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	06/12/2026

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

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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 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, record review, and interview, the facility failed to store, prepare, and maintain food and food-contact sanitation in accordance with food safety standards. Specifically, the facility failed to ensure: 1) Sanitizer solutions used for food-contact surfaces were maintained at the manufacturer-recommended concentration; and 2) Food items available for resident use were labeled with required use-by dates and/or removed when expired; and 3) Culinary staff followed hand hygiene and glove-use practices to prevent cross-contamination during food preparation. These failed practices had the potential to cause cross contamination during food preparation and to allow contaminated and/or expired food to be served to 54 residents who received food from the kitchen, out of a total of 55 residents, placing these residents at risk for foodborne illness. Findings:.Sanitizer Concentration An observation on 6/10/26 at 10:39 AM, in the main kitchen, revealed two sanitizer buckets available for use. When tested with QT-10 Hydrion test strips, the sanitizer solutions read 0 parts per million (ppm) and 100 ppm. [NAME] #7 verified the readings, and the buckets were removed from service. Review of the Ecolab (sanitizer manufacturer) poster titled Ecolab Apex Solid Quat Broad Range Sanitizer, posted in the dishwashing area, copyright 2012, revealed: . Testing [sanitizer] solution should be between 150 - 400 ppm. Review of the Ecolab poster titled Ecolab Oasis 146 Multi-Quat Sanitizer, posted in the janitor's closet, copyright 2015, revealed: .Testing [sanitizer] solution should be between 150 - 400 ppm. An observation on 6/10/26 at 12:15 PM, in the main kitchen, revealed follow-up testing of the sanitizer buckets showed both sanitizer solutions tested at 100 ppm. [NAME] #4 verified the readings, and the sanitizer buckets were removed from service. During an interview on 6/10/26 at 12:30 PM, [NAME] #4 stated that the sanitizer buckets contained a sanitizer solution that could either be dispensed from the dishwashing area or the janitor's closet. He/she stated that the sanitizer buckets should have been dispensed from the dishwashing area because the concentration of the janitor's closet solution was too strong. He/she further stated that the solution should have been tested before being placed into service. During an interview on 6/10/26 at 12:40 PM, the Food Services Supervisor (FSS) stated that staff should have filled the sanitizer buckets from the dispenser in the janitor's closet. He further stated that the dispenser in the kitchen area was calibrated for the large sink, and that the dispenser in the janitor's closet was calibrated for buckets. An observation on 6/11/26 at 12:07 PM, in the main kitchen, revealed follow-up testing of both sanitizer buckets showed sanitizer concentration at 350 ppm. An observation on 6/12/26 at 9:04 AM in the main kitchen revealed follow-up testing of the sanitizer buckets showed sanitizer concentration at 0 ppm. The FSS verified the reading, and the sanitizer buckets were immediately removed from service. During an interview on 6/12/26 at 9:59 AM, the Director of Culinary and Nutrition Services (DCNS) stated both sanitizer dispensers were calibrated and he did not expect staff to test sanitizer buckets after dispensing the solution and before placing the buckets into service. Review of the Ecolab sanitizer dispenser maintenance document, Regular Service Call, dated 3/19/26 at 3:43 PM, revealed: . Installed new LDS [Liquid Dilution System- a water and sanitizer dispenser] for orange force 146 quat sanitizer and wash and walk. Sink and Surface Sanitizer: 300 (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ppm. Review of the Ecolab sanitizer dispenser maintenance document, Ecolab Service Visit Report, dated 6/10/26 at 5:09 PM, revealed: . Sink and Surface Sanitizer. 250 ppm. Validating the dilutions and procedures are compliant to protect your employees and guests. Review of the facility policy Cleaning and Sanitizing Food Contact Surfaces, dated 5/25/12, revealed: . A.2. Wash, rinse and sanitize food contact surfaces using the following procedure: A.2.1. Wash surface with detergent solution. A.2.2 Rinse surface with clean water. A.2.3. Sanitize surface using a sanitizing solution mixed at a concentration specified on the manufacturer's label. Expired and Unlabeled Food An observation on 6/8/26 at 2:52 PM, in the main kitchen's walk-in refrigerator, revealed multiple food items in containers that were labeled with the name of the food item and the date prepared by writing on blue painter's tape and placing the painter's tape onto the plastic wrap covering the food container. Further observation revealed multiple food items that were not labeled with a use-by date, not identified with an open date, were not labeled to identify the contents, or were expired: Foods not labeled with a use-by date: Seven packages of pancakes and French toast in a metal container, dated 6/6/26. The metal container included one package of pancakes and one package of French toast wrapped in plastic wrap that was not the manufacturer's packaging;One metal container of pureed fish, dated 6/4/26;One metal container of pureed chicken, dated 6/7/26;One metal container of ground chicken, dated 6/7/26;One metal container of diced roast pork, dated 6/5/26;One clear plastic container with a red lid which contained chopped celery, dated 6/12/26;One clear plastic container of squash, dated 6/3/26;One clear plastic container of zucchini, dated 6/3/26;One clear plastic container with a red lid with approximately 4 quarts of shredded mozzarella cheese, dated 6/3/26;One clear