social Services Office, and locked grievance boxes collected daily. Upon reviewing the admission packets, the SSD noted that they did not include written information identifying the Grievance Officer or providing contact details, and no additional written notification of her role had been provided to residents or their representatives. The SSD also stated that she had not yet introduced herself at Resident Council meetings, believing attendance requires an invitation, but she planned to introduce herself to residents when possible. Upon reviewing the grievance procedure notice posted throughout the facility, the SSD also noted that the contact information should no longer be for the GO #1, not accurately reflecting the change in grievance officers. During the Resident Council meeting on 12/17/25 at 3:08 PM, Residents (#25, #35, #47, #69, #74, #95, #102) stated they did not know who the new GO was. The council reported they were aware the former GO had left in September, but the new GO had not approached the council for an introduction. Record review of Resident Council meeting minutes, dated 9/8/25, revealed complaints regarding missing laundry, with the facility response documented as: .We will try and educate the staff. Record review of Resident Council meeting minutes, dated 10/13/25, revealed the introduction of the new Activities Director and Admissions Director. The minutes also documented discussion of old business related to missing laundry and Certified Nurse Assistants (CNA) clearing call lights and failing to return to residents. Record review of Resident Council meeting minutes dated 11/10/25, revealed discussion of new business noting many newly hired CNAs; there was no mention of a new Grievance Officer. Old business again included missing laundry and call light concerns. Record review of Resident Council meeting minutes, dated 12/8/25 revealed no discussion regarding a new Grievance Officer. Old business continued to include missing laundry and call light concerns. Review of RESIDENT GRIEVANCE FORM, undated, posted on each court's entrance board near a locked wooden box, (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	revealed a structured document that included fields for the date and time of the grievance or concern, the resident's name and room number, and the name of the person completing the form. It provided a section to describe the nature of the grievance, followed by areas for investigation findings and interventions/action taken. The form also included a section for the date follow-up to resolution occurred, with signature lines and dates for the person conducting follow-up (by whom), the administrator, the grievance officer, and the resident. No additional instructions were provided regarding how or where to submit the completed form. Review of the policy and procedure titled Grievance, last revised 3/2015 revealed: .the facility will have a designated Grievance Officer who is responsible for overseeing the grievance process, receiving, investigating, tracking grievances through to their conclusion and maintain the confidentiality of all information associated with grievances. Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance. PROCEDURE: 1. The Social Services Director/Designee should assure that residents and/or their representative(s) receive a review of their rights and responsibilities upon admission. 2. The Activities Director/Designee should complete a grievance form when a global issue is raised at a Resident Council Meeting. 3. The Social Services Director/Designee or ANY staff member should assist concerned resident(s), resident representative(s), other family member(s), or advocate that have issues or concerns to complete a Grievance/Concern Form. Review of the posted document RESIDENT RIGHTS, undated, revealed: Choice, Medical Care, Privacy & Confidentiality, Free from Abuse & Restraint, Visitors & Association, Activities & Work, Personal Possessions, Grievances & Complaints, Financial Affairs, Transfer & Discharge. A detailed document of the above Resident Rights Summary is available from the admission Office or Social Worker.		

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. .Based on record review and interview, the facility had failed to ensure the activities program was directed by a qualified professional. This failed practice placed all residents (based on a census of 97) at risk of not having an activities program directed by a qualified professional that met their physical, mental, and psychosocial needs Findings: Record review on 12/17/25 at 2:29 PM of the Activities Director (AD) appointment letter revealed the AD was hired into the director position on 9/3/25. During an interview on 12/16/25 at 1:20 PM, the AD stated she had been the AD for about a month, and she reported directly to the Human Resources Manager (HRM). The AD understood that the HRM had an AD certification but still needed to obtain her own certification once she had enough qualifying hours. During an interview on 12/17/25 at 2:33 PM, the HRM stated she held an Advanced Activity Professional board certification. During the same interview on 12/17/25 at 2:33 PM, when asked if the HRM was involved with directing the Activities program, the HRM stated: No. The HRM reported that beginning on 8/6/24, the AD had previously worked as a dietary aide and helped out with the activities program when she was available. Then sometime in 1/2024, the AD became the receptionist, where she occasionally assisted with the activities program. The HR Director added that the AD's prior program experience had never been full-time before assuming responsibility for directing the activities program. Review of the facility provided: Job Description: Activity Director, undated, revealed: . Qualification. Activity Director Certification.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review, interview, and observation the facility failed to ensure sufficient nursing staff to meet residents' needs, (based on a census of 97) as established by the facility assessment (a mandatory, comprehensive evaluation to understand the specific resident population's needs and match them with necessary staffing, equipment, and resources to meet those needs). Specifically:The facility assessment identified minimum staffing requirements for weekends; however, actual staffing schedules showed fewer certified nursing assistants (CNAs), and licensed nurses (LNs) than defined.Residents reported dissatisfaction with care, including delays in call light response times and provision of hygiene.These deficient practices resulted in delays in care and unmet needs for residents and had the potential to negatively impact residents' health, safety, and quality of life.Findings:Review of the Payroll Based Journal (PBJ) Staffing Data Report (a mandatory electronic staffing data submission system created by the Centers for Medicare & Medicaid Services [CMS]) for the fourth quarter (7/1/25 to 9/30/25) revealed: Excessively Low Weekend Staffing was triggered.Review of the facility provided Centennial Post Acute Facility Assessment, updated on 11/25/25, revealed: . The facility is struggling with securing FT [full time] staff for nurses and CNAs. The assessment indicated staffing should include: . 6 nurses on day/eve[NAME]] shift and minimum of 3 on NOC/night shift.12-15 CNAs on day shift/eve shift and 9-12 on NOC/night shift. 2 restorative aides daily.Review of 12 randomly selected weekend staffing schedules for the fourth quarter (7/1/25-9/30/25) revealed staffing consistently fell below the facility assessment's established levels. Specifically:On 8/9/25, 2 LNs were scheduled, the established minimum was 3.Dayshift, CNAs, the established minimum was 12:On 7/5/25, 10 day shift CNAs were scheduled;On 7/6/25, 11 day shift CNAs were scheduled;On 7/12/25,11 day shift CNAs were scheduled; [NAME] 7/13/25, 9 day shift CNAs were scheduled.Nightshift, CNAs, the established minimum was 9:On 7/5/25, 7 night shift CNAs were scheduled;On 7/6/25, 8 night shift CNAs were scheduled;On 7/13/25,6 night shift CNAs were scheduled; [NAME] 9/6/25, 7 night shift CNAs were scheduled.Restorative Aides (RAs) - established minimum was 2 daily:On 7/5/25, 1 RA was scheduled;On 7/6/25, 0 RAs were scheduled;On 7/12/25,1 RA was scheduled;On 7/13/25,1 RA was scheduled;On 8/9/25,1 RA was scheduled;On 8/10/25,1 RA was scheduled;On 8/23/25,1 RA was scheduled;On 8/24/25,1 RA was scheduled;On 9/6/25, 1 RA was scheduled;On 9/7/25, 1 RA was scheduled;On 9/27/25, 0 RAs were scheduled; [NAME] 9/28/25, 1 RA was scheduled.Resident #48Record review on 12/14-24/25 revealed Resident #48 was admitted to the facility with diagnoses that included quadriplegia (paralysis of all four limbs). The resident fully relied on staff to dress and get the resident up and out of bed.During an interview and concurrent observation on 12/14/25 at 11:11 AM, Resident #48 stated that he/she had called for staff around 9:00 a.m. to assist with getting out of bed and was still waiting. The resident remained in bed with a Hoyer lift positioned beside the bed and the wheelchair near the doorway. The resident stated that he/she had requested to be out of bed by 9:30 a.m. and reported that long waits had been common since admission, expressing concern that the facility seemed very short-staffed. Staff assisted Resident #48 out of bed at 11:23 a.m., a total wait time of 2 hours and 23 minutes.During an interview on 12/18/25 at 4:15PM CNA #2 stated residents who are wanting to get out of bed would have to wait longer if other residents need to use the restroom. CNA #2 stated there wasn't enough staff to be everywhere at the same time. Sometimes there would only be one CNA assigned to a court and there would be another staff assigned to float between several courts.Resident #77During an interview and concurrent observation on 12/14/25 at 9:19 AM, Resident #77's room had an odor of urine. The resident was in bed with an open urinal about one-quarter full hanging from the bed rail. When asked how long it had been there, the resident said about an hour. The resident explained staff were busy and would empty it (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	eventually, noting they were always helpful but short-staffed. Further observation revealed Resident #77 was on enhanced barrier precautions (EBP, an infection control measure that requires staff to wear gowns and gloves during high-contact care activities for residents with wounds, indwelling devices, or multidrug-resistant organisms, to prevent the spread of infections). It was noted there were no gowns available to use for Resident #77's room. During an interview on 12/14/25 at 10:02 AM, when asked about EBP gowns for Resident #77, CNA #5 stated the night shift must have used them up and didn't have time to replace them. The CNA further stated the urinals would be taken care of when they rounded on the resident, however, if the CNA was helping other residents, it can be difficult to round regularly. Resident Council During an interview on 12/17/25 at 3:00 PM, with those who attended Resident Council meetings, Resident #95 reported long delays in staff response when residents needed help. They stated on weekends, only one CNA was assigned to a unit while another floated between units, causing further delays if both staff were occupied or if the float staff was in another unit. Resident #95 stated, There's just not enough people to help us. Resident #25 added that CNAs sometimes forgot to return after answering call lights. All seven attendees (Resident #'s 25, 35, 47, 69, 74, 95, and 102) agreed response times were slow due to not enough staff. When asked how the facility responded to the Resident Council's concern regarding staffing