STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025027	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wildflower Court	2000 Salmon Creek Lane Juneau, AK 99801

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. . Based on record review, observation, and interview, the facility failed to ensure 1 resident (#49), out of 5 residents observed for medication administration, was appropriately assessed for safe self-administration of medications. This failed practice placed the resident at risk of medication errors and adverse outcomes. Findings: Record review on 5/7/25 revealed Resident #49 was admitted to the facility with diagnoses that included cellulitis of the right lower limb (a bacterial skin infection causing redness, swelling, and pain), other chronic pain, and arthritis of the right knee due to other bacteria (inflammation of the joints that causes pain, stiffness, and swelling). An observation on 5/6/25 at 12:14 PM, revealed a medication cup containing two tablets of Tylenol sitting on Resident #49's bedside table. Review of Resident #49's Electronic Medication Administration Record (EMAR), dated 5/6/25, revealed an entry which documented that two tablets of Tylenol were administered at 12:00 PM. During an interview on 5/6/25 at 12:29 PM, Resident #49 stated the nurses usually left his/her medications in his/her room. He/she would take the two Tylenol with lunch or sometimes he/she would take it later. An observation on 5/7/25 at 9:00 AM, revealed Licensed Nurse (LN) #4 prepared and administered medications for Resident #49. LN #4 handed the resident a medication cup containing 9 medications, asked the resident to rate his/her pain level, and then exited the room. LN #4 did not observe the resident to ensure he/she ingested the medications. The medications included a controlled substance, oxycodone (an opioid pain medication used to treat moderate to severe pain, with potential for abuse and dependence). Further observation revealed the medications that were left with the resident, without being observed as being taken, were: - Entresto (a medication used to treat heart failure) 49mg/51mg tablet; - Eliquis (a blood thinner used to reduce risk of stroke and blood clots) 5mg tablet; (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Allopurinol (a medication used for gout and kidney stone prevention) 100mg tablet; - Florastor (a probiotic used to promote gut health) 250mg capsule; - Metoprolol succinate (a medication used to treat high blood pressure, heart failure, and to reduce heart rate) ER (extended release) 50mg tablet; - Jardiance (a medication that lowers blood sugar) 10mg tablet; - Eplerenone (a medication used to treat high blood pressure and/or heart failure) 25mg tablet; - Torsemide (a medication used to reduce fluid buildup in the body) 20mg tablet; and - Oxycodone (a federally controlled substance, opioid pain medication) 5mg tablet. During an interview on 5/7/25 at 11:00 AM, LN #4 stated, [Resident # 49] takes the medications [himself/herself]. [He/She] is very independent, so we don't stand over [him/her]. There is an order to leave the medication with [him/her]. During an interview on 5/7/25 at 2:55 PM, when asked if it was appropriate for the LN's to leave medication with the residents, the Director of Nursing (DON) stated there was, No medication the nurse should walk away from . The nurse should watch the resident swallow the medication. When asked to provide a medication self-administration assessment or a physician's order authorizing medications to be left with Resident #49, the facility was unable to provide either document. Record review of Resident #49's current care plan, undated, revealed no documentation of Resident #49 being able to self-administer his/her own medications. Record review of Resident #49's PHYSICIAN ORDERS FOR 05/07/2025, revealed no orders for self-administered medications. Review of the facility's policy Administering Medications, dated 11/6/23, revealed: Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. . Based on record review, observation, and interview, the facility failed to ensure the care plan was implemented for 1 resident (#40), out of 14 sampled residents. Specifically, a Certified Nurse Aide (CNA #2) failed to follow Resident #40's care plan for basic care needs while assisting the resident out of bed to the toilet. This failed practice had the potential to injure the resident and negatively impact the resident's physical well-being. Findings: Record review during 5/5-9/25 revealed Resident #40 was admitted to the facility with diagnoses that included anoxic brain damage (a brain injury that occurs when the brain is deprived of oxygen), and other reduced mobility. The resident also used ankle-foot orthoses (AFOs, devices designed to support the foot and ankle) to help him/her stand and perform transfers. Review of Resident #40's Care Plan, with a start date of 4/15/25, revealed: Approach . TRANSFERS: I need 2 PEOPLE to assist with my transfers. Sara Steady and 2-person extensive assist . TOILETING: I need 2 PEOPLE to assist with my toileting for using the flush toilet . An observation and concurrent interview on 5/5/25, at 2:58 PM, revealed upon entering Resident #40's room, a Hoyer lift (a lift device designed to assist caregivers in safely transferring residents with limited mobility) was obstructing the room's internal entryway. Also, Resident #40 was laying down in bed, with the head of the bed elevated to approximately 45 degrees and the upper quarter side rails were raised. A Sara Steady device was positioned by the side of the bed. CNA #2 was standing with his/her feet firmly planted, leaning forward while holding the resident by the wrists. The CNA then leaned backward and used a tugging motion to assist the resident up into a seated position as the resident simultaneously twisted toward the bed's edge, with his/her face briefly resting on the side rail. After achieving a seated position, CNA #2 released the resident's wrists. The resident then adjusted his/her position by slightly swinging both feet back and forth, which were fitted with AFOs, and scooted his/her bottom toward the Sara Steady. With the