plastic container with a red lid with approximately 5 quarts of shredded cheddar cheese, dated 6/4/26;One sheet of raspberry cake on a metal pan, dated 6/8/26;One sheet of three loaves of uncooked garlic bread, dated 6/8;One metal container of approximately 12 hard-boiled eggs without the shell, dated 6/8/26;One clear plastic container with a greed lid containing approximately two quarts of diced tomatoes, dated 6/7;One plastic container containing five one-ounce individual plastic containers of tartar sauce, dated 5/28/26; Individual containers not labeled or dated;Four clear plastic tubs with green lids approximately half full of Emerald pears, dated 6/4/26;One clear plastic bin with 24 one-ounce individual plastic containers of Emerald pears. Bin labeled 6/4/26. The individual containers inside the plastic bin were not labeled or dated;Four clear plastic containers of pound cake, dated 6/8/26;One clear plastic bin with 24 one-ounce individual plastic containers of pound cake puree. Bin dated 6/8/26. The individual containers inside the plastic bin were not labeled or dated; andOne metal container with one sealed portion of pork in manufacturer's packaging and one resealable bag containing pork labeled 6/7, metal container labeled 6/6. and no use by date. Foods without an open date or a use-by date: Five slices of whole wheat bread in manufacturer packaging;Nine slices of gluten free bread in manufacturer packaging; andApproximately eight ounces of butter, opened, labeled 6/8/26. Expired food: One metal container containing a bag of diced celery labeled with a prep date of 5/5 and use by date of 6/5, the metal container was labeled 6/7 and had no use by date. An observation on 6/8/26 at 3:07 PM, in the main kitchen's freezer, revealed multiple food items again labeled with blue painter's tape. Further observation revealed food items that were not labeled to identify the food, had no open date, an expiration date, or a use-by date: Foods with no label to identify the food item, had no open date, or an expiration date: One clear plastic bag of what appeared to be chicken tenders;One clear plastic bag of what appeared to be tater tots;One clear plastic bag of what appeared to be fried fish;One clear plastic bag of what appeared to be pepperoni;One package of what appeared to be pancakes wrapped in facility plastic wrap;One clear plastic bag of what appeared to be pizzas; andOne clear plastic bag of what appeared to be hoagie rolls. Foods not labeled with a use-by date: One plastic bag of Talapia, dated 6/4/26;One plastic bag of pepperoni, dated 2/22; One plastic bag of cinnamon rolls, dated 5/27/26; andTwo plastic bags of garlic bread, dated 5/26/26. An observation on 6/8/26 at 3:19 PM, in the main kitchen's dry storage area, revealed food items that were not properly labeled or were expired: One clear plastic container (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with a blue lid containing dry rice, dated 6/2 with no use by date on label;One clear plastic bin with unsecured purple lid containing granulated sugar. There was no open date or use by date on label;One unopened cardboard box of Bread Mix Puree, expiration date 4/15/26;One opened plastic squeeze bottle of Strawberry Dessert Sauce, with no open date, expiration date 5/25/26; andOne unopened plastic squeeze bottle of Kiwi Lime Dessert Sauce, expiration date 5/24/26.An observation on 6/8/26 at 3:27 PM, in the main kitchen's nourishment cooler, revealed multiple larger containers labeled with blue painter's tape. Further observation revealed these containers contained smaller individual serving-sized plastic cups of food items and the large container was labeled with the food item and preparation date. The individual cups were not labeled or dated, and there was no use-by date on the larger container, or the individual cups: One plastic container containing about 24 small individual cups of egg salad, dated 6/5/26;One plastic container containing about 24 small individual cups of cottage cheese, dated 6/8/26;One plastic container containing about 24 small individual cups of stewed prunes, dated 6/3/26;One plastic container containing about 24 small individual cups of chicken salad, dated 6/4/26; andOne plastic container containing about 24 small individual cups of dried prunes, dated 6/2/26. An observation on 6/8/26 at 4:10 PM, in the Salmonberry unit kitchen, revealed the following food items were not labeled properly, or were expired: Four packages of [NAME] Krispies cereal, expiration date 5/31/26; and One unlabeled bowl containing a malodorous liquid substance, which was undated. Home Attendant (HA) #2 was unable to identify the contents and disposed of it immediately. An observation on 6/8/26 at 4:24 PM, in the Cranberry unit kitchen, revealed the following food items that were expired:One small plastic cup labeled Cinnamon, use by 5/25;One loaf of whole wheat bread, dated 6/1/26, with a use by date of 6/7/26; andOne clear plastic resealable bag full of butter pats, with an open date of 4/2/26, and a use by date of 6/2/26.An observation on 6/8/26 at 4:24 PM, in the Cranberry unit kitchen, revealed one plastic container with green lid containing brown sugar with a scoop utensil inside the container within the sugar. During an interview on 6/11/26 at 8:38 AM, the DCNS stated the scoop utensil should not have been stored in the container with the brown sugar. An observation on 6/8/26 at 4:59 PM, in the [NAME] unit kitchen, revealed the following undated food items with no use-by date, or were expired: The following individually packaged food items had no use-by date: One plastic bag containing seven packages of sugar free syrup;One plastic bag containing nine packages of peanut butter;One plastic bag containing six packages of peanut butter;One plastic bag containing eight packages of syrup;One plastic bag containing seven packages of syrup;One plastic bag containing 