issues, the group stated they were told that the staff was being educated and that the facility was working on staffing, however, they did not see any improvement. Review of the Resident Council Meeting Minutes revealed: Minutes from the 8/18/25 meeting: . Nursing: Concern: CNA's are leaving pee containers in rooms and they are starting to smell. Response from Manager: Nursing Staff will be educated. ; Minutes from the 9/8/25 meeting: . Nursing: CNA's are clearing call lights and telling residents they'll get back to them and forgetting to get back with them. Concern Response from Manager: Nursing staff will be educated. ; Minutes from the 10/13/25 meeting: . old business. CNA's are clearing call lights and telling residents they'll get back to them and forgetting to get back with them. There were no facility responses recorded in the minutes regarding this matter. ; Minutes from the 11/10/25: . old business. CNA's call lights are not being answered in a timely manner. Nursing: Concern: Need more staff. Response from Manager: We are working on it. ; Minutes from the 12/8/25 meeting: . old business. CNA's call lights are not being answered in a timely manner. There were no facility responses recorded in the minutes regarding this matter. During an interview on 12/17/25 at 1:07 PM, the Administrator stated he was not aware of the low weekend staffing, and that the staffing reports generated from their party vendor showed the facility was meeting their Patient Per Day (PPD) goals, which were based on the nursing union and California standards. Further review of the facility provided Centennial Post Acute Facility Assessment, updated on 11/25/25, revealed: . The facility assessment should drive staffing decisions. to carry out facility functions.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview, and record review, the facility failed to develop, implement, and maintain a system to ensure licensed nursing staff were competent and practiced within their authorized scope of practice in accordance with the State Nurse Practice Act and professional standards. This deficient practice occurred for 4 of 6 licensed nurses reviewed and placed all residents (based on a census of 97) at risk for inaccurate assessment, inappropriate care planning, and delayed identification of changes in condition FindingsRecord review of Resident Care Manager [RCM] (LVN/LPN[Licensed vocational nurse/licensed practical nurse]) dated 8/2025, revealed: The Resident Care Manager (LVN/LPN) is responsible for overseeing the care and well-being of assigned residents, ensuring that care plans are properly implemented, and that residents receive high-quality, person-centered care in accordance with state and federal regulations. The Resident Care Manager serves as a liaison between residents, families, healthcare providers, and the interdisciplinary team. Essential duties: Care coordination & oversight: Develop, update, and monitor individualized resident care plans in collaboration with the interdisciplinary team. Ensure that care plans reflect the physical, emotional, and psychosocial needs of each resident. Conduct routine assessments and communicate changes in condition to the physician and appropriate staff. Supervise and support CNAs [Certified Nurse Assistant] and other nursing staff in the delivery of daily care. Provide training, guidance, and feedback to staff to ensure adherence to care standards and policies . Complete MDS [Minimum Data Set - a federally required assessment] information on residents as required Subsequent to Human Resources providing the above job description, facility administration provided surveyors with a second version of the RCM (LVN/LPN) job description, dated 9/2025, which contained the same duties and role expectations, except the terms develop and update were removed.Record review of the Resident Care Manager (RN[Registered Nurse]) job description, dated 9/2025, revealed the position contained the same title, role expectations, duties, and essential functions as the RCM (LVN/LPN) position, including responsibility for developing, updating, and monitoring resident care plans; conducting routine assessments; communicating changes in condition to physicians; supervising nursing staff; and completing MDS information, indicating the facility assigned identical job responsibilities to RN and LPN Resident Care Managers.Record review of facility staffing records and the current organizational chart , provided by the facility's Human Resources (HR) on 12/17/25, revealed the facility employed 6 Resident Care Managers (RCMs) at the time of survey, of which four were Licensed Practical Nurses (LPNs) and two were Registered Nurses (RNs) assigned to the RCM role; further review indicated all six RCMs shared equal responsibilities, identical essential duties, and functioned independently from one another in carrying out the role.Record review of Director of Staff Development (DSD) job description dated 2/2024, revealed: The Director of Staff Development (DSD) is responsible to plan and implement facility orientation, job skills training, in-service education and a Certification Training Program (if applicable) for the nursing assistants as required by regulations. Work with the Director of Nursing (DON) and Administrator to ensure that the highest degree of quality care is maintained at all times. The DSD also provides direct resident/patient care. Essential duties: Coordinate and participate in the recruiting and hiring of staff . Plan, conduct and document and/or coordinate all required Fire/Internal Disasters and External Mass Casualty Drills Utilize information from Licensing and Certification Surveys, Employee Evaluations, Facility Rounds, and recommendations from the Administrator and department heads to identify education needs. Organize In-Service education program for staff including assessment, planning, implementation and evaluation of education provided. Prepare and post a monthly In-Service calendar. Maintain records of In-Services as required by regulations. Plan and conduct meaningful In-Service education programs according to requirements for nursing personnel and all facility staff to assure competency in and new (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	skills, and as directed by Administrator. Make rounds and observe delivery of patient care. Coordinate infection control surveillance program. Supervise staff, including taking or assisting with appropriate disciplinary measures. Complete all forms required by the Department of Health in relation to the In-Service and education programs . Provide direct resident/patient care. Assist with the overall supervision of and management of the staff. Record review of facility staffing records and the current organizational chart revealed the facility employed one Licensed Practical Nurse (LPN #1) who was assigned and functioning in the roles of DSD, Infection Control Preventionist and RCM. Further review confirmed the individual was not a Registered Nurse (RN) and was licensed through the State of Alaska to practice as an LPN. During an interview on 12/18/25 at 12:00 PM, RCM #2 stated he/she was responsible for completing treatment orders, wound care coordination, chart reviews, risk management activities, and updating resident plans of care. RCM #2 confirmed he/she independently developed plans of care as needed, stating he/she could go in and update them and was able to create new care plan focuses, goals, and interventions on their own. When asked if these care plan updates required RN review or co-signature, RCM #2 stated there was no sign-off required, explaining he/she did not sign care plans but independently entered updates without RN approval. RCM #2 further indicated that while the DON generally supervised the RCM role, the DON did not routinely review or approve the care plan updates, and he/she performed these duties independently in his/her role as RCM. During an interview on 12/18/25 at 8:30 AM, RN #1 stated he/she had recently completed orientation and indicated he/she did not receive separate classroom training or formal competency validation beyond unit-based orientation. RN #1 was unable to initially identify the nurse educator or infection preventionist but acknowledged that guidance related to training, competencies, and clinical practice was obtained through facility leadership. During an interview on 12/18/25 at 8:40 AM, RN #2 stated that LPN #1 functioned as the facility's primary nurse educator and infection prevention resource and was responsible for staff development, competency guidance, and infection control oversight. RN #2 further stated that LPN #1 assisted nursing staff with resident assessments, care planning development, and clinical decision-making, and was the individual he/she would consult for questions related to competencies, assessments, treatment plans, and changes in resident condition. During an interview on 12/18/25 at 8:50 AM, RN #3 stated that although there was some confusion regarding official titles, LPN #1 functioned as a key clinical resource for resident assessments, care plan development, and coordination of care, and that nursing staff felt comfortable seeking guidance from LPN #1 for assessment findings, care plan interventions, risk assessments, and competency-related questions. During an interview on 12/18/25 at 9:03 AM, RN #4 stated he/she routinely sought guidance from LPN #1 regarding resident assessments and care planning and identified LPN #1 as the primary point of contact for competency-related questions and clinical guidance. Collectively, the interviews indicated that RN staff relied on LPN #1 for guidance and support related to assessments, care planning, and nursing competencies, demonstrating that LPN #1 functioned in a role requiring RN-level clinical oversight and decision-making. During an interview on 12/17/25 at 4:30 PM, LPN #1 stated that in the role of RCM, he/she was able to enter and edit resident plans of care, explaining that his/her name appeared on care plans on its own because he/she updated them; LPN #1 further stated he/she had also assumed the role of Staff Development/Educator within the past few months and was responsible for conducting staff orientation, coordinating and providing in-service education, arranging external training programs, scheduling student experiences, and providing education in response to grievances or identified needs. LPN #1 reported he/she spent most of the scheduled time performing nurse management and administrative duties, and although he/she occasionally assisted on the floor, this rotated among nurse managers. LPN #1 stated he/she was frequently sought out to assist with blood draws, wound care, safety planning, infection control coordination, and data analysis related to education and infection prevention, and that nursing staff consulted him/her when making decisions about changes in resident condition and potential hospital transfers, at which time he/she would advise staff and (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	contact or direct contact with the physician as appropriate. LPN #1 described functions he/she performed independently, including blood draws and wound dressings, stating he/she could not administer IV antibiotics or fluids without certification, could not stage wounds, and could not administer blood products. LPN #1 stated he/she routinely reviewed resident diagnoses, medications, treatments, and equipment needs when updating plans of care and that RN review occurred during new admissions and periodic reviews. During an interview on 12/18/25 at 2:30 PM, LPN #1 stated that in the role of Infection Preventionist (IP), he/she independently coordinated and carried out the core duties