resident's feet positioned on the Sara Steady, CNA #2 assisted the resident with grasping the support bar, and the resident proceeded to stand. Further observation revealed CNA #2 transported the resident to the bathroom. Resident #40 was positioned in front of the toilet. The CNA took down the resident's brief, and the resident lowered himself/herself shakily down to the toilet with no assistance. Next, CNA #2 hung several wet wipes from the bar of the Sara Steady that was parked in front of the resident. Afterwards, CNA #2 closed the bathroom door partially and went to make the resident's bed. While making the bed, CNA #3 stuck his/her head in the room and told CNA #2 that the tub will be available for Resident #40 at 4:00 PM. Afterwards, CNA # 2 and #3 both left the room while the resident was still on the toilet. Outside in the hallway, CNA #2 stated Resident #40 was good about pulling the call light when he/she finished and went on to further explain how different locations in a resident's room will make a different alert noise based on different initiation of call lights. CNA #2 then went back into the room stating he/she needed to make the bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/25 at 9:31 AM, the Director of Nursing (DON) stated that CNA's were trained on transferring residents and lift devices during orientation. She further stated Resident #40 was a 2-person assist, and staff should never pull on residents while assisting them. During an interview on 5/9/25 at 10:25 AM, CNA #4 stated that Resident #40 was always a 2 person assist out of bed and to the toilet. Review of the facility's policy Safe Patient Movement and Handling, undated, revealed: . It is the duty of each employee to take reasonable care of their own health and safety as well as that of their co-workers and of patients during patient handling activities . .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review and interview, the facility failed to ensure 1 Certified Nurse Aide (CNA #1), out of 3 CNAs personnel file reviewed, had Cardiopulmonary Resuscitation (CPR) certificate before providing direct patient care. This failed practice had the potential to place all residents (based on a census of 53) at risk of not receiving CPR immediately during an emergency. Findings: Review of facility personnel files on [DATE] at 3:35 PM, revealed the Human Resources (HR) Manager stated CNA #1 was hired on [DATE]. Further review revealed CNA #1's personnel file did not contain a CPR certificate. During an interview on [DATE] at 4:20 PM, the HR Manager confirmed that CNA #1 had no CPR certificate since hire. The HR Manager explained that the CNA was enrolled in the CPR class, but the CNA did not complete the course. The HR Manager also added that the Staff Development Office should have followed up with the completion of the course. During an interview on [DATE] at 4:27 PM, when asked if the CNA was allowed to work on the floor without a CPR certificate, the HR Manager did not answer the question. Review of the facility's policy Emergency Procedure- Cardiopulmonary Resuscitation, dated [DATE], revealed: Policy statement [:] Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR). Review of the facility's policy Mandatory Education for All hospital Staff (that the HR Manager confirmed was applicable to Wildflower Court staff as well), dated [DATE], revealed: .F. Mandatory classes and competencies for clinical staff are.BLS (Basic Life Support) is required for all clinical employees providing direct patient care. Unit Assignments During an interview on [DATE] at 4:06 PM, the Assistant Director of Nursing (ADON) stated CNA #1 was assigned mostly to the [NAME] unit, but the CNA could be assigned to other units. The ADON further stated CNA #1 was assigned to different units during the orientation period from 9/2024 to [DATE]. A request was made to ADON for CNA #1's unit assignments since his/her hire date ([DATE]), along with the unit census for each assigned unit. This document was not provided at the end of the survey. .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. . Based on record review, observation, and interview, the facility failed to ensure 1 resident (#40), out of 14 sampled residents received quality care. Specifically,1) a Certified Nurse Aide (CNA #2) failed to follow 2 person assist during a transfer and toileting as specified in the comprehensive care plan; 2) CNA #2 did not safely handle the resident during transfer; and 3) the internal doorway to Resident #40's room was obstructed. This failed practice had the potential to place the resident at risk of injury and negatively impact the resident's physical health and well-being. Findings: Record review during 5/5-9/25 revealed Resident #40 was admitted to the facility with diagnoses that included anoxic brain damage (a brain injury that occurs when the brain is deprived of oxygen), and other reduced mobility. The resident also used ankle-foot orthoses (AFOs, devices designed to support the foot and ankle) to help him/her stand and perform transfers. Review of Resident #40's Care Plan, with a start date of 4/15/25, revealed: Approach . TRANSFERS: I need 2 PEOPLE to assist with my transfers. Sara Steady and 2-person extensive assist . TOILETING: I need 2 PEOPLE to assist with my toileting for using the flush toilet . An observation and concurrent interview on 5/5/25, at 2:58 PM, revealed upon entering Resident #40's room, a Hoyer lift (a lift device designed to assist caregivers in safely transferring residents with limited mobility) was obstructing the room's internal entryway. Also, Resident #40 was laying down in bed, with the head of the bed elevated to approximately 45 degrees and the upper quarter side rails were raised. A Sara Steady device was positioned by the side of the bed. CNA #2 was standing with his/her feet firmly planted, leaning forward while holding the resident by the wrists. The CNA then leaned backward and used a tugging motion to assist the resident up into a seated position as the resident simultaneously twisted toward the bed's edge, with his/her face briefly resting on the side rail. After achieving a seated position, CNA #2 