17 packages of grape jelly;One plastic bag containing nine packages of honey mustard;One plastic bag full of mayonnaise packets;One plastic bag containing 36 assorted jellies; andOne plastic bag with numerous single serve dairy creamers. Food items that were expired: Five packages of Ensure Clear therapeutic nutrition, expiration date 4/1/26. During an interview on 6/8/26 at 2:52 PM, the FSS stated that opened food items should have been labeled with the date opened and expiration date, and that prepared items should have been labeled with their expiration date, or use-by date. During an interview on 6/8/26 at 3:20 PM, the DCNS stated that he did not rely on expiration dates and that he considered food to be sufficiently labeled when it contained the name of the product and the date it was prepared. He further stated that he used FATTOM [Food, Acidity, Temperature, Time, Oxygen and Moisture - a food safety acronym used to describe the six conditions bacteria need to grow] factors to determine suitability of food to be served to residents. Review of the facility policy Food Storage, Handling and Preparation, undated, revealed: . B. Potentially hazardous foods shall be labeled and dated. B.1. Refrigerated, potentially hazardous foods shall be clearly marked to indicate the name of the food, the date the food was prepared or opened, and the date by which the food must be consumed. Review of Code of Federal Regulations (CFR) 483.60(i)(2), Rev. 232, Issued 7/23/25, revealed: Store, prepare, distribute and serve food in accordance with professional standards for food service safety. CMS recognizes the U.S. Food and Drug Administration's (FDA) Food Code and the Centers for Disease Control and Prevention's CDC food safety guidance as national standards to procure, store, prepare, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	distribute, and serve food in long term care facilities in a safe and sanitary manner. Review of the FDA Food Code, dated 2022, revealed: On-premises preparation. Prepare and hold cold 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date, Marking. refrigerated, ready-to-eat, time/temperature control for safety of food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises. when held at a temperature of 41 F [Fahrenheit] or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. 3-501.18. A food. shall be discarded if it. is in a container or package that does not bear a date or day. Further review revealed FATTOM is not an FDA approved guideline. Review of the CDC Food Service Guidelines for Federal Facilities, dated 2017, revealed: . Food Safety Standards. The United States government works to protect the American public from foodborne illnesses through the collaborative efforts of HHS's [U.S. Department of Health and Human Services] Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC), and USDA's [U.S. Department of Agriculture] Food Safety and Inspection Service. FDA publishes the Food Code, which provides guidance for a uniform system of addressing food safety issues in all retail food and food service establishments, such as restaurants, cafes, and cafeterias. While not a regulation itself, the Food Code has served as the primary model for retail food regulations and ordinances at state, local, and tribal levels since the publication of the first edition in 1993. It has also served as the basis for food safety policy and recommendations of numerous federal agencies that have responsibility for the oversight of food service and retail facilities on federal property. The primary Food Safety standard in the Food Service Guidelines for Federal Facilities states that contractors operating in federal facilities are expected to adhere to the most recently published Food Code. Food Preparation Contamination An observation on 6/10/26 at 10:40 AM, in the main kitchen, revealed [NAME] #7 preparing raw chicken thighs on a stainless steel table and sheet pan using kitchen shears while wearing gloves. During the observation, [NAME] #7 stopped food preparation, walked to a speaker that was playing music, touched the speaker to turn it off while wearing the same gloves used during raw chicken preparation, then returned to the food preparation area and resumed handling raw chicken without removing the contaminated gloves or performing hand hygiene. During an interview on 6/12/26 at 10:27 AM, the DCNS stated [NAME] #7 should not have touched the speaker with contaminated gloves. The DCNS stated the expectation was for the cook to remove gloves before touching the speaker, wash hands, and put on clean gloves before returning to food preparation. During an interview on 6/11/26 at 10:10 AM, the Infection Preventionist (IP) stated the facility's infection prevention program included all departments and that new employees received infection prevention education during orientation, including hand hygiene, standard precautions, and cleaning and disinfection. The IP further stated staff were educated to use soap and water when hands were visibly soiled. Review of the facility policy Food Storage, Handling and Preparation, undated, revealed: . R.9. Wash hands:. R.9.2. Immediately before preparing food or handling equipment. R.9.3. As often as necessary during food preparation when contamination occurs. R.9.4. when you return to your work station. R.9.5. When switching between working with raw foods and working with ready-to-eat or cooked foods. R.9.8. After touching door knobs or handles. R.9.11. Any other time an unsanitary task has been performed.