of the infection control program, including surveillance, assessment, data analysis, provider notification, and follow-up. LPN #1 explained that when a resident was started on antibiotics, he/she independently completed an infection evaluation, assessed reported and observed symptoms (such as fever, confusion, skin changes, or urinary symptoms), documented findings in the electronic system, and determined whether the information triggered a potential infection case. LPN #1 stated that he/she monitored residents 48-72 hours after antibiotic initiation to assess symptom improvement or persistence and contacted the physician regarding continuation, modification, or discontinuation of antibiotics based on findings. LPN #1 further stated that he/she analyzed infection data using automated reports and trend tools to identify infection patterns by unit or resident population, and used this analysis to determine the need for staff education, audits, or targeted interventions. LPN #1 stated that while infection control committee meetings included the Director of Nursing, RCMs, and other interdisciplinary members, he/she independently prepared reports, presented findings, and initiated follow-up actions. LPN #1 acknowledged consulting a regional infection prevention resource for guidance with the annual infection risk assessment due to being newly transitioned into the role; however, he/she otherwise described performing day-to-day infection surveillance, assessment, decision-making, and coordination of infection control activities independently, including staff exposure tracking, outbreak reporting, and communication with public health authorities. Review of the LPN Scope of Practice Advisory Opinion - Alaska Board of Nursing, 7/2016, revealed: The RN and LPN should recognize the level and depth of knowledge and decision making that various nursing activities demand. This accountability and responsibility exists regardless of directives, policies, protocols or staffing patterns implemented by employing agencies. The advisory opinion further states that When an RN is directing LPN practice, it is the RN who establishes the nursing regimen and communicates the nursing practice needs of the client. Highly complex and variable situations are most appropriately placed within the RN scope of practice and outside the scope of the LPN. This document further reveals that LPN practice is not independent, stating that the LPN contributes to the planning, implementation and evaluation of nursing care but does not independently develop or make changes to a plan of nursing care, and must consult with the RN or LIP [Licensed Independent Provider] to seek guidance in providing client care. The document explicitly identifies activities NOT appropriate for the LPN to perform, including 1. Comprehensive assessments of a client who has been admitted to an institution or unit, 2. Assimilation and analysis of objective and subjective data to formulate the plan of care, 6. Administer IV push medications other than saline to flush an intermittent infusion device, 7. Phlebotomy unless additional training and demonstration of competency has been documented, 12. Administration of chemotherapy drugs, 14. flushing [NAME] catheters or PICC [Peripherally Inserted Central Catheter] lines, 16. Identify unlabeled medications, 17. Complete physicals, 18. Work independently, 19. Triage patients. Review of Alaska Administrative Code 12 AAC 44.137, Licensed Practical Nurse Scope of Practice, accessed at https://nalpn.org/wp-content/uploads/2023/06/NURSE-PRACTICE-STANDARDS05.30.2023.pdf states that The standards of practice set out in the Nurse Practice Standards for the Licensed Practical & Licensed Vocational Nurse, May 30, 2023 edition, of the National Association of Licensed Practical Nurses are adopted by reference as the authorized scope of practice for a practical nurse licensed under this chapter. The adopted standards establish that Licensed Practical Nurses (LPNs) practice under direction, contribute to-but do not independently perform-comprehensive assessments, nursing care plan development, or independent clinical decision-making		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview, and record review, the facility failed to ensure food items were prepared, stored, and labeled in accordance with professional standards and/or manufacturer instructions for food service safety for 87 residents (#1, #2, #3, #5, #8, #9, #10, #11, #12, #13, #15, #17, #18, #19, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #33, #35, #36, #37, #38, #39, #40, #41, #43, #44, #45, #47, #48, #50, #51, #52, #53, #54, #55, #56, #58, #59, #60, #61, #62, #63, #64, #65, #67, #68, #69, #70, #71, #73, #74, #75, #76, #77, #78, #79, #80, #82, #83, #84, #85, #87, #88, #89, #90, #92, #94, #95, #96, #97, #102, #103, #104, #105, #106, #107, #108, #109) out of 97 residents that received meals from the kitchen. Specifically: 1) the dry storage and kitchen area contained expired food items; 2) sanitizing solution used was improperly diluted and produced out-of-range results; and 3) hair restraints were improperly used. These failed practices placed the residents who received meals from the kitchen, at risk of receiving contaminated food and/or contracting foodborne illnesses . Findings: Expired Items During the initial kitchen tour on 12/14/25 at 8:15 AM, the following items were observed to be expired in the dry storage and kitchen area: 4 boxes- Gold Medal Carrot Cake Mix 5 lb. (pound), expired 7/6/24; 8 bags- Ruffles Original Potato Chip Foodservice package 16 oz. (ounce), expired 12/2/25; 1 bottle- [NAME] [NAME] Style Cooking Wine 1 gallon, expired 11/26/24; 1 bottle- [NAME] Fine Burgundy Cooking Wine 1 gallon, with faded and illegible expiration date; and 1 container- Monarch Baking Powder 5 lb. container, with a faded and illegible expiration date. During an interview on 12/14/25 at 9:20 AM, the Food and Nutrition Manager (FNM) stated food items were audited weekly in the pantry and expired items were to be discarded immediately to prevent further use. If an item was damaged, including items with illegible expiration dates, then the expectation would be to discard the items to prevent further consumption. Record review of the facility provided policy, Food Receiving and Storage, last revised 11/2022, revealed: 3. Dry foods are stored in buns are removed from original packaging, labeled and dated (use by date). Such foods are rotated using a first in- first out system. 7. Foods are labeled, dated and monitored so they are used by their use-by date. or discarded. Sanitizing Solution During an observation on 12/16/25 at 9:58 AM, Dietary Aide (DA) #3 was by the ice machine in the kitchen area with a rag and a red sanitizing bucket. DA #3 placed the rag inside the red sanitizing bucket, then used the rag to wipe the outer surface of the ice machine. DA #3 tested the red sanitizing bucket with the Ecolab test strips which revealed a reading of a light green color. DA #3 stated that the light green color would be in the recommended range and showed the Ecolab canister's color reference range. He/she further stated that the bucket being used to clean the ice machine was made approximately 20 minutes ago. During an interview on 12/16/25 at 10:17 AM, DA #3 stated the solution in the red bucket was called Ecolab Sink & Surface Sanitizer and was used to clean the surfaces in the kitchen. DA #3 demonstrated the process by going to the janitor closet and poured an unmeasured amount by the attached hose of the Ecolab Sink & Surface Sanitizer dispenser. DA #3 then went to the sink across the janitor closet and placed an unmeasured amount of hot water into the red sanitizing bucket. He/she then tested this new solution with a test strip and received the same reading of a light green color. During a follow-up interview on 12/16/25 at 10:30 AM, DA #3 stated, he/she clarified with the FNM what the recommended color range reading for the sanitizer test strips. DA #3 further stated he/she initially thought the light green color was within the recommended range however the correct reading indicated the appropriate range was dark green or teal. During an observation on 12/16/25 at 10:58 AM, FNM and DA #1 tested the red sanitizing bucket in the mini kitchen by the dining area where residents come out to eat their meals. DA #1 stated this bucket was used to clean the surfaces in the dining area. DA #1 tested the solution and received the test strip result indicated a light green color. During an interview on 12/16/25 at 11:00 AM, DA #1 stated he/she placed the Ecolab Sink & Surface Sanitizer solution in the red sanitizing bucket and (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	mixed it with hot water. The FNM then told DA #1 to not further dilute the solution as it would not yield accurate results. DA #1 remade the solution as-is and received a teal color when he/she tested the second solution. Review of Ecolab Sink & Surface Cleaner Sanitizer FAQ [Frequently Asked Questions], accessed at https://www.ecolab.com/offerings/sink-surface-cleaner-sanitizer, dated 12/29/25, revealed: .What are the active ingredients? Dodecylbenzenesulfonic Acid (DDBSA, 272 - 700 ppm [parts per million]) and Lactic Acid (704 - 1875 ppm) . Are the ingredients approved for food-contact surface sanitizing.all ingredients in Sink & Surface Cleaner Sanitizer have been reviewed.for use in food-contact surface sanitizing solutions and are approved for use on food-contact surfaces.Review of the Ecolab Sink and Sanitizer poster, copyright dated 2020, .Sanitization Range Testing. Testing should be at or above room temperature 65 F [Fahrenheit]. Withdraw a test strip from a canister. Dip test strip for 5 seconds in test solution. Shake off excess solution.Compare colors after 10 seconds with colors on the test strip canister to determine concentration (oz[ounce]/gal[gallon]), ALWAYS COMPARE AGAINST CANISTER SCALE. Testing solution should be between 272-700 ppm DDBSA and [PHONE NUMBER] ppm Lactic Acid.Review on 12/16/25 of Sink & Surface Cleaner Sanitizer Test Strips, Item Number: 20318-01-11, revealed instructions: .Immerse the test strip in sample for 5 seconds. Excess sample should be shaken off of strip.Evaluate the color 10 seconds after removing the test strip from the sample.Match the center of the test strip pad to the color chart to determine concentration. Further review of the instructions indicated a blue box where the color of the test strip should fall within that is approved as an active range of Sink & Surface Cleaner Sanitizer. The blue box contained a dark green (700 ppm DDBSA, 1875 ppm Lactic Acid) and teal color range (272 DDBSA, 704 ppm Lactic Acid). The light green and yellow green color range was noted to be below the approved range.During an interview on 12/16/25 at 11:05 AM, the FNM stated the Ecolab Sink & Surface Sanitizer coming out of the dispenser was a pre-mixed solution that was already diluted as serviced by the manufacturer and did not indicate further additional dilution as it could prevent the solution from properly cleaning the surfaces as it is intended to do.Review of the facility-provided Job Description of Dietary Aide, prepared 2/2024, revealed: .Essential Duties. To leave the kitchen in a clean and sanitary manner. clean work surfaces and refrigerators.Review of the facility provided policy, Sanitization, dated 2023, revealed, .2. All surfaces, equipment, countertops, shelving, dishware and utensils are kept clean and maintained in good condition.3. All equipment, food contact surfaces, dishware, and utensils are properly cleaned and sanitized through heat or chemical sanitization.Hair RestraintsDuring a continuous observation on 12/16/25 at 11:17 AM-11:38 AM, DA #1 was at the other side of the steam table in the long-term care (LTC) kitchen serving the residents in the dining room as the food was being plated. DA #1 was observed to have no hairnet for the duration of this observation. DA #1 put on a hairnet at 11:39 AM.During a continuous observation on 12/16/25 at 11:17 AM-11:45 AM, DA #2 was at the other side of the steam table in the LTC kitchen serving the residents in the dining room as the food was being plated. DA #2 was observed to have approximately 1 inch width strands of hair sticking out from the left and right front side of the hairnet and strands of hair from the back side of the hairnet.During an interview on 12/16/25 at 1:08 PM, the FNM stated hair restraints such as a hairnet or a cap should cover the entirety of the worker's head, as loose hair would not be acceptable when working with food. FNM stated that there was no policy regarding hairnets but provided a handbook that was used as a curriculum for kitchen staff training.Review of the facility-provided document titled, Foodservice Employee Safety Handbook, copyright dated 2006, revealed: .Personal Hygiene. Most foodservice jobs require you to wear some type of protective equipment (PPE). This includes items such as hairnets, beard covers. PPE must be worn in a way that protects against the contamination of food and equipment. Wear hairnets, beard covers, caps, and other hair restraints that appropriately covers all visible hair. Loose hair can fall into food. Further review of the handbook revealed: Harmful bacteria can be found on your skin and in your hair can easily be transferred to food. Again, these bacteria can make people sick. It is your responsibility to wear a hair restraint effectively. Make sure your hair is completely under your hair restraint.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**.Based on record review, interview, and observation, the facility failed to develop, implement, and maintain an effective Quality Assurance and Performance Improvement (QAPI) program that identified, analyzed, and corrected systemic quality deficiencies. The facility failed to use available data to identify trends, failed to prioritize high-risk issues, and failed to implement and sustain corrective actions. Specifically, the facility failed to identify and/or address ongoing patterns of deficient practice related to staffing, grievance process, clinical care, activities, medication management, therapy services, discharge planning, environmental conditions, and care planning. These issues were evident through internal reports, resident council concerns, medical record documentation, staffing data, and direct observation, yet were not recognized and/or effectively acted upon through the QAPI process. These failed practices placed all residents (based on a census of 97) at risk of receiving less than optimal care and poor quality of life Findings: During an interview on 12/18/25 at 4:34 PM, the Regional Director of Clinical Nursing Services (RDCNS) and the Administrator stated the QAPI committee collected data from different metrics. When asked to clarify what metrics were used, the RDCNS stated for clinical metrics that they look into were electronic health record, corporate dashboard, HR (human resources) reporting work day, maintenance through TELS (a maintenance software) that track and document activities, sanitation rounding in the kitchen, activities, resident council minutes, feedback from residents and staff. The RDCNS stated data from the metrics were brought into the QAPI meeting. The RDCNS stated the committee prioritized patient safety, resident and staff satisfaction, maintenance, activities, impacts quality of life such as high risk, adverse events. They also had a quick review of accidents and events, and post incident interventions. The RDCNS also stated the team would come up with a plan based on the prioritized data. When asked about their monitoring process, the RDCNS stated a sub-committee would be assigned to look into the root cause of the issue then a PIP (Performance Improvement Project) would be created. She explained that the PIP lead would report to the QAPI committee, then the QAPI committee would give their feedback if the plan would be updated or sustained. She further stated that currently the QAPI committee had Infection control and skin integrity PIP. Low Weekend Staffing Review of the Payroll Based Journal (PBJ) Staffing Data Report (a mandatory electronic staffing data submission system created by the Centers for Medicare & Medicaid Services [CMS]) for the fourth quarter (7/1/25 to 9/30/25) revealed: Excessively Low Weekend Staffing was triggered. Review of the facility provided Centennial Post Acute Facility Assessment, updated on 11/25/25, revealed: . The facility is struggling with securing FT [full time] staff for nurses and CNAs. The assessment indicated staffing should include: . 6 nurses on day/eve[[NAME]] shift and minimum of 3 on NOC/night shift. 12-15 CNAs on day shift/eve shift and 9-12 on NOC/night shift. 2 restorative aides daily. Review of 12 randomly selected weekend staffing schedules for the fourth quarter (7/1/25-9/30/25) revealed staffing consistently fell below the facility assessment's established levels. Specifically:- On 8/9/25, 2 LNs were scheduled, the established minimum was 3. Dayshift, CNAs, the established minimum was 12:- On 7/5/25, 10 day shift CNAs were scheduled;- On 7/6/25, 11 day shift CNAs were scheduled;- On 7/12/25, 11 day shift CNAs were scheduled; and- On 7/13/25, 9 day shift CNAs were scheduled. Nightshift, CNAs, the established minimum was 9:- On 7/5/25, 7 night shift CNAs were scheduled;- On 7/6/25, 8 night shift CNAs were scheduled;- On 7/13/25, 6 night shift CNAs were scheduled; and- On 9/6/25, 7 night shift CNAs were scheduled. Restorative Aides (RAs) - established minimum was 2 daily:- On 7/5/25, 1 RA was scheduled;- On 7/6/25, 0 RAs were scheduled;- On 7/12/25, 1 RA was scheduled;- On 7/13/25, 1 RA was scheduled;- On 8/9/25, 1 RA was scheduled;- On 8/10/25, 1 RA was scheduled;- On 8/23/25, 1 RA was scheduled;- On 8/24/25, 1 RA was scheduled;- On 9/6/25, 1 RA was scheduled;- On 9/7/25, 1 RA was scheduled;- On 9/27/25, 0 RAs were scheduled; and- On 9/28/25, 1 RA was scheduled. Resident #48 Record review on 12/14-24/25 (continued on next page)		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	revealed Resident #48 was admitted to the facility with diagnoses that included quadriplegia (paralysis of all four limbs). The resident fully relied on staff to dress and get the resident up and out of bed. During an interview and concurrent observation on 12/14/25 at 11:11 AM, Resident #48 stated that he/she had called for staff around 9:00 a.m. to assist with getting out of bed and was still waiting. The resident remained in bed with a Hoyer lift positioned beside the bed and the wheelchair near the doorway. The resident stated that he/she had requested to be out of bed by 9:30 a.m. and reported that long waits had been common since admission, expressing concern that the facility seemed very short-staffed. Staff assisted Resident #48 out of bed at 11:23 a.m., a total wait time of 2 hours and 23 minutes. During an interview on 12/18/25 at 4:15PM CNA #2 stated residents who are wanting to get out of bed would have to wait longer if other residents need to use the restroom. CNA #2 stated there wasn't enough staff to be everywhere at the same time. Sometimes there would only be one CNA assigned to a court and there would be another staff assigned to float between several courts. Resident #77 During an interview and concurrent observation on 12/14/25 at 9:19 AM, Resident #77's room had an odor of urine. The resident was in bed with an open urinal about one-quarter full hanging from the bed rail. When asked how long it had been there, the resident said about an hour. The resident explained staff were busy and would empty it eventually, noting they were always helpful but short-staffed. Further observation revealed Resident #77 was on enhanced barrier precautions (EBP, an infection control measure that requires staff to wear gowns and gloves during high-contact care activities for residents with wounds, indwelling devices, or multidrug-resistant organisms, to prevent the spread of infections). It was noted there were no gowns available to use for Resident #77's room. During an interview on 12/14/25 at 10:02 AM, when asked about EBP gowns for Resident #77, CNA #5 stated the night shift must have used them up and didn't have time to replace them. The CNA further stated the urinals would be taken care of when they rounded on the resident, however, if the CNA was helping other residents, it can be difficult to round regularly. Resident Council During an interview on 12/17/25 at 3:00 PM, with those who attended Resident Council meetings, Resident #95 reported long delays in staff response when residents needed help. They stated on weekends, only one CNA was assigned to a unit while another floated between units, causing further delays if both staff were occupied or if the float staff was in another unit. Resident #95 stated, There's just not enough people to help us. Resident #25 added that CNAs sometimes forgot to return after answering call lights. All seven attendees (Resident #'s 25, 35, 47, 69, 74, 95, and 102) agreed response times were slow due to not enough staff. When asked how the facility responded to the Resident Council's concern regarding staffing issues, the group stated they were told that the staff was being educated and that the facility was working on staffing, however, they did not see any improvement. Review of the Resident Council Meeting Minutes revealed:- Minutes from the 8/18/25 meeting: . Nursing: Concern: CNA's are leaving pee containers in rooms and they are starting to smell. Response from Manager: Nursing Staff will be educated. ; - Minutes from the 9/8/25 meeting: . Nursing: CNA's are clearing call lights and telling residents they'll get back to them and forgetting to get back with them. Concern Response from Manager: Nursing staff will be educated. ; - Minutes from the 10/13/25 meeting: . old business. CNA's are clearing call lights and telling residents they'll get back to them and forgetting to get back with them. There were no facility responses recorded in the minutes regarding this matter. ; - Minutes from the 11/10/25: . old business. CNA's call lights are not being answered in a timely manner. Nursing: Concern: Need more staff. Response from Manager: We are working on it. ; - Minutes from the 12/8/25 meeting: . old business. CNA's call lights are not being answered in a timely manner. There were no facility responses recorded in the minutes regarding this matter. During an interview on 12/17/25 at 1:07 PM, the Administrator stated he was not aware of the low weekend staffing, and that the staffing reports generated from their party vendor showed the facility was meeting their Patient Per Day (PPD) goals, which were based on the nursing union and California standards. Further review of the facility provided Centennial Post Acute Facility Assessment, updated on 11/25/25, revealed: . The facility assessment should drive staffing (continued on next page)		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	decisions. to carry out facility functions.During an interview on 12/18/25 at 4:34 PM, the Administrator stated the facility was adequately staffed in the weekend following the Patient Per Day (PPD) 4.0 and 5.0. He further stated the union guideline was 1 Certified Nurse Assistant (CNA) was to 9 residents (1:9) per night shift and 1:7 day shift. One nurse on each court and majority of nurses were RNs (Registered Nurse).He further stated the committee was not aware of