released the resident's wrists. The resident then adjusted his/her position by slightly swinging both feet back and forth, which were fitted with AFOs, and scooted his/her bottom toward the Sara Steady. With the resident's feet positioned on the Sara Steady, CNA #2 assisted the resident with grasping the support bar, and the resident proceeded to stand. Further observation revealed CNA #2 transported the resident to the bathroom. Resident #40 was positioned in front of the toilet. The CNA took down the resident's brief, and the resident lowered himself/herself shakily down to the toilet with no assistance. Next, CNA #2 hung several wet wipes from the bar of the Sara Steady that was parked in front of the resident. Afterwards, CNA #2 closed the bathroom door partially and went to make the resident's bed. While making the bed, CNA #3 stuck his/her head in the room and told CNA #2 that the tub will be available for Resident #40 at 4:00 PM. Afterwards, CNA # 2 and #3 both left the room while the resident was still on the toilet. Outside in the hallway, CNA #2 stated Resident #40 was good about pulling the call light when he/she finished and went on to further explain how different locations in a resident's room will make a different alert noise based on different initiation of call lights. CNA #2 then went back into the room stating he/she needed to make the bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/25 at 9:31 AM, the Director of Nursing (DON) stated that CNA's were trained on transferring residents and lift devices during orientation. She further stated Resident #40 was a 2-person assist, and staff should never pull on residents while assisting them. In addition, resident doorways should remain clear because resident safety was a priority. During an interview on 5/9/25 at 10:25 AM, CNA #4 stated when a Hoyer lift was needed inside of a resident's room, he/she would park it by the end of the resident's bed or in the bathroom, but never in front of the door where it could block someone from coming in to help. CNA #4 further stated that Resident #40 was always a 2 person assist out of bed and to the toilet. Review of the facility's policy Safe Patient Movement and Handling, undated, revealed: . It is the duty of each employee to take reasonable care of their own health and safety as well as that of their co-workers and of patients during patient handling activities . .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review, observation, and interview, the facility failed to ensure residents' environment remains free of accident hazards. Specifically, the facility failed to ensure: 1) resident's room internal entryway was not obstructed for 1 resident (#40), out of 14 sampled residents; and 2) 1 exit door, out of 11 possible exit doors, was secured to prevent elopement of 6 residents (#'s 9, 1, 14, 20, 34, and 41), out of 53 residents (total census) who were at risk of wandering. This failed practice: 1) placed the resident at risk of delay in timely assistance in his/her room in emergency situations; and 2) placed residents who wandered at risk for unsafe situations if they eloped from the facility. Findings: Blocked Doorway Record review during 5/5-9/25 revealed Resident #40 was admitted to the facility with diagnoses that included anoxic brain damage (a brain injury that occurs when the brain is deprived of oxygen), and other reduced mobility. An observation on 5/5/25 at 2:58 PM, when this surveyor opened the door to Resident #40's room, revealed a Hoyer lift (a lift device designed to assist caregivers in safely transferring residents with limited mobility) was positioned on the opposite side of the door, which obstructed the room's door from opening fully. To access the room, this surveyor had to step over the Hoyer lift's legs and slide into the room sideways through the small space available. It was noted there were other open areas away from the entryway in the room where the lift could have been positioned. During an interview on 5/5/25 at 3:10PM, Certified Nurse Aide (CNA) #2 stated Resident #40 used a Hoyer lift to get into his/her wheelchair for a shower. During an interview on 5/9/25 at 10:25 AM, CNA #4 stated that when a Hoyer lift was needed inside of a resident's room, he/she would park it by the end of the resident's bed or in the bathroom, but never in front of the door as it could delay help in cases of emergency. During an interview on 5/8/25 at 9:31 AM, the Director of Nursing (DON) stated the resident doorways should have remained clear of obstruction because the resident's safety was a priority. Review of the facility's policy Safe Patient Movement and Handling, undated, revealed: . It is the duty of each employee to take reasonable care of their own health and safety as well as that of their co-workers and of patients during patient handling activities . Risk of elopement Review of the facility-provided list Wildflower Court Resident's at Risk for Elopement, date revised 4/24/25, revealed six residents (#'s 9, 1, 14, 20, 34, and 41) were listed with pictures. This list was available for the front desk staff to identify residents that may wander out of the main door. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Random observations on 5/5-9/25 revealed Resident #41 was actively wandering around the facility. Record review on 5/5-9/25, Resident #41 was admitted to the facility with diagnosis of dementia (a decline in cognitive functioning including memory, thinking and reasoning). Review of Resident #41's physician's order, dated 11/22/24, revealed: Check Roam Alert Tag [a system that triggers an alarm when a resident approaches a monitored exit door] . Review of Resident #41's care plan, dated 4/9/25, revealed: . [Resident #41] is at risk for elopement . from anxiety, as evidenced by panic, exit seeking, pacing and trembling. [Resident #41] will remain safe within the facility. Review of the facility's reported incident (FRI) to the State of Alaska Health Facilities Licensing and Certification (HFLC) office, revealed Resident #41 eloped from the facility on 12/9/24 through a door going out of Cranberry Unit. Further review of the report revealed: .during the