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to ensure: 1. The Centers for Medicare & Medicaid Services (CMS) Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, was completed with the required Quality Improvement Organization (QIO) name and toll-free telephone number before issuance for 3 residents (#18, #58, and #62), out of 3 residents who were reviewed for beneficiary notifications; and 2. The Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN), Form CMS-10055, was provided when required for 1 resident (#18), out of 3 residents who were reviewed. Instead, the facility issued an expired Advance Beneficiary Notice of Non-Coverage (ABN), Form CMS-R-131, which was retired from use by CMS on [DATE]. These failed practices had the potential to prevent residents from receiving complete and accurate information regarding their Medicare appeal rights, including the right to request an expedited QIO review before termination of covered services, and could have limited their ability to make informed decisions regarding potential financial liability. Findings: Review of the NOMNC forms for Residents #18, #58, and #62 revealed each form retained generic template language and was not completed with required specific information. The forms stated, in part: .Your provider and/or health plan determined that Medicare probably won't pay for your {insert type} services after the above date. The forms further stated: .Call your QIO at {insert QIO name and toll-free number of QIO} to appeal, or if you have questions. The facility's QIO name and toll-free contact number were not entered on any of the three NOMNC forms reviewed. Resident #18 Record review of the Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review for Residents who Received Medicare Part A Services, from 6/8-12/26, revealed Resident #18's Medicare Part A skilled services episode began on [DATE], and the last covered day of Part A service was [DATE]. Review of Resident #18's NOMNC, Form CMS-10123-NOMNC, revealed the form was signed by Resident #18 on [DATE]. The form indicated the resident's Medicare-covered services would end after [DATE]; however, the form retained the {insert type} placeholder for the Medicare service description and did not include the QIO name or toll-free number. Review of the ABN, Form CMS-R-131 (Exp[iration date]. [DATE]). revealed the ABN was signed by Resident #18 on [DATE]. The ABN form had expired before Resident #18 signed it. Review of the CMS website, accessed on [DATE] at: https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-abn, revealed SNFs .issue the ABN to transfer potential financial liability for items/services expected to be denied under Medicare Part B only . During an interview on [DATE] at 11:48 AM, the Administrator stated Resident #18 should have received the correct form, CMS-10055, instead of the expired Form CMS-R-131. The Administrator stated she had no knowledge that staff attempted to correct the error or provide the appropriate form to Resident #18. The Administrator also acknowledged the ABN form used for Resident #18 had expired prior to the date it was signed. Resident #58 Record review of the SNF Beneficiary Protection Notification Review for Residents who Received Medicare Part A Services, from 6/8-12/26, revealed Resident #58's Medicare Part A skilled services episode began on [DATE], and the last covered day of Part A service was [DATE]. Review of Resident #58's NOMNC, Form CMS-10123-NOMNC, revealed the form was signed by Resident #58 on [DATE]. The form indicated the resident's Medicare-covered services would end after [DATE]; however, the form retained the {insert type} placeholder for the Medicare service description and did not include the QIO name or toll-free number. Resident #62 Record review of the SNF Beneficiary Protection Notification Review for Residents who Received Medicare Part A Services, from 6/8-12/26, revealed Resident #62's Medicare Part A skilled services episode began on [DATE], and the last covered day of Part A service was [DATE]. Review of Resident #62's NOMNC, Form CMS-10123-NOMNC, revealed the form was signed by Resident #62 on [DATE]. The form indicated the resident's Medicare-covered services would end after [DATE]; however, the form retained the {insert type} placeholder for the Medicare (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	service description and did not include the QIO name or toll-free number. During an interview on [DATE] at 11:53 AM, the Administrator acknowledged the facility used a generic Form CMS-10123 template and stated the form should have been completed with the correct information before residents received it

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. .Based on record review, interview, and observation, the facility failed to provide adequate supervision and effective use of assistive fall-prevention devices for 2 residents (#17 and #37), out of 4 residents reviewed for fall precautions. Specifically, the facility failed to: 1) Ensure adequate supervision and effective use of an assistive fall-prevention device for resident #37, who was found on the floor following an unwitnessed fall; and2) Ensure the Smart Caregiver sensor pad monitoring system used for Residents #17 and #37 were functioning properly and set at an audible volume to alert staff. These failures resulted in Resident #37 experiencing an unwitnessed fall and placed both residents at risk for delayed staff response, falls, and fall-related injury. Findings: 1) Adequate Supervision and Effective Use of Device Record review on 6/8-12/26, revealed Resident #37 was admitted to the facility with diagnoses that included unspecified dementia (cognitive decline and memory loss), age-related osteoporosis (brittle bones), history of transient ischemic attack (a temporary blockage of blood flow to the brain, sometimes referred to as a mini stroke), and cognitive impairment. During an interview on 6/9/26 at 9:23 AM, Resident #37's Power of Attorney (POA) stated prior to the resident's admission to the facility, the resident had suffered an upper right femur fracture in January 2026. This had made the resident weak, and because of the resident's dementia, the resident was not able to participate in physical therapy, leaving the resident weak and