the low weekend staffing. He stated their PBJ (Payroll Based Journal) report was directly reported from their clocking-in system. The Administrator further stated he would look deeper into the staffing issue.Grievance processDuring random observations from 12/14-18/25, the grievance procedure notice was observed posted throughout residents' courts. The notice indicated that residents and others could submit complaints or grievances anonymously, either orally or in writing, with grievance forms available in the Social Services Office. The notice stated that all concerns would be addressed within a reasonable timeframe and that the Grievance Officer should be notified immediately of any suspected resident abuse, neglect, misappropriation, or exploitation. The notice identified the designated Grievance Officer as Grievance Officer (GO) #1 and listed the following contact information: 9100 Centennial Circle, Anchorage, AK 99504; email: [name of GO#1]@centennialpa.com; phone number: [PHONE NUMBER]. The notice further stated that a copy of the Grievance Policy or a written grievance decision was available upon request.During an interview on 12/17/25 at 10:00 AM, the Social Services Director (SSD) stated that she currently serves as the facility's Grievance Officer (GO #2), a role she assumed upon starting her position in November 2025. The SSD was unsure of the exact departure date of the previous Grievance Officer (GO #1). She stated that residents were informed about the grievance process through admission packets, grievance forms located on each court and outside of the Social Services Office, and locked grievance boxes collected daily. Upon reviewing the admission packets, the SSD noted that they did not include written information identifying the Grievance Officer or providing contact details, and no additional written notification of her role had been provided to residents or their representatives. The SSD also stated that she had not yet introduced herself at Resident Council meetings, believing attendance requires an invitation, but she planned to introduce herself to residents when possible. Upon reviewing the grievance procedure notice posted throughout the facility, the SSD also noted that the contact information should no longer be for the GO #1, not accurately reflecting the change in grievance officers.During the Resident Council meeting on 12/17/25 at 3:08 PM, Residents (#25, #35, #47, #69, #74, #95, #102) stated they did not know who the new GO was. The council reported they were aware the former GO had left in September, but the new GO had not approached the council for an introduction.Record review of Resident Council meeting minutes, dated 9/8/25, revealed complaints regarding missing laundry, with the facility response documented as: .We will try and educate the staff.Record review of Resident Council meeting minutes, dated 10/13/25, revealed the introduction of the new Activities Director and Admissions Director. The minutes also documented discussion of old business related to missing laundry and Certified Nurse Assistants (CNA) clearing call lights and failing to return to residents.Record review of Resident Council meeting minutes dated 11/10/25, revealed discussion of new business noting many newly hired CNAs; there was no mention of a new Grievance Officer. Old business again included missing laundry and call light concerns.Record review of Resident Council meeting minutes, dated 12/8/25 revealed no discussion regarding a new Grievance Officer. Old business continued to include missing laundry and call light concerns.Review of RESIDENT GRIEVANCE FORM, undated, posted on each court's entrance board near a locked wooden box, revealed a structured document that included fields for the date and time of the grievance or concern, the resident's name and room number, and the name of the person completing the form. It provided a section to describe the nature of the grievance, followed by areas for investigation findings and interventions/action taken. The form also included a section for the date follow-up to resolution occurred, with signature lines and dates for the person conducting follow-up (by whom), the administrator, the grievance officer, and the resident. No additional instructions were provided (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and interview, the facility failed to review, revise, and implement comprehensive, person-centered care plans in accordance with resident needs. Specifically, the facility failed to:1. ensure residents or resident representatives participated in and that the facility conducted and documented required quarterly interdisciplinary care plan reviews for 3 residents (Residents #1, #3, and #64) of 20 sampled residents; and2. revise the comprehensive care plan to reflect a significant change in condition for 1 closed record (Resident #99), including the addition of appropriate interventions following the onset of a seizure disorder and initiation of anticonvulsant therapy.These failed practices demonstrated a pattern of deficient care planning practices and denied residents and resident representatives the opportunity to participate in care planning, make preferences and decisions known, and receive care and interventions aligned with current medical conditions and assessed needs Findings: Care ConferenceResident #1Record review on 12/14-24/25, revealed Resident #1 was admitted to the facility with diagnoses that included cervical disc disorder with myelopathy (impaired function of the spinal cord caused by degenerative changes of the discs and facets joint in the neck), intestinal obstruction, protein-calorie malnutrition, chronic respiratory failure and diabetes mellitus (chronic disease characterized by high levels of sugar in the blood).During an interview on 12/14/25 at 11:38 AM, when asked if he/she participated in a care planning meeting, Resident #1 stated he/she could not remember when the last time he/she participated in the care planning meeting.Record review of Resident #1's electronic health record (EHR) on 12/14-24/25, revealed, two admission assessment IDT (Interdisciplinary Team) conferences dated 8/12/25 and 8/28/25.Further review revealed there were no other documented IDT quarterly care conferences.During an interview on 12/16/25 at 12:43 PM, Resident Care Manager (RCM) #1 stated care planning meetings should have been conducted quarterly through an IDT care conference which were organized by Social Services (SS) staff, however, because the facility had no SS Director (SSD) since 9/2025, the SS Assistant (SSA) was the only one covering the care conferences. RCM #1 further stated there should have been one IDT meeting with Resident #1 on 11/2025.During an interview on 12/17/25 at 11:01 AM, the SSD confirmed there were no subsequent IDT care conferences conducted for Resident #1 after 8/2025. Resident #3Record review on 12/14-24/25, revealed Resident #3 was admitted to the facility with diagnoses that included amputation involving multiple toes and fingers, acquired absence of right and left fingers, type 2 diabetes mellitus and chronic obstructive pulmonary disease.During an interview on 12/14/25 at 1:14 PM, when asked if Resident #3 participated in his/her care planning meeting, Resident #3 stated he/she had not.During an interview on 12/16/25 at 12:43 PM, RCM #1stated there was no care conferences conducted for Resident #3, however, the SSA had talked to the resident about his/her discharge plan.During an interview on 12/17/25 at 11:01 AM, SSD stated there were no quarterly IDT care conferences conducted for Resident #3 within the past year. Resident #64Record review on 12/14-24/25, revealed Resident #64 was admitted to the facility with diagnoses that included sepsis (severe immune response to infection), acute cholecystitis (inflammation of the gallbladder), benign prostatic hyperplasia (enlarged prostate) with urinary tract symptoms.Record review on 12/14-24/25 revealed an IDT conference was conducted for Resident #64 on 7/1/25. Further review revealed there were no other documented IDT quarterly care conferences.During an interview on 12/17/25 at 11:01 AM, the SSD confirmed no subsequent IDT care conferences were conducted for Resident #64 after 7/1/25.During an interview on 12/17/25 at 11:01 AM, SSD and SSA stated quarterly IDT care conferences should have been conducted every three months. The SSD stated the facility recognized the issue and would ensure care conferences would be completed in the future.Review of the facility's Care Conference policy and procedure, last revised 2/2025, revealed: . It is the policy of this center to hold care conference to review care plans developed and discuss current care plan goals (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and interventions with the resident and /or resident representative. Procedure: 1) A care conference will be scheduled with the resident and/or representative to review care plan goals and interventions. Care conferences will be held upon admission, quarterly and with any significant change in condition in conjunction with MDS [Minimum Data Set] Assessment. The Initial Care Management Meeting does not replace the required care conference to review the Comprehensive Care Plan. Revision of Comprehensive Care Plan Resident #99 Record review from 12/14-24/25 revealed Resident #99 was admitted to the facility with diagnoses that included Parkinson's disease (movement disorder of the nervous system), unspecified atrial fibrillation (irregular, rapid heart rhythm which can result to poor blood flow in the heart's lower chambers), type 2 diabetes mellitus without complications, and unspecified bipolar disorder (mood disorder characterized by significant mood fluctuations). Further review of the medical record revealed no seizure disorder diagnosis. Review of Resident #99's LTC (Long Term Care) Progress Notes, dated 11/10/25 revealed, .CNA [Certified Nursing Assistant] saw resident shaking, like having seizure during their rounds. Priority nurse was called. LN [Licensed Nurse] assessed resident, not shaking, but is unresponsive to verbal and painful stimuli. Vitals were taken: 194/80 [mmHg- millimeter of mercury, standard unit used for pressure measurement], pulse: 102. [temperature] 97.4 [Fahrenheit], 20 [respiratory rate], 98% on room air, BS [blood sugar]: 165. Called 911, paramedics came and assessed vitals. BP [blood pressure] went down to 70/35 [mmHg]. Resident became responsive but still not answering questions which is not [his/her] baseline. Paramedics took [him/her] and went to Alaska Regional Hospital and said that they're keeping [him/her] for observation. Review of Resident #99's [Hospital] History and Physical, dated 11/13/25 revealed, .Assessment and Plan. patient reported to have tonic clonic seizure [type of seizure involving sudden loss of consciousness, followed by muscle stiffening (tonic phase) and rhythmic jerking movements (clonic phase)] by EMS [Emergency Medical Services]. Has no known h/o [history of] seizure. minimize sedating medicines, frequent redirection, minimize external stimuli. seizure/fall precautions. Review of Resident #99's discharge summary from his/her hospitalization, dated 11/13/25 revealed, .Start taking these medications. levetiracetam [Levetiracetam (Keppra) is an anticonvulsant medication used to prevent and control seizures by stabilizing electrical activity in the brain] 250 MG [milligrams] tablet .commonly known as: KEPPRA. Instructions. Take 1 tablet (250 mg total) by mouth in the morning and 1 tablet (250 mg total) before bed time. For: Seizure disorder. Other Orders. admission Type: Readmission. Primary Diagnosis: Seizure disorder. Review of the Resident #99's LTC Order Recap Report on 12/18/25, revealed: .levetiracetam Oral Tablet 250 MG. Give 250 mg by mouth every morning and at bed time for Seizure Disorder. Start Date. 11/13/25. End Date. 11/20/25. LaMictal Oral Tablet 25 MG (Lamotrigine) [Lamotrigine (Lamictal) is an anticonvulsant medication used to treat epilepsy and bipolar disorder by stabilizing electrical activity in the brain and helping regulate mood] Give 1 tablet by mouth two times a day for seizure d/o [disorder]. Start Date. 11/21/2025. Review of the MDS (Minimum Data Set, a federally required nursing assessment), dated 11/19/25, revealed in Section I-Active Diagnosis, the response was unmarked for I5400. Seizure Disorder or Epilepsy. Review of the Care Plan Report, on 12/18/25, revealed no interventions/tasks were initiated for seizures. During an interview on 12/17/25 at 12:08 PM, RCM #3 stated he/she mostly focuses on the MDS portion and explained that active diagnoses were filled out in the MDS based off the diagnosis list in the EHR. He/she further stated when residents were admitted and/or were transferring back from a facility, the RCM would go over the documentation received such as a discharge summary or history and/or history and physical. RCM #3 stated the provider would then be contacted, and the respective information and/or orders would be placed in the EHR. During an interview on 12/17/25 at 11:46 AM, RCM #1 stated active diagnoses would be a part of the care plan to be able to lay out person-centered goals and interventions/tasks. He/she further stated the care plan was a working document and would be updated as necessary when a resident's condition changes. Review of the facility's policy, Care Plans, Comprehensive Person-Centered, last revised 3/2022 revealed: .A comprehensive, (continued on next page)		

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Printed: 07/30/2026
Form Approved OMB
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem area and their causes and relevant clinical decision making. 11. Assessments of resident are ongoing and care plans are revised as information about the residents and the residents' conditions change.12. The interdisciplinary team revises and updates the care plan: a. when there has been a significant change in the resident's condition.c. when the resident has been readmitted to the facility from a hospital stay.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. .Based on record review and interview, the facility failed to develop and implement an ongoing program of individualized, meaningful activities in accordance with resident assessments and care plans for 3 residents (#12, #27, and #67) of 20 sampled residents. Specifically, the facility failed to consistently offer activities aligned with each resident's identified interests and documented activity goals over extended periods of time, as evidenced by prolonged gaps in activity offerings and participation. This failed practice resulted in residents not being provided opportunities for socialization, engagement, and cognitive stimulation consistent with their assessed needs, placing the affected residents at risk for social isolation, decreased psychosocial well-being, and decline in quality of life Findings:Resident #12Record Review from 12/14-24/25 revealed Resident #12 was admitted to the facility with diagnoses that included a fracture of the left femur, and major depressive disorder (a mental disorder characterized by low moods, low self-esteem, and loss of interest in or pleasure in normally enjoyable activities).During an interview with Resident #12 on 12/15/25 at 9:34 AM, when asked about which activities the resident enjoyed at the facility, Resident #12 stated no one came to offer him/her activities.Review of Resident #12's ACTIVITY ASSESSMENT., dated 7/29/25, revealed the resident had interests that included cooking, birthday parties, happy hour and beauty days.Review of Resident #12's Care Plan Report, last reviewed 7/30/25, revealed: I know I have the right to do what I want. Will have daily socialization with staff or visitors as desires. cooking, birthday parties, happy hour, beauty days. Encourage autonomy and independence with preferred activity pursuits. Support choices for preferences regarding customary routine and activities. ActivitiesSeptember:Review of Resident #12's Activities Flowsheet, dated 9/1-30/25, revealed the activities staff interacted with Resident #12 twice for the month of September (9/12/25 and 9/30/25).November:Review of Resident #12's Activities Flowsheet dated 11/1-30/25, revealed the activities staff interacted with Resident #12 once for the month of November (11/4/25).December:Review of Resident #12's Activities Flowsheet dated 12/1-16/25 revealed the activities staff interacted with Resident #12 once for the month of December (12/2/25). Resident #27Record Review from 12/14-24/25 revealed Resident #27 was admitted to the facility with diagnoses that included weakness, mild cognitive impairment of uncertain or unknown etiology and osteoarthritis (chronic degenerative joint disease characterized by the progressive breakdown of joint cartilage and underlying bone).During an interview with Resident #27 on 12/14/25 at 10:30AM, when asked about the activities that had been offered, he/she stated: I've never been offered to participate in any activities, and I don't recall ever attending an activity. It would be nice if something like that existed.Review of Resident #27's ACTIVITY ASSESSMENT., dated 10/15/25, revealed the resident had interests that included walks, investment banking, and being with animals and pets.Review of Resident #27's Care Plan Report, last reviewed 10/14/25 revealed no activities care planning. ActivitiesOctober:Review of Resident #27's Activities Flowsheet dated 10/14-31/25 revealed the resident participated in activities on seven dates (10/15-16/25, 10/20-23/25, and 10/29/25), with no additional documentation indicating the resident was offered or participated in activities for the remaining 12 days.November:Review of Resident #27's Activities Flowsheet, dated 11/1-30/25 revealed the resident participated in activities on two dates (11/3-4/25), with no additional documentation indicating the resident was offered or participated in activities for the remaining 28 days.December:Review of Resident #27's Activities Flowsheet dated 12/1-16/25 revealed no documentation that the resident was offered or participated in any activities. Resident #67Record Review from 12/14-24/25 revealed Resident #67 was admitted to the facility with diagnoses that included depression and adult failure to thrive (condition characterized by a decline in overall health and function, marked by social and psychosocial withdrawal, reduced engagement in activities or interactions, decreased motivation, and diminished ability to meet basic physical and emotional needs, often accompanied by functional decline or poor nutritional intake).Review of Resident #67's (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plan Report, last revised 12/12/25 revealed the following activities care planning: .Resident will maintain current cognitive-communication skills to delay further decline. Coordinate with activities staff for participation in cognitive stimulation activities. My preferred activities are arts/crafts (drawing, sewing, and coloring), education (jeopardy, wheel of fortune), cooking/baking, gardening, listening to country music, family visits, pet therapy, reading magazines, reminiscing, horse racing, taking naps, socializing with staff, and beauty break. Staff will continue to encourage resident to participate in activities of stated interest. ActivitiesJanuary:Review of Resident #67's Activities Flowsheet, dated 1/1-31/25 revealed the resident participated in activities on one date (1/1/25), with no additional documented activity participation or offers for the remaining 30 days.February:Review of Resident #67's Activities Flowsheet, dated 2/1-28/25 revealed the resident participated in activities on five dates (2/8/25, 2/15/25, 2/25/25, and 2/28/25), with no additional documentation indicating the resident was offered or participated in activities for the remaining 23 days.March:Review of Resident #67's Activities Flowsheet, dated 3/1-31/25 revealed the resident participated in activities on one date (3/6/25), with no additional documented activity participation or offers for the remaining 30 days.April:Review of Resident #67's Activities Flowsheet, dated 4/1-30/25 revealed the resident participated in activities on two dates (4/1/25 and 4/7/25), with no additional documented activity participation or offers for the remaining 28 days.May:Review of Resident #67's Activities Flowsheet dated, 5/1-31/25 revealed the resident participated in activities on one date (5/7/25) with no additional documented activity participation or offers for the remaining 30 days.June:Review of Resident #67's Activities Flowsheet, dated 6/1-30/25 revealed no documentation that the resident was offered or participated in any activities.July:Review of Resident #67's Activities Flowsheet, dated 7/1-31/25 revealed the resident participated in activities on one date (7/21/25), with no additional documented activity participation or offers for the remaining 30 days.August:Review of Resident #67's Activities Flowsheet, dated 8/1-31/25 revealed the resident participated in activities on two dates (8/23/25 and 8/27/25), with no additional documented activity participation or offers for the remaining 29 days.September:Review of Resident #67's Activities Flowsheet, dated 9/1-30/25 revealed the resident participated in activities on two dates (9/5-6/25), with no additional documented activity participation or offers for the remaining 28 days.October:Review of Resident #67's Activities Flowsheet, dated 10/1-31/25 revealed the resident participated in activities on two dates (10/16/25 and 10/18/25), with no additional documented activity participation or offers for the remaining 29 days.November:Review of Resident #67's Activities Flowsheet, dated 11/1-30/25 revealed the resident participated in activities on one date (11/3/25), with no additional documented activity participation or offers for the remaining 29 days.December:Review of Resident #67's Activities Flowsheet, dated 12/1-17/25 revealed the resident participated in activities on one date (12/15/25) with no additional documented activity participation or offers for the remaining 16 days.During an interview with the Activities Director on 12/16/25 at 1:30 PM, she stated that if a resident participated in an activity, or was offered to participate in an activity, it would be documented on the Activities Flowsheet. She further stated that if documentation was not present on the Activities Flowsheet, it meant the resident was not offered to participate in an activity. When asked how she tracked which residents had not participated in activities she stated that it was done by memory.Record review of the facility policy Activity Programs, last revised 6/2018 revealed: .2. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident. 3. The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities. 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. 9. Activities are documented in the resident's medical record. 13. Residents are encouraged, but not required, to participate in scheduled activities.