investigation it was found that the door the resident used to go out had a locking failure. An observation on 5/7/25 at 3:10 PM, revealed Resident #41, who was accompanied by Home Attendant (HA) #1, was going back to the [NAME] Unit, which was Resident #41's home unit. The staff stated he/she found Resident #41 in the main hallway by the Cranberry Unit. The Cranberry Unit is located on the opposite side of the of the facility away from the [NAME] Unit. An observation on 5/7/25 at 3:12 PM, revealed while CNA #1 demonstrated the operation of the wander guard alarm system on the [NAME] Unit's main door, Resident #41 wheeled himself/herself down the [NAME] hallway through the door that went into the Salmonberry Unit. No alarm/lock system was triggered. CNA #1 reported there was no alarm or locking system on the [NAME] door leading to Salmonberry, allowing residents to move freely throughout the two units. Further observation revealed Resident #41 wheeled himself/herself up to the front desk, which was by the building's main entrance. An observation and concurrent interview on 5/7/25 at 4:00 PM, revealed Licensed Nurse (LN) #7 accompanied the surveyor to inspect all exits when asked about the functionality of the wander guard alarm and locking system throughout the facility. During the inspection, it was noted that the door in the activity room kitchen lacked a wander guard locking or alarm system. LN #7 confirmed that the door had neither a locking system nor an alarm. Additionally, a no exit sign was observed above the door, which led to the outside. The door had a doorknob that could be opened from the kitchen, providing access to the outside. When asked if a resident with wander guard could exit through this door, LN #7 acknowledged this possibility and stated that it could be reported to the facility's maintenance team. During this observation, in the activity room, a piano session was in progress, with several residents listening to the music. Review of the attendance sheet of the piano session on 5/7/25, revealed Resident # 41 was on the list. Review of the facility's policy Wandering and elopements, dated 12/6/23, revealed checking the security of all exit doors was not included. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. . Based on record review and interview, the facility failed to ensure that residents who received opioid pain medications (a class of strong pain-relieving medications that act on the nervous system, with potential for dependence, overdose, and serious side effects) were re-evaluated for pain for 11 residents (#1, #2, #6, #12, #20, #24, #26, #37, #49, #51, and #259), out of 53 residents reviewed for pain management. Specifically, the facility failed to re-evaluate the residents' pain level within 30 to 60 minutes following opioid administration. This failed practice had the potential to result in unrelieved pain, delayed identification of medication ineffectiveness, or overmedication. Findings: Resident #1 Record review on 5/5-9/25 revealed Resident #1 was admitted to the facility with diagnoses that included cerebral palsy (a group of neurological disorders that affect movement and muscle tone), hemiplegia (paralysis on one side of the body), and anxiety disorder. Review of Resident #1's Electronic Medication Administration Record (eMAR) and clinical progress notes revealed the Resident received an opioid pain medication: .Hydrocodone 5 mg-acetaminophen 325 mg tablet. as needed for severe back & hip pain, from 4/19/25 through 5/8/25. Further review revealed 25 instances in which opioid medications were administered, but no documentation of a pain reassessment was found within 30 to 60 minutes following administration. Resident #2 Record review on 5/5-9/25 revealed Resident #2 was admitted to the facility with diagnoses that included post-traumatic stress disorder (PTSD), neurogenic bladder (a condition where nerve damage affects bladder control), and heart failure (a chronic condition where the heart cannot pump blood effectively). Review of Resident #2's eMAR and clinical progress notes revealed the Resident received an opioid pain medication: .Norco 5 mg-325 mg tablet.as needed.for pain, from 4/16/25 through 5/5/25. Further review revealed two instances in which opioid medications were administered, but no documentation of pain reassessment was found within 30 to 60 minutes following administration. Resident #6 Record review on 5/5-9/25 revealed Resident #6 was admitted to the facility with diagnoses that included depression, renal insufficiency (impaired kidney function that affects waste elimination and fluid balance), and anemia (a condition marked by low red blood cell count or hemoglobin, leading to fatigue and weakness). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's eMAR and clinical progress notes revealed the Resident received opioid pain medications: .Oxycodone 5mg tablet.Oxycodone 15 mg tablet.as needed for pain, from 4/20/25 through 5/9/25. Further review revealed 37 instances in which opioid medications were administered, but no documentation of pain reassessment was found within 30 to 60 minutes following administration. Resident #12 Record review on 5/5-9/25 revealed Resident #12 was admitted to the facility with diagnoses that included peripheral vascular disease (narrowing of blood vessels outside of the heart and brain, causing poor circulation), heart failure, and anemia. Review of Resident #12's eMAR and clinical progress notes revealed the Resident received an opioid pain medication: .Tylenol-Codeine #3 300mg-30 mg tablet.PRN (as needed) for DJD [degenerative joint disease] knee pain, from 4/17/25 through 5/8/25. Further review revealed 25 instances in which opioid medications were administered, but no documentation of pain reassessment was found within 30 to 60 minutes following administration. Resident #20 Record review on 5/5-9/25 revealed Resident #20 was admitted to the facility with diagnoses that included multiple sclerosis (a progressive disease of the central nervous system affecting movement, sensation, and coordination), dementia (a decline in memory and cognitive ability that interferes with daily function), and neurogenic