bedbound. Resident #37 was completely dependent on staff for most things which included eating, hygiene, mobility, and toileting. Resident #37's POA further stated earlier that morning he/she received a call from the facility reporting Resident #37 was found on the floor by his/her bed. It was reported to the POA that Resident #37 was not injured. The POA further stated the resident frequently forgot he/she required assistance and had attempted to get up without assistance in the past. The POA was unsure if the resident's bed alarm was on when this happened. The POA added that Resident #37 was not a good historian and would not be able to remember and tell staff what had happened. Review of Resident #37's care plan dated 4/1/26, revealed, .Falls.Bed alarm per orders. During an interview on 6/9/26 at 9:31 AM, Licensed Nurse (LN) #1 stated he/she was there that morning and did not hear the bed alarm go off when Resident #37 fell out of bed. LN #1 stated that the resident was found on the floor by the bed. When asked how staff were alerted when the bed alarms were triggered, LN #1 stated the resident's sensor pad would alert the wireless monitor at the nurses' station. Staff were expected to hear the alert at the nurses' station and respond. An observation on 6/9/26 at 9:34 AM, revealed Resident #37 was lying on a Smart Caregiver sensor pad positioned beneath the resident's buttocks. Observation revealed the sensor pad was wirelessly connected to a remote monitoring system intended to alert staff when the resident attempted to rise from bed. An observation on 6/9/26 at 9:40 AM, revealed the Smart Caregiver monitor assigned to Resident #37 was located at the Cranberry Unit nurses' station. The monitor's volume control was set to LOW. An observation on 6/9/26 at 10:04 AM, revealed no staff were present at the nurses' station or in the immediate hallway area. Review of the facility-provided Event Report, dated 6/9/26, revealed, . found on floor next to bed. Was Fall Witnessed? No [was checked]. INTERVENTIONS - Immediate measures taken. None of Above [was checked, however, bed pad alarm was a choice, but was not checked]. The report did not identify that a bed alarm alerted staff before the resident was found on the floor. Review of nursing progress notes, dated 6/9/26 at 8:04 PM, revealed: . Around 0710 [7:10 AM], CNA [Certified Nursing Assistant] was heard asking for help . resident had a fall, unwitnessed . The facility was unable to provide evidence that Resident #37's bed alarm intervention functioned as intended or alerted staff prior to the resident being found on the floor. (2) Smart Caregiver Monitoring Device Functionality An observation on 6/11/26 at 3:30 PM, revealed two Smart Caregiver monitor/alert boxes at the Cranberry Unit nurses' station were set to the LOW volume setting. The chime volume settings were facing the back wall of the desk so that the name labels would face outward. These monitor/alert (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	boxes were labeled for Resident #17. One of the monitor/alert boxes was labeled for Resident #17's recliner and another for the resident's bed. Review of Resident #17's care plan dated 5/11/26, revealed, . Bed alarm in place per orders. During an interview and concurrent observation on 6/11/26 at 3:35 PM, CNA #1 attempted twice to activate Resident #17's recliner alarm system from the resident's room. On both attempts, the monitor located at the nurses' station failed to illuminate or sound an alert. A second CNA observed the testing and confirmed the monitor did not activate. CNA #1 then changed the batteries, but did not test it to see if it would work. During the same interview, both CNAs stated they could hear alarms only if they were near the nurses' station and did not recall receiving training regarding operation or testing of the monitoring devices. Both CNAs stated they rounded on everyone regularly. During the interview, Resident #17's bed monitor activated and emitted a faint chime. CNA #1 stated he/she could not hear the soft chime down the hallway or in another resident's room. The CNA further added that if they were turned up, they would be able to hear them. During an interview on 6/11/26 at 3:54 PM, the Facility Director (FD) stated the facility did not perform preventive maintenance on the Smart Caregiver monitoring devices and relied on staff to ensure the devices functioned properly. The FD was unable to provide the manufacturer's operating instructions for the remote monitors. Review of the Smart Caregiver Cordless Caregiver Alert Monitor Installation and Use Instructions, undated, accessed at: https://smartcaregiver.com/pages/instructionitem/chair-and-bed-alarm-with-wireless-monitor, revealed: .Test the System. Test all components before use. Smart CordLess utilize wireless technology which is subject to physical and environmental considerations. These products do not have an out of range function and as such should be tested periodically in the setting in which they are to be used to understand their area of effective operation . We recommend that all personnel receive periodic training in the operation of these systems and that the systems are tested before each use . The Smart Caregiver Corporation wireless device is designed to be installed by the end user. As such, it is the entire responsibility of the buyer to verify that Smart CordLess products are properly installed and tested successfully, before each use, in the setting in which they are to be used . The system is not designed to replace good caregiving practices including, but not limited to: A.) Direct patient supervision, B.) Adequate training for staff personnel in fall management and elopement, C.) Testing of the system before each use. Review of the facility-provided policy, Managing Falls and Fall Risk, undated, revealed: .The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner.