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review and interview, the facility failed to ensure pharmacy services met professional standards of practice and facility policy for the accountability and documentation of controlled substances. Specifically, the facility failed to ensure licensed nursing staff consistently completed required shift to shift narcotic count documentation, as evidenced by repeated missing required signatures in narcotic tracking books over a three-month period. This failed practice resulted in incomplete controlled substance records and compromised accountability for narcotic medications, placing 50 out of 97 residents (census) at risk for medication diversion and administration errors. Findings: During an interview on 12/18/25 at 10:07 AM, Licensed Nurse (LN) #3 stated that during shift change, both the incoming and outgoing nurses were required to conduct a narcotic count together. LN #3 further stated this process was documented on the Shift Audit Record, located in the narcotic tracking books and required four total signatures: - Two signatures in the section labeled Signature of Nurse Leaving Shift, and - Two signatures in the section labeled Signature of Nurse Coming on Shift. Record review on 12/14-24/25 revealed that 3 out of 3 reviewed narcotic logbooks ([NAME] Court, Cedar Court, and Spruce Court) for the period October through December 2025 contained incomplete narcotic count documentation, evidenced by missing required signatures on the Shift Audit Record on the following days: [NAME] Court October 2025: 10/10, 10/19, 10/20, 10/22 November 2025: 11/1, 11/2, 11/3, 11/11, 11/12, 11/14, 11/15, 11/16, 11/19, 11/20, 11/24, 11/26, 11/27, 11/28, 11/29, 11/30 December 2025: 12/4, 12/5, 12/11, 12/13 Cedar Court October 2025: 10/25, 10/26, 10/30 November 2025: 11/4, 11/17, 11/22, 11/23 December 2025: 12/1, 12/2, 12/9 Spruce Court October 2025: 10/1, 10/2, 10/5, 10/6, 10/8, 10/9, 10/10, 10/12, 10/13, 10/14, 10/18, 10/19, 10/20, 10/22, 10/27, 10/28, 10/31 November 2025: 11/2, 11/4, 11/6, 11/9, 11/10, 11/11, 11/13, 11/17, 11/18, 11/20, 11/21, 11/23, 11/24, 11/25, 11/26, 11/27, 11/28, 11/30 December 2025: 12/1, 12/3, 12/4, 12/5, 12/7, 12/9, 12/10, 12/11, 12/17 During an interview on 12/22/25 at 9:30 AM with the PharMerica (Centennial's contracted pharmacy services provider) Manager , when asked about the narcotic tracking books, she stated that PharMerica provided the narcotic tracking books, however it was the responsibility of the facility to handle all tracking and documentation in the books. Review of the facility provided Pharmacy Services Agreement, signed on 7/29/24, revealed: .Obligations of the client [Centennial]. Client shall, or require the Customer to, as the case may be . Store and handle all Medications in accordance with Applicable Law . Upon Client's request, Pharmacy shall provide the following and any other additional consulting services . Perform random quarterly audits of medication carts or audit medication storage areas for controlled and non-controlled medications . Perform on-site audits of Medical Records, contents of medication carts and/or Resident treatment charts, if provided by pharmacy. During an interview on 12/24/25 at 1:00 PM with the Director of Nursing (DON) , she stated that counting narcotics from each unit's medication cart was to occur each shift. She further stated: We have had a lot of turnover and maybe I just need to re-implant that policy and procedure to everyone. The DON further stated that the pharmacy came to the facility once a month to perform audits of narcotic tracking books, medication carts, and medication rooms, however she was not made aware of missed signatures in the narcotic tracking books. Review of the facility provided policy Pharmacy Services Overview, undated, revealed: .Medications are received, labeled, stored, administered and disposed of according to all applicable state and federal laws and consistent with standards of practice . The consultant pharmacist, in collaboration with the dispensing pharmacy and the facility, oversees the development of procedures related to pharmacy services, including (but not limited to) . (1) Receipt, labeling and storage of medications; (2) Reconciliation of medications from the pharmacy; (3) Control of medications from point of receipt to secured storage areas; (4) Facility staff roles and responsibilities (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during the receipt and storage of medication . d. Disposition of medications . f. Documentation of processes, as applicable.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review, observation, and interview, the facility failed to ensure a culture where residents were treated with dignity and respect for 2 residents (#s 48 and 64), out of 20 sampled residents. Specifically, the facility failed to:1) provide Resident #48 a bed bath at a reasonable time of day;2) maintain Resident #48's dignity and privacy by leaving the catheter urine collection bag uncovered and visible in common areas; and3) maintain Resident #64's dignity and privacy by failing to cover the resident's buttocks while transporting the resident to the resident's room from the shower room through 2 separate courts on 2 separate floors. These failures subjected residents to distressing and undignified care practices and placed them at risk for emotional distress and reduced quality of life. Findings: Resident #48 Record review on 12/14-24/25 revealed Resident #48 was admitted to the facility with diagnoses that included quadriplegia (paralysis of all four limbs), insomnia and neuromuscular dysfunction of the bladder (a condition where nerve or muscle problems interfere with normal bladder control, leading to issues such as incomplete emptying, urinary retention, or incontinence) which resulted for the need of an indwelling urinary catheter, nightmare disorder (a sleep disorder characterized by repeated, vivid, and disturbing dreams that cause awakenings and significant distress or impairment in daytime functioning) and Post-Traumatic Stress Disorder (PTSD, a mental health condition that occurs after experiencing or witnessing a traumatic event). Bathing During an interview on 12/14/25 at 10:55 AM, Resident #48 stated that staff woke him/her at 2:00 a.m. to provide a bed bath, which was very distressing due to frequent insomnia. The resident added that he/she experiences night terrors and was relieved not to have one when awakened. The resident stated it was very difficult to return to sleep after the bed bath. Review of Resident #48's Treatment Administration Record for bathing dated 12/13/25, revealed: . Was a shower or bath provided? . The record indicated a check mark under . Yes. and was time stamped at 2:22 AM, indicating Resident #48 was bathed at 2:22 AM on 12/13/25. Review of Resident #48's MDS (Minimum Data Set- A federally required assessment) comprehensive assessment, dated 11/25/25, revealed: . Section F.: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Very Important. How important is it to you to choose your own bedtime? Very Important. Review of Resident #48's care plan, dated 11/18/25, revealed: . The resident experiences frequent distressing nightmares and symptoms of PTSD, including sleep disruption, anxiety, hypervigilance, and emotional distress. These symptoms may impact quality of life, rest, and participation in daily activities. Resident has episodes of Insomnia. Resident will sleep 6/8 hours per night. During an interview on 12/18/25 at 4:15 PM, Certified Nursing Assistant (CNA) #2 stated that it was not acceptable to wake residents for a bath or shower. CNA #3 added that if residents request a shower very late at night, staff will accommodate; however, showers should typically occur during the first four hours of the night shift if not completed during the day shift. CNA #3 further stated that Resident #48 usually went to bed around midnight. During an interview on 11/18/25 at 4:31 PM, the Infection Preventionist (IP) stated that staff were expected to perform showers during the day shift. She further stated that if residents requested showers late, staff could honor those requests, as it was not unusual for residents to want showers later in the evening. However, staff should not wake residents for showers or baths. Urine Collection [NAME] observation on 12/14/25 at 10:55 AM, revealed Resident #48 was seated in an electric powered wheelchair with a family member in a main floor sitting area near a side door. The resident's catheter collection bag hung on the left side of the wheelchair and was about one-quarter full of yellow urine. When asked about the bag, the resident stated that he/she did not like having the urine bag exposed to everyone to see. The family member stated that he/she wished the bag could be hidden but there was no good place to position it on the wheelchair. During an interview on 12/18/25 at 4:15 PM, CNA #2 stated urine collection bags should (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been covered when residents were out of their rooms, however CNA #2 was unsure if Resident #48 had a urine collection bag cover. During an interview on 12/18/25 at 4:31 PM, IP stated when residents were out of their rooms and in the community the urine collection bag should have been covered. Review of Resident #48's care plan, dated 11/20/25, revealed: Bladder: At risk for complications with urinary system. Privacy cover to catheter bag as indicated to promote dignity. Resident #64 Record review on 12/14-24/25 revealed Resident #64 was admitted to the facility with diagnoses that included dementia, and a history of transient ischemic attack (an episode of stroke like symptom that completely resolves), and cerebral infarction (occurs when a blood clot blocks a brain artery). Review of Resident #64's care plan, dated 10/8/25, revealed: . [Resident #64] has an ADL [activities of daily living] Performance Deficit r/t [related to] weakness, reduced mobility. Ambulation - does not walk. Assistive Devices - Wheelchair. Bathing Preference: Shower Sunday/Thursday Day shift. An observation on 12/14/25 at 8:48 AM, revealed Resident #64 was transported in a shower chair from his/her room to the elevator, passing through the Birch Court common area and hallway. The resident had no clothing on but was covered with a white blanket that concealed the front of the body. When CNA #4 turned the chair toward the elevator, the resident's buttocks were exposed through the opening between the seat and backrest, making the resident's buttocks visible to others in the court. Staff present at the time included LN #3 and this surveyor. During an interview 12/14/25 at 8:50 AM, LN #3 stated Resident #64 was going to the [NAME] Court shower room downstairs. An observation on 12/14/25 at 9:05 AM, revealed Resident #64 was transported in a shower chair from the [NAME] Court shower room to the elevator with a blanket covering the resident's front from shoulders to feet; however, Resident #64's buttocks were exposed from the back of the chair through the opening between the seat and backrest. To reach the elevator, the resident passed through a common area where Resident #31 was seated at a table. Resident #64, fresh from a shower, with buttocks exposed, passed directly in front of Resident #31 and a surveyor before boarding the elevator. During an interview 12/16/25 at 3:15 PM, CNA #4 stated he/she brought the resident to the first floor shower room because it was safe to transfer Resident #64 in that shower room. He/she further stated when transporting a resident, he would cover the resident with a blanket so no skin would peak through and to keep the resident warm. During an interview on 12/17/25 at 10:13 AM, Resident Care Manager (RCM) #2 and RCM #3 stated the CNAs were trained on ADL during their CNA training. Residents were supposed to be covered to protect privacy and dignity when going down to the shower room and going back to their room. Review of the facility's Resident Rights, undated, revealed: Centennial Post Acute acknowledged the rights accorded to everyone admitted to our care. Review of the facility's Nursing Home Resident Rights, undated, revealed: Residents of nursing homes have rights that are guaranteed by the federal Nursing Home Reform Law. The law requires nursing homes to promote and protect the rights of each resident and stresses individual dignity and self-determination. Right to a dignified existence. Be treated with consideration, respect, and dignity.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/24/2025