bladder. Review of Resident #20's eMAR and clinical progress notes revealed the Resident received an opioid pain medication: .Percocet 5 mg-325 mg tablet.as needed for pain, from 4/2/25 through 5/8/25. Further review revealed 17 instances in which opioid medications were administered, but no documentation of pain reassessment was found within 30 to 60 minutes following administration. Resident #24 Record review on 5/5-9/25 revealed Resident #24 was admitted to the facility with diagnoses that included schizophrenia (a serious mental disorder affecting perception, thought, and behavior) and PTSD. Review of Resident #24's eMAR and clinical progress notes revealed the Resident received an opioid pain medication: . Oxycodone 5 mg tablet.as needed for pain, from 4/23/25 through 5/3/25. Further review revealed 36 instances in which opioid medications were administered, but no documentation of pain reassessment was found within 30 to 60 minutes following administration. Resident #26 Record review on 5/5-9/25 revealed Resident #26 was admitted to the facility with diagnoses that included hemiplegia, seizure disorder, and depression. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #26's eMAR and clinical progress notes revealed the Resident received an opioid pain medication: .Oxycodone 5 mg tablet.as needed for pain, from 4/19/25 through 5/8/25. Further review revealed 10 instances in which opioid medications were administered, but no documentation of pain reassessment was found within 30 to 60 minutes following administration. Resident #37 Record review on 5/5-9/25 revealed Resident #37 was admitted to the facility with a diagnosis of anxiety disorder. Review of Resident #37's eMAR and clinical progress notes revealed the Resident received an opioid pain medication: .Oxycodone 5 mg tablet.as needed for pain, from 4/11/25 through 5/9/25. Further review revealed seven instances in which opioid medications were administered, but no documentation of pain reassessment was found within 30 to 60 minutes following administration. Resident #49 Record review on 5/5-9/25 revealed Resident #49 was admitted to the facility with diagnoses that included cellulitis (a bacterial skin infection causing redness, swelling, and pain) of the right lower limb, chronic pain, and arthritis (inflammation of one or more joints causing pain, stiffness, and reduced mobility) of the right knee. Review of Resident #49's eMAR and clinical progress notes revealed the Resident received an opioid pain medication: .Oxycodone 5 mg tablet.as needed for septic arthritis, from 4/22/25 through 5/9/25. Further review revealed 44 instances in which opioid medications were administered, but no documentation of pain reassessment was found within 30 to 60 minutes following administration. Resident #51 Record review on 5/5-9/25 revealed Resident #51 was admitted to the facility with diagnoses that included paraplegia, anxiety disorder, and neurogenic bladder. Review of Resident #51's eMAR and clinical progress notes revealed the Resident received an opioid pain medication: .Endocet 5 mg-325 mg tablet.PRN for pain, from 4/20/25 through 5/9/25. Further review revealed 62 instances in which opioid medications were administered, but no documentation of pain reassessment was found within 30 to 60 minutes following administration. Resident #259 Record review on 5/5-9/25 revealed Resident #259 was admitted to the facility with diagnoses that included neurogenic bladder and multiple sclerosis. Review of Resident #259's eMAR and clinical progress notes revealed the Resident received opioid pain medications: . Norco 5mg-325 mg tablet. as needed for pain. Dilaudid 2mg tablet. as needed for severe pain, from 4/12/25 through 5/9/25. Further review revealed 14 instances in which opioid medications were administered, but no documentation of pain reassessment was found within 30 to 60 minutes following administration. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/9/25 at 4:35 PM, the Director of Nursing (DON) stated that nurses were to perform pain reassessments within 30 to 60 minutes after administering pain medications. Review of the facility policy, Administering Pain Medications, dated 12/17/23, revealed: . Re-evaluate the resident's level of pain 30-60 minutes after administering. Review of an article from the U.S. Government's National Library of Medicine: Improving the Quality of Care Through Pain Assessment and Management, accessed at: https://www.ncbi.nlm.nih.gov/books/NBK2658/#:~:text=Assessment%20of%20effect%20should%20be,45%E2%80%9360%20minutes%20after%20administration. revealed: .Assessment of effect should be based upon the onset of action of the drug administered.oral opioids and nonopioids are reassessed 45-60 minutes after administration. .

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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 record review and interview, the facility failed to ensure nursing staff have the specific competencies and skills set necessary to care for residents' needs. Specifically, the facility failed to ensure: 1) 6 Licensed Nurses (LN #'s 1, 2, 3, 4, 5, and 6), out of 15 LN personnel files reviewed, had current training for safe oxygen handling; and 2) 1 Certified Nurse Aide (CNA #1), out of 3 CNA personnel files reviewed, had a valid Cardiopulmonary resuscitation (CPR) certificate. This failed practice had the potential to place all residents (based on a census of 53) at risk of not receiving the necessary treatment and care and immediate assistance during an emergency. Findings: Oxygen Safety Education During an interview on [DATE] at 3:35 PM, during a review of personnel files, the Human Resources (HR) Manager stated LN #4 had no training for oxygen handling safety. During an interview on [DATE] at 4:33 PM, the Assistant Director of Nursing (ADON) stated oxygen safety education was required annually for all licensed nurses. She stated LN #4 was a traveler nurse and had been to the facility before 2024. Since then, there was no record of oxygen safety training. The ADON stated LN #4 had no designated unit because he/she was a traveler. Review of oxygen safety education documents on [DATE] at 10:13 