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	025027	A. Building B. Wing	06/12/2026

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

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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. .Based on record review, interview, and observation, the facility failed to ensure staff treated 1 resident (#39), of 14 sampled residents, with dignity and respect by honoring the resident's expressed preference for how staff announced themselves before entering the resident's room. Specifically, staff knocked on Resident #39's door despite the resident's known request that staff ring the mounted doorbell instead of knocking due to knocking being a trigger related to the resident's history of trauma and post-traumatic stress disorder (PTSD - a mental health condition that's caused by an extremely stressful or terrifying event). This failed practice had the potential to cause psychosocial harm by triggering trauma related symptoms, decreasing the resident's sense of safety, diminishing dignity, and reducing quality of life. Findings: Record review on 6/8-12/26 revealed Resident #39 was admitted to the facility with diagnoses that included PTSD and frontal lobe and executive function deficit (impaired cognitive functioning related to the area of the brain responsible for judgment, planning, organization, impulse control, problem-solving, attention, emotional regulation, and the ability to initiate and complete tasks). During an interview on 6/9/26 at 1:02 PM, Resident #39 stated that he/she had a history of trauma and PTSD and that knocking on his/her door was a known trigger. When the resident desired privacy, he/she shut the door and preferred that staff comply with a posted sign that requested staff use the mounted doorbell instead of knocking. An observation on 6/9/26 at 1:15 PM, revealed Certified Nursing Assistant (CNA) #2 approached Resident #39's room while surveyors conducted an interview with the resident. CNA #2 knocked on the resident's door and rang the mounted doorbell. CNA #2 then opened the door. Resident #39 stated, Not now, I'm busy, and CNA #2 closed the door. Further observation revealed a paper sign posted on the outside of Resident #39's door that read, Pls. [please] Ring the Bell, Don't Knock! STOP A doorbell was mounted next to the sign. During an interview on 6/11/26 at 9:50 AM, the Assistant Director of Nursing (ADON) stated all staff members received training on traumaˆinformed care and PTSD during new hire orientation. She stated that staff were aware of Resident #39's preference to use the doorbell, and her expectation was that staff honor the resident's wishes. During an interview on 6/11/26 at 11:00 AM, CNA #9 stated all staff received traumaˆinformed care training during orientation and annually. He/she further stated staff are informed about residents with PTSD and their triggers, which included the reason behind each trigger. Knocking was a known trigger for Resident #39 which would make him/her very upset, and that staff were to comply with the posted sign and use the doorbell. Review of Resident #39's care plan, initiated 4/3/26, revealed: . Problem: Resident has a potential for OR actual psychosocial well being issue d/t [due to]: hx [history] of past trauma. Approach: Encourage resident to voice concerns/feelings; provide reassurance as needed. Approach: Determine resident's expectations and discuss in realistic terms. Review of the facility policy Trauma- Informed and Culturally Competent Care, undated, revealed: . Purpose. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. All staff are provided in-service training about trauma and trauma-informed care in the context of the healthcare setting.For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. e. Empowerment, voice and choice: (1) Ensure that the resident's choices and preferences are honored and that residents are empowered to be active participants in their care.(4) Avoid one-size-fits-all approaches, which can make individuals feel discounted.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. .Based on record review, observation, and interview, the facility failed to complete all sections of the Resident Assessment Instrument 3.0 Minimum Data Set (MDS, a federally required nursing assessment for long term care residents) required to accurately make a comprehensive assessment for 1 Resident (#33), of 14 sampled residents. Specifically, the facility failed to complete Sections D (Mood), and E (Behavior) on both an annual and a quarterly MDS assessment, despite documentation in the medical record identifying mood concerns, refusal behaviors, and resident preferences. This failed practice had the potential to result in an inaccurate assessment of the resident's mood, behavioral, psychosocial, and care needs, placing the resident at risk for inconsistent or unmet care. Findings: Record review on 6/8-12/26, revealed Resident #33 was admitted to the facility with diagnoses that included a below the knee amputation of the right leg, heart failure, and hypothyroidism (a condition where the thyroid gland is underactive). Review of Resident #33's MDS Annual Comprehensive Assessment, completed on 3/16/26, revealed: Section D: Mood. Not assessed/no information.; and Section E: Behavior. Not assessed/no information. Review of Resident #33's MDS Quarterly Assessment, completed on 6/9/26, revealed: Section D: Mood. Not assessed/no information.; Section E: Behavior. Not assessed/no information. Review of Resident #33's care plan, dated 3/9/26, revealed: . [Resident #33] has the potential for depressed mood.