NAME OF PROVIDER OR SUPPLIER Centennial Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 9100 Centennial Drive Anchorage, AK 99504	
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. .Based on record review and interview, the facility failed to ensure 3 residents (#'s 10, 68 and 88), out of 3 residents 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 blood pressure measurements were taken on the appropriate extremity. This failed practice placed the residents at risk for damage to their AV (arteriovenous) fistula (connection made between an artery and vein that is used for dialysis access) Findings: Resident #10Record review from 12/14-24/25 revealed Resident #10 was admitted to the facility with diagnoses that included Type 2 diabetes mellitus (DM- a chronic disease characterized by high levels of sugar in the blood) with diabetic chronic kidney disease (CKD- gradual loss of kidney function), dependence on renal dialysis, and end stage renal disease (ESRD- last stage of CKD).Review of Resident #10's Care Plan Report, initiated 11/18/25 revealed: .Dialysis: Resident Requires [dialysis] and has an AV fistula (shunt) and is at risk for complications related to treatment . Avoid taking blood pressure [BP], performing venipuncture, giving injections, strenuous activity, or applying restrictive clothing or restraints on the AV site extremity . Check AV Fistula (Left Arm) site dressing upon return from dialysis .Review of Resident #10's Blood Pressure Summary, dated from 11/7/25-12/15/25 revealed the facility measured Resident #10's blood pressure in his/her left arm on 5 occasions. Resident #68Record review from 12/14-24/25 revealed Resident #68 was admitted to the facility with diagnoses that included Type 2 DM, dependence on renal dialysis, and peripheral vascular disease (progressive disorder affecting blood vessels outside the heart leading to reduced blood flow and various symptoms).Review of Resident #68's Care Plan Report, initiated 10/4/25 revealed: .Dialysis: Resident requires Hemodialysis due to End Stage Renal Failure and has an AV Fistula (shunt) .Avoid taking blood pressure, performing venipuncture, giving injections, strenuous activity, or apply restrictive clothing or restraints on the AV site extremity .Review of Resident #68's Electronic Health Record (EHR) revealed a physician order dated 11/18/25: . No BP or venipuncture to Left arm due to dialysis fistula .Review of Resident #68's Blood Pressure Summary, dated 9/30/25-12/14/25 revealed the facility measured Resident #68's blood pressure in his/her left arm on 30 occasions. Resident #88Record review from 12/14-24/25 revealed Resident #88 was admitted to the facility with diagnoses that included dependence on renal dialysis, ESRD, and other complications of vascular dialysis catheter.Review of Resident #88's Care Plan Report, initiated on 11/20/25, revealed: .Dialysis: Resident Requires [X] Hemodialysis related to [X] End Stage Renal Failure and has an [X] AV Fistula (shunt) located (Left upper arm). Interventions/Tasks. Avoid taking blood pressure, performing venipuncture, giving injections, strenuous activity, or applying restrictive clothing or restraints on the AV site extremity.Review of Resident #88's EHR revealed a physician order dated 11/20/25: .Avoid taking blood pressure, performing venipuncture, giving injections, strenuous activity, or applying restrictive clothing or restraints on the AV site extremity.Review of Resident #88's Blood Pressure Summary, dated from 11/18/25-12/17/25 revealed the facility measured Resident #88's blood pressure in his/her left arm on 25 occasions.During an interview on 12/17/25 at 2:39 PM, the facility's Interim Director of Nursing (DON) stated the blood pressure measurements should not be obtained from an arm with an AV fistula when there was a physician's order that indicated such restriction.Review of the facility-provided standard used in resident care Lippincott Nursing Procedures, Eleventh Edition book, published in 2018, revealed the following education when caring for a resident with dialysis access: .Avoid taking blood pressure in an arm with an arteriovenous shunt or fistula.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. .Based on record review and interview, the facility failed to ensure the medical record accurately and completely reflected the resident's current clinical condition for 1 resident (#99) of 3 closed records reviewed. Specifically, the facility failed to update the resident's active diagnosis list and practitioner documentation to include seizure disorder, despite hospital documentation identifying seizure disorder as the primary diagnosis and the continued administration of anticonvulsant medications for that condition following readmission. This failed practice resulted in an incomplete and inaccurate medical record, which placed the resident at risk for inconsistent clinical decision-making, ineffective care coordination, and incomplete communication among caregivers responsible for implementing and monitoring seizure-related treatment and precautions Findings: Record review from 12/14-24/25 revealed Resident #99 was admitted to the facility with diagnoses that included Parkinson's disease (movement disorder of the nervous system), unspecified atrial fibrillation (irregular, rapid heart rhythm which can result to poor blood flow in the heart's lower chambers), type 2 diabetes mellitus without complications (chronic disease characterized by high levels of sugar in the blood), and unspecified bipolar disorder (mood disorder characterized by significant mood fluctuations). Review of Resident #99's LTC (Long Term Care) Progress Notes, dated 11/10/25 revealed, .CNA [Certified Nursing Assistant] saw resident shaking, like having seizure during their rounds. Priority nurse was called. LN [Licensed Nurse] assessed resident, not shaking, but is unresponsive to verbal and painful stimuli. Vitals were taken: 194/80 [mmHg- millimeter of mercury, standard unit used for pressure measurement], pulse: 102. [temperature] 97.4 [Fahrenheit], 20 [respiratory rate], 98% on room air, BS [blood sugar]: 165. Called 911, paramedics came and assessed vitals. BP [blood pressure] went down to 70/35 [mmHg]. Resident became responsive but still not answering questions which is not [his/her] baseline. Paramedics took [him/her] and went to .[name of hospital] and said that they're keeping [him/her] for observation. Review of Resident #99's [Hospital] History and Physical, dated 11/13/25 revealed, .Assessment and Plan. patient reported to have tonic clonic seizure [type of seizure involving sudden loss of consciousness, followed by muscle stiffening (tonic phase) and rhythmic jerking movements (clonic phase)] by EMS [Emergency Medical Services]. Has no known h/o [history of] seizure. minimize sedating medicines, frequent redirection, minimize external stimuli. seizure/fall precautions. Review of Resident #99's discharge summary from his/her hospitalization, dated 11/13/25 revealed, .Start taking these medications. levetiracetam [Levetiracetam (Keppra) is an anticonvulsant medication used to prevent and control seizures by stabilizing electrical activity in the brain] 250 MG [milligrams] tablet .commonly known as: KEPPRA. Instructions. Take 1 tablet (250 mg total) by mouth in the morning and 1 tablet (250 mg total) before bed time. For: Seizure disorder. Other Orders. admission Type: Readmission. Primary Diagnosis: Seizure disorder. Review of Resident #99's LTC Order Recap Report on 12/18/25, revealed: .levetiracetam Oral Tablet 250 MG. Give 250 mg by mouth every morning and at bed time for Seizure Disorder. Start Date. 11/13/25. End Date. 11/20/25. LaMictal Oral Tablet 25 MG (Lamotrigine) [Lamotrigine (Lamictal) is an anticonvulsant medication used to treat epilepsy and bipolar disorder by stabilizing electrical activity in the brain and helping regulate mood] Give 1 tablet by mouth two times a day for seizure d/o [disorder]. Start Date. 11/21/2025. Review of Resident #99's active medical diagnoses did not list seizure disorder in the electronic health record (EHR). Review of the practitioner's notes, PACMSG [Pacific Medical Specialty Group] Progress Note, signed 11/19/25 revealed, .Chief complaint: acute visit. ICD Codes: 149.91 Unspecified atrial fibrillation. E11.9 Type 2 diabetes mellitus without complications. F31.9 Bipolar disorder, unspecified. Further review revealed that seizure disorder was not mentioned in the progress note. During an interview on 12/18/25 at 2:42 PM, the Medical Director (MD) stated the resident had been prescribed Keppra from the hospital and was continued in the LTC facility upon readmission. He stated that these medications were continued (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	due to the indication for seizure disorder. MD further stated the diagnoses list should have been updated to reflect Resident #99's current status. During an interview on 12/18/25 at 6:02 PM, Interim Director of Nursing stated the facility had no policy regarding accuracy and completeness of medical records		

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to ensure their facility assessment (a mandatory, comprehensive evaluation to understand the specific resident population's needs and match them with necessary staffing, equipment, and resources to meet those needs) was up to date and accurate. This failed practice had the potential to place all residents (based on a census of 97) at risk of not receiving services that enable them to attain or maintain their highest practicable physical, mental, and psychosocial well-being .Findings:Record review on 12/14-24/25 revealed the facility provided Centennial Post Acute Facility Assessment, was last updated on 11/25/25.Review of the facility's Facility Assessment, dated 11/25/25 revealed: . Persons (names/titles) involved in the process and completing assessment. The list, labeled: Nursing Home Leadership and Management, included individual names who were no longer employed at the facility or did not currently hold the listed position during the time of the update.Specifically:Administrator- A new administrator, not listed, was appointed in 8/2025;Director of Nursing (DON) - The current DON, not listed, began in 5/2025;Medical Director - The current medical director, not listed, began in 12/2024;Business Development - The individual listed was the new administrator appointed in 8/2025;Medical Records - The current medical records director, not listed, began in 9/2025;Business Office - The current business office manager, not listed, began in 2/2025;Registered Dietitian - The current registered dietitian, not listed, began in 4/2025.Further review revealed: Date of assessment or update. [DATE] Names and Titles updated within 30 days of any changes. However, the leadership list was not updated.During an interview via email from 12/22-23/25, when asked about the outdated leadership list, the Administrator acknowledged the assessment had not been updated to reflect staffing changes and confirmed that it will be updated moving forward.Review of the facility's Facility Assessment, dated 11/25/25 revealed: .The facility must review and update this assessment annually or whenever the facility implements or plans for any change that would require modification to any part of this assessment.		