AM, revealed LN #s 1, 2, 3, and 5 had just completed their training on [DATE]; and LN #4 and #6 had just completed their training on [DATE] (during the survey). During an interview on [DATE] at 10:13 AM, when asked if the training was conducted after the personnel files review on [DATE] at 3:35 PM, the ADON stated, yes. An observation on [DATE] at 11:00 AM, revealed 13 compressed gas cylinders were stored at the Salmonberry unit. During an interview on [DATE] at 1:37 PM, ADON confirmed that there were oxygen tanks in the Salmonberry unit storage reserved for residents who might need oxygen. CPR certification Review of the personnel files on [DATE] at 3:35 PM, the HR Manager stated CNA #1 was hired on [DATE]. Further review revealed CNA #1's personnel file did not contain a CPR certificate. During an interview on [DATE] at 4:20 PM, the HR Manager confirmed that CNA #1 had no CPR certificate since hire. The HR Manager explained that the CNA was enrolled in a CPR class, but the CNA had not completed the course. The HR Manager also added that the Staff Development Office should have followed up with the completion of the course. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 4:27 PM, when asked if CNA #1 was allowed to work on the floor without a CPR certificate, HR Manager did not answer the question. Review of the facility's Emergency Procedure- Cardiopulmonary Resuscitation, dated [DATE], revealed: Policy statement [:] Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR). Review of the facility's policy Mandatory Education for All hospital Staff (that the HR Manager confirmed was applicable to Wildflower Court staff as well), dated [DATE], revealed: .F. Mandatory classes and competencies for clinical staff are.BLS (Basic Life Support) is required for all clinical employees providing direct patient care. .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. . Based on observation and interview, the facility failed to ensure the medication error rate was below 5%. The medication error rate was 36%. 9 medication administration errors were identified, out of 25 opportunities, during medication administration observations. This failed practice placed the resident at risk for adverse medication effects. Findings: Record review on 5/7/25 revealed Resident #49 was admitted to the facility with diagnoses that included cellulitis of the right lower limb (a bacterial skin infection causing redness, swelling, and pain), other chronic pain, and arthritis of the right knee due to other bacteria (inflammation of the joints that causes pain, stiffness, and swelling). An observation on 5/7/25 at 9:00 AM, revealed Licensed Nurse(LN) #4 prepared and administered medications for Resident #49. LN #4 handed the resident a medication cup containing the following 9 medications: - Entresto (a medication used to treat heart failure) 49mg-51mg tablet; - Eliquis (a blood thinner used to reduce risk of stroke and blood clots) 5mg tablet; - Allopurinol (a medication used for gout and kidney stone prevention) 100mg tablet; - Florastor (a probiotic used to promote gut health) 250mg capsule; - Metoprolol succinate (a medication used to treat high blood pressure, heart failure, and to reduce heart rate) ER (extended release) 50mg tablet; - Jardiance (a medication that lowers blood sugar) 10mg tablet; - Eplerenone (a medication used to treat high blood pressure and/or heart failure) 25mg tablet; - Torsemide (a medication used to reduce fluid buildup in the body) 20mg tablet; and - Oxycodone (a federally controlled substance, opioid pain medication) 5mg tablet, as needed. LN #4 asked the resident to rate his/her pain level and then exited the room. LN #4 did not observe the resident to ensure he/she ingested the medications. During an interview on 5/7/25 at 11:00 AM, LN #4 stated, [Resident #49] takes the medications [himself/herself]. [He/She] is very independent, so we don't stand over [him/her] . There is an order to leave the medication with [him/her]. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/25 at 2:55 PM, when asked if it was appropriate for the LN's to leave medication with the residents, the Director of Nursing (DON) stated there was, No medication the nurse should walk away from and The nurse should watch the resident swallow the medication. When asked to provide a medication self-administration assessment or a physician's order authorizing medications to be left with Resident #49, the facility was unable to provide either document. Review of Resident #49's MEDICATION RECORD FOR 05/2025 revealed 4 medications (Entresto, Eliquis, Allopurinol, and Florastor) were recorded on 5/7/25 as administered at 8:00 AM, and the remaining 5 medications (Metoprolol, Jardiance, Eplerenone, Torsemide and Oxycodone 5mg) were recorded as administered at 9:00AM. Record review of the facility's policy Administering Medications, dated 11/6/23, revealed: .As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered. Review of the facility's policy Resident Self-Administration of Medications, dated 11/9/23, revealed: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so . .

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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 store and prepare food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure: 1) expired food was discarded; and 2) the temperature of cooked potentially hazardous food was recorded after cooking. These failed practices had the potential of causing or spreading foodborne illness to all residents, based on a census of 53, who received food from the affected kitchens. Findings: Main Kitchen Observation on 5/5/25 at 10:55 AM, during the initial main kitchen tour with the Director of Nutrition Services (DNS), revealed: 1) Dry Storage: - One- 12-quart clear plastic container with a blue lid and a handwritten label that said, Brown Sugar 5-1-25 which contained two pieces of brown bread on top of the contents in the container. -Four- gallon size plastic bags which contained single servings of Smucker's Apple Butter not labeled with manufactures expiration or best used by date. -One- large clear plastic container with a blue lid labeled, Perfect [NAME] 4/30, no expiration date or best used by date. -One- small clear plastic container with a blue lid labeled, Perfect [NAME] 4/30, no expiration date or best used by date. During an interview on 5/5/25 at 11:10 AM, the DNS stated the bread was placed on top of the brown sugar in the container to keep the sugar from getting hard. The date on the label was when the contents were placed in the container. When the DNS was asked how long the bread was kept, the DNS stated dry goods were on a 2-week rotation. 