[Resident #33]'s psychosocial well-being is impaired to having little interest/pleasure in doing things as evidenced by [him/her] self reporting. [Resident #33] has a mood state problem related to little interest/pleasure in doing things. [Resident #33] has impaired behavior related to refusal of cares that would reduce risk for skin breakdown; refusal of medications and weights. WC [wheel chair] MOBILITY: Patient Refuses. Pt [patient] declines getting out of bed. The care plan identified impaired psychosocial well-being and documented symptoms including little interest or pleasure and depressed mood. Further review revealed the resident exhibited refusal behaviors, including refusing medications and weights. The care plan included interventions directed to address these behaviors. Review of Wildflower Court- Site 001 Continuity of Care Document, goals for Resident #33, with a goal date of 9/11/26, revealed: . Resident will exhibit a decrease in the number of behavior episodes by the next review date. An observation and concurrent interview on 6/8/26 at 4:40 PM, revealed Resident #33 was lying in bed on his/her side in a hospital gown. When asked if he/she wanted to speak with this surveyor, Resident #33 agreed, answered several questions, then stated, It's not a good time to talk and proceeded to roll over onto his/her other side. The resident displayed limited engagement, had flat facial expressions, and did not participate in conversation beyond brief responses. Random observations from 6/8-12/26 revealed Resident #33 remained in bed, slept, and had minimal interactions with staff. Review of Resident #33's nursing progress note, dated 6/7/26, revealed: .Resident refused [his/her] V/S [vital signs] to be taken. Review of Resident #33's nursing progress note, dated 6/8/26, revealed: .Resident refused [his/her] medications scheduled this morning and lunchtime; offered twice; reiterated the importance of [him/her] taking [his/her] medications but resident stated, ?Not right now.' [Provider] was contacted. and updated regarding resident frequent refusal of medications. During an interview on 6/11/26 at 9:34 AM, the MDS Coordinator, who worked remotely, stated certain sections of the MDS were completed by other staff members. She reported that the Social Worker (SW) completed sections C, D, E, and Q. When asked how she ensured the accuracy of the assessment, the MDS Coordinator stated she could not verify the correctness of others' observations and relied on staff responsible for each section to complete it accurately. She further explained that the assessments needed to be backed up by the documentation in the resident's medical record such as progress notes, electronic medication administration records, and treatment administration records. During an interview on 6/11/26 at 10:12 AM, the SW confirmed she was responsible for completing sections C, D, E, and Q. She explained that she normally attempted to (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contact the resident to complete the assessment. If that was not possible, she would then complete the staff assessment sections instead. She stated that Resident #33 had been difficult to reach and that she had not spoken with the resident. Upon reviewing Resident #33's MDS assessments, the SW stated that those sections had not been completed and that it was possible the assessment dates were missed. Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, effective 10/1/25, revealed: . The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20(b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status;. (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Further review of the RAI User's Manual, Chapter 2, stated that an Item Set refers to the MDS items that are active on a particular assessment type or tracking form and that the Comprehensive (NC) [annual] Item Set and Quarterly (NQ) Item Set consists of the items active on an annual and quarterly assessment. Review of the CMS MDS 3.0 Item Matrix v1.20.1v4, dated 10/2025, revealed Section D (Mood) and Section E (Behavior) items are active on the NC-Comprehensive and NQ Quarterly Assessment item set

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. .Based on record review, observation, and interview, the facility failed to develop, implement, and revise the comprehensive person-centered care plan for 1 resident (#39) out of 14 sampled residents. Specifically, the facility failed to: 1) implement the care-planned fall prevention intervention of placing floor mats at the resident's bedside; and 2) include interventions for multiple high risk medications with fall-related side effects. These failed practices placed Resident #39 at risk for falls and fall-related injury, with the potential to negatively affect the resident's ability to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. Findings: Record review on 6/8-12/26 revealed Resident #39 was admitted to the facility with diagnoses that included osteoarthritis (a degenerative joint disease), spinal stenosis (narrowing of the spinal cord), neurosarcoidosis (inflammatory disease of the central nervous system), obstructive sleep apnea (repeated interruptions of breathing during sleep), macular degeneration (eye disease that affects and impairs central vision) and restless leg syndrome (irresistible urge to move legs). 