2) Walk-in Cooler: -One- Arrezzion, Shredded Low Moisture Part Skim Mozzarella Cheese - 5-pound plastic bag- no expiration date, manufacture labeled #2329413, packed 11/11/24 13:13 400. The DNS was not able to provide an expiration date of the cheese. -One- unidentified large clear plastic container was not labeled and not dated. The DNS stated that the container was prepared celery to be used that day. 3) [NAME] Unit Kitchen: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-One- expired PORK LOIN CHOPS, CENTER CUT, BONELESS, FROZEN - 16-ounce package- with manufacture best if use by 02/25/2025; -One- expired Johnsonville JALAPENO CHEDDAR Smoked Sausage - 14-ounce package- with manufacture best by date of 4/14/25. 4) Blueberry Unit Kitchen: - One box expired Instant Quaker Original Oatmeal- 10 packets- with manufacture best if used before Apr. [April] 12 25. An observation of the main kitchen dry storage area, on 5/8/25 at 4:10 PM, revealed a 12-quart clear plastic container with a blue lid and a handwritten label that said, Brown Sugar 5-1-25, which contained multiple pieces of brown bread on top of the contents in the container. Review of Sysco Food Safety & Quality Assurance, Customer Specification, for Mozzarella Cheese, revised 4/29/25, revealed: . 2329413 . ARREZZION . Shred Low Moisture Part Skim Mozzarella Cheese .5 pound . Shelf Life . Dry and Refrigerated 90 Days . Review of the facility's policy HOW TO: Properly Store Food, dated 2019, revealed: Label & Date All Stored Food . Review of the facility's policy Food Storage, Handling and Preparation, undated, revealed: Purpose: All foods will be stored, prepared, cooked and served using appropriate practices and procedures to ensure safety . Policy: A. Foods are stored, handled and prepared by safe methods that conserve nutritive value. Review of the facility's POSITION DESCRIPTION, dated 3/29/23, revealed: . [NAME] II . Ensures proper food storage procedures are being followed in all coolers, freezers and food storage areas . Follows all health department guidelines for safe handling of food . Review of the facility's POSITION DESCRIPTION, dated 11/21/24, revealed: . Director of Nutrition Services . This position independently manages the full food service and nutritional operations and assists with . patient and staff dietary needs for the. Wildflower Court . The Director of Nutrition Services is responsible for planning, coordination, staffing. of the Dietary Department. coordinate employee training, maintain effective communication, and participate in teaching and directing staff .Establishes and maintains standards of food . storage, sanitation, safety. Develops and mentors' staff . Makes department rounds to identify issues; observes and coaches staff . Education: Facilitates the education necessary for staff to perform competently . Must comply with all workplace health and safety requirements . Potentially Hazardous Cooked Foods During an observation on 5/5/25 at 11:05 AM, of the main kitchen, revealed a poster from the State of Alaska Division of Environmental Health posted on walk-in cooler listed cooking for meat and eggs. Cook to this temperature or hotter: . Poultry 165 [degrees] F [Fahrenheit] . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/5/25 at 11:45 AM, with the Home Attendant (HA) #5 in the Cranberry Unit kitchen, when asked if the HAs took the temperature of the food before serving the resident, HA #5 stated they stopped taking the food temperatures on the unit and that the main kitchen took the temperatures. HA #5 further stated the food steamer was prepared 30 minutes prior to the food arriving from the kitchen. HA #5 stated in order to prepare the steamer, water was put in and the steamer was turned on. HA#5 stated the temperature did not need to be adjusted on the steamer, he/she stated the steamer water needed to be 165 degrees or higher. During an interview on 5/5/25 at 12:10 PM, with HA #6 in the [NAME] Unit kitchen, HA #6 stated the food arrived warm and was served family style. HA #6 further stated the food was not kept in the steamer longer than 2 hours. During an interview on 5/6/25 at 4:05 PM, with HA #4 in the Blueberry Unit kitchen, HA #4 stated the temperature was not adjusted on the steam table. HA #4 further stated he/she took the temperature of the water in the steam table and the temperature was to be 165 degrees or higher. HA #4 stated once food was delivered by the kitchen and placed on the steamer it was served to the residents immediately. HA #4 further stated food was discarded after 1 1/2 to 2 hours. During an observation and concurrent interview on 5/7/25 at 11:20 AM, in the main kitchen, Food Service (FS) staff #1 removed chicken from the oven, FS staff #1 took the temperature with a digital thermometer and stated it was 167 degrees F. FS staff #1 did not document the temperature. FS staff #1 placed the cooked noon meal into metal pans and transferred to the steamer unit. The steamer unit temperature displayed 200 degrees F. During an observation and concurrent interview on 5/7/25 at 11:56 AM, in the main kitchen, FS staff #1 removed the noon meal from the steamer and obtained the temperatures of the food. FS staff #1 read off the temperatures after the recording: Chicken 162 degrees F, ground chicken 156 degrees F and pureed chicken 150 degrees F. FS staff #1 and FS staff #2 stated they were to only record temperatures of the food before it was taken to the dining units. FS staff #1 stated this was a recent change that was directed by management. FS staff #1 further stated the temperatures used to be documented after cooking. FS staff #1 and FS staff #2 stated they continued to take temperatures after cooking to ensure the food reached the recommended temperatures to prevent foodborne illnesses but no longer have a place to document them. When asked what temperature chicken needs to be, FS staff #1 and FS staff #2 stated 165 degrees F or higher. During an interview and concurrent observation on 5/8/25 at 4:15 PM, the DNS stated the cooks have a poster to use for guidance of minimum food temperatures before serving. The DNS further stated the temperature log was to make sure the food was cooked to the minimum temperature before going upstairs. The temperature log was titled Cart Temp Log. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview and concurrent observation on 5/9/25 at 11:17 AM, FS staff #2 was asked for the food temperature logs for 5/6-8/25. FS staff #2 stated he/she knew where the documents were located. FS staff #2 retrieved the clipboard that had sheets titled, Cart Temp Log. FS staff #2 stated those requested dates were not on the clipboard. FS staff #2 then started going through a stack of paper on the desk in the main kitchen. FS staff #3 then asked FS staff #2 what he/she was looking for. FS staff #2 stated he/she was looking for temperature logs for 5/6-8/25. FS staff #3 advised FS staff #2 to look in the garbage can by the dishwashing area. FS staff #2 stated the garbage can, FS staff #3 stated the DNS had thrown a bunch of papers in the garbage can previously. FS staff #2 retrieved 5/6-8/25 Cart Temp Log sheets that appeared to be the original documents. This surveyor obtained pictures of the documents as they had been taken out of the garbage can. FS staff #2 kept the original log sheets. Review of the facility's Cart Temp Log revealed: Dated 5/9/25- Chicken 162; Ground 156; Puree 150; Dated 5/8/25 - Chicken no recorded temperature- Ground no recorded temperature- Puree no recorded temperature; Dated 5/4/25- Chicken 164- Ground 162- Puree 162; Dated 5/3/25- Chicken . Ground 161; Puree 162; Dated 5/1/25- Chicken no recorded temperature; Ground 162- Puree 162; Dated 4/29/25- Chicken . Puree 162; Dated 4/23/25- Turkey. Ground 161- Puree 161; Dated 4/20/25- Chicken. Ground 161- Puree 162 . Pizza no recorded temperature- Veg [Vegetable] no recorded temperature- Mash [potatoes] no recorded temperature- Gravy no recorded temperature- Ground no recorded temperature- Puree no recorded temperature. Review of the facility's FOOD TEMP LOG revealed: Dated 4/15/25- Turkey. Puree 161; Dated 4/13/25- Chicken 164- Ground 161- Puree 161; Dated 4/12/25- Turkey. Ground 162- Puree 161; Dated 4/7/25- Turkey. Puree 163; Dated 4/6/25- Chicken 164- Ground 161- Puree 160; Dated 4/5/25- Chicken. Ground 162- Puree 162; Dated 3/31/25- Chicken. Ground 161- Puree 162; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dated 3/28/25- Turkey. Ground 162- Puree 162; Dated 3/26/25- Turkey. Ground 162- Puree 162; Dated 3/25/25- Chicken. Puree 161; Dated 3/23/25- Chicken. Ground 162- Puree 162; Dated 3/19/25- Chicken. Ground 162- Puree 162; Dated 2/23/25- Chicken. Ground 161- Puree 162; Dated 2/19/25- Chicken. Ground 162- Puree 162; Dated 2/17/25- Chicken. Puree 156; Dated 2/15/25 Turkey. Ground 164- Puree 162; Dated 2/12/25- Chicken. Ground 162- Puree 162; Dated 2/11/25- [NAME] no recorded temperature- Chicken no recorded temperature- Veggies no recorded temperature- Mash no recorded temperature- Gravy no recorded temperature- Ground no recorded temperature- Puree no recorded temperature; Dated 2/9/25- Chicken 164- Ground 162- Puree 162; Dated 2/8/25- Chicken. Ground 162- Puree 162; Dated 1/15/25- Chicken 162- Ground 162- Puree 162; Dated 1/12/25- Chicken. Ground 162- Puree 162; Dated 1/11/25- Chicken. Ground 162- Puree 162; Dated 1/9/25- Chicken. Ground 159. Review of the facility's POSITION DESCRIPTION, dated 3/29/23, revealed: . [NAME] II . Follows all health department guidelines for safe handling of food . Completes required documentation for temperatures of food . Must comply with all workplace health and safety requirements . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025027	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wildflower Court	2000 Salmon Creek Lane Juneau, AK 99801

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's POSITION DESCRIPTION, dated 11/21/24, revealed: . Director of Nutrition Services . This position independently manages the full food service and nutritional operations and assists with . patient and staff dietary needs for the. Wildflower Court . The Director of Nutrition Services is responsible for the planning, coordination, staffing. of the Dietary Department. coordinate employee training, maintain effective communication, and participate in teaching and directing staff . ensure food is prepared. and served at proper temperatures. Establishes and maintains standards of food . storage, sanitation, safety. Develops and mentors' staff . Makes department rounds to identify issues; observes and coaches staff . Education: Facilitates the education necessary for staff to perform competently . Must comply with all workplace health and safety requirements . Review of the facility's policy Food Storage, Handling and Preparation, undated, revealed: Purpose: All foods will be stored, prepared, cooked and served using appropriate practices and procedures to ensure safety . Policy: A. Foods are stored, handled and prepared by safe methods that conserve nutritive value. H. Potentially hazardous foods requiring cooking are heated to the appropriate temperature and held at that temperature . H.1.1. All poultry, all food made from poultry, all stuffed meats, and the stuffing in them must reach 165 [degrees] F [Fahrenheit] or hotter to destroy Salmonella and other bacteria . H.2.6. Temperatures of foods placed in steam tables or other hot holding units must be taken when the product is placed . Review of Food and Drug Administration (FDA), 2022 Food Code U.S. Food and Drug Administration, dated 12/28/22. Accessed at this link: https://www.fda.gov/media/184685/download?attachment, revealed: 3-401 Cooking, 3-401.11 Raw Animal Foods. (A) . POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts of the FOOD to a temperature . (3) 74 C (165 F) or above . .