1) Fall Mats Record review on 6/11/26 revealed Resident #39 experienced three falls since the previous recertification survey. The falls occurred on 5/13/26 at 4:24 AM, 5/19/26 at 11:45 PM, and 6/10/26 at 4:00 AM. The fall on 6/10/26 resulted in shoulder pain, and diagnostic imaging was obtained for evaluation. Review of Resident #39's care plan, initiated 5/15/26, revealed: .Resident is at risk for falls and/or fall related injury r/t [related to]: generalized weakness, limited endurance, impaired balance, unsteady gait, history of falls, and decreased vision. Start date 04/03/2026. Resident will minimize risk of fall related injuries with staff interventions thru next review date. Floor mats to sides of bed per orders. During an interview on 6/9/26 at 1:00 PM, Resident #39 stated that he/she did not currently have fall mats in place but would like them. During an interview on 6/11/26 at 9:50 AM, the Assistant Director of Nursing (ADON) stated fall mats were identified in Resident #39's care plan. The ADON further stated that orders for fall mats would be expected in the resident's order set; however, she was unable to locate fall mat orders in Resident #39's electronic medical record (EMR). During an interview on 6/12/26 at 8:28 AM, Certified Nursing Assistant (CNA) #7 stated that the Director of Nursing (DON) or the unit nurse communicated to staff when to put the mats out. CNA #7 further stated Wednesday, 6/10/26, was when staff first started using fall mats for Resident #39. During an interview on 6/12/26 at 10:37 AM, the Administrator stated the facility was aware of Resident #39's increased falls. The Administrator stated she had been involved in ongoing discussions with Resident #39 regarding his/her falls and that Resident #39 had consented to fall mats. The Administrator stated that approximately one month earlier, the facility identified it did not have enough fall mats and ordered more. The Administrator stated the fall mats had recently arrived and were implemented on the night of 6/11/26. An observation on 6/12/26 at 8:35 AM of Resident #39's room, revealed fall mats in place at the bedside. 2) Fall-Related Medication Risk Factors Review of the MDS (Minimum Data Set, a federally required assessment) last completed on 4/8/26, and current order set, revealed Resident #39 received medications in the high-risk categories: antianxiety, antidepressants, and opioids. - Diazepam (an anti-anxiety or sedative/hypnotic medication), 5 milligram (mg) tablet by mouth at bedtime for restless legs. Review of Davis's Drug Guide for Nurses, copyright 2026 revealed potential side effects for diazepam included: hypotension (low blood pressure) blurred vision, dizziness, drowsiness, lethargy (fatigue and drowsiness) and ataxia (loss of muscle coordination). Further review revealed the black box warning: .use with benzodiazepines or other CNS [Central Nervous System] depressants, including other opioids, nonbenzodiazepine sedative/hypnotic, anxiolytics, general anesthetics, muscle relaxants antipsychotics may cause profound sedation, respiratory depression, coma and death. - Escitalopram (an anti-depressant), 20mg tablet by mouth daily for depression. Review of Davis's Drug Guide for Nurses, copyright 2026 revealed potential side effects for escitalopram included: insomnia, dizziness, drowsiness, fatigue, and serotonin syndrome (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(a serious drug reaction caused by medications that build up high levels of serotonin in the body; symptoms include fast heartbeat, hallucinations, loss of coordination, twitching muscles, and/or agitation/restlessness). - Gabapentin (an analgesic) 400mg capsule by mouth three times a day for nerve pain. Review of Davis's Drug Guide for Nurses, copyright 2026 revealed potential side effects for gabapentin included: abnormal vision, ataxia (loss of muscle coordination, unsteady gait), confusion, dizziness, drowsiness, altered reflexes, sedation, vertigo (feeling of spinning or feeling off balance), and weakness. - Oxycodone (opioid narcotic pain medication) 5mg tablet - 1/2 tablet every four hours as needed for pain. Review of Davis's Drug Guide for Nurses, copyright 2026 revealed potential side effects for oxycodone included: orthostatic hypotension (a drop in blood pressure upon standing that can lead to dizziness or fainting), blurred vision, confusion, sedation, dizziness, floating feeling, and hallucinations. Further review revealed the black box warning: . use with benzodiazepines or other CNS depressants, including other opioids, nonbenzodiazepine sedative/hypnotic, anxiolytics, general anesthetics, muscle relaxants antipsychotics may cause profound sedation, respiratory depression, coma and death. Review of Resident #39's care plan revealed no interventions addressing medication related fall risk, despite documentation that Resident #39 experienced three falls within approximately one month and received multiple high-risk medications associated with dizziness, sedation, impaired coordination, and orthostatic hypotension. Review of the facility policy Managing Falls and Fall Risk - Resident-Centered Approaches to Managing Falls and Fall Risk, undated, revealed: .The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) for falls for each resident at risk for or with a history of falls. If underlying causes cannot be readily identified or corrected, staff will try various interventions based on assessment of the nature or category of falling until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable . Review of the facility policy Falls-Clinical Protocol, undated, revealed: .The physician will help identify individuals with a history of falls and risk factors for falling. The staff and practitioner will review each resident's risk factors for falling and document in the medical record. Examples for risk factors include light headedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, visual impairment, hypotension and medical conditions affecting the central nervous system. Treatment/Management. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessments of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation . Review of the facility policy Care Plan Goals and Objectives, undated, revealed: .When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goal and objectives have been established. Care plans will be modified accordingly .