STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025032	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Searhc Sitka Long Term Care	209 Moller Avenue Sitka, AK 99835

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 42377 Based on record review, observation and interview, the facility failed ensure self-administration of medication was clinically appropriate for one resident (#11), out of five residents reviewed for medication self-administration. Specifically, the facility failed to accurately assess the resident's capability for appropriateness of administering an inhaler. This failed practice had the potential to place the resident at risk of receiving incorrect medication dosages and subtherapeutic treatment of inhalants for medical conditions. Findings: Record review on 4/7-10/25 revealed Resident #11 was admitted to the facility with diagnoses that included Vascular Dementia (a condition caused by reduced blood flow to the brain, resulting in cognitive impairment) and Asthma (a respiratory condition marked by spasms in the bronchi of the lungs, causing difficulty in breathing). Record review on 4/7/25 of Resident #11's Minimum Data Set (MDS - a standardized assessment of a resident's health, function, and preferences), dated 1/28/25, revealed a Brief Interview for Mental Status (BIMS - a numerical score used to assess a person's cognitive functioning) score of 12 (8-12: Indicates moderate cognitive impairment). Review of Resident #11's medication orders revealed: Budesonide/Formoterol Fumarate (Symbicort 160-4.5 Mcg Inhaler - medication used to treat Asthma) 2 puff IH BIDNP [inhaled twice daily at noon and nightly] . Problem . Pulmonary emphysema [a chronic lung disease that permanently damages the lung's air sacs] (the resident had no active diagnosis for pulmonary emphysema). Medication Administration: An observation on 4/8/25 at 9:25 AM, revealed Licensed Nurse (LN) #2 gave Resident #11 a Budesonide/Formoterol Fumarate inhaler. Resident #11 self-administered the medication, taking three puffs in quick succession, without holding his/her breath in between puffs. LN #2 then took the inhaler away and stated: You were only supposed to take two puffs. LN #2 then exited the resident's room without having Resident #11 rinse his/her mouth with water. During an interview on 4/8/25 at 9:35 AM, when asked if Resident #11 was assessed for medication self-administration capability, LN #2 stated: Yes, [he/she] self-administers the inhaler, however I'm not sure if there was an assessment completed. (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	Assessments for Self-Administration of Medications: Review of Resident #11's Medication Self-Administration Safety Screen, dated 11/3/22, revealed: . The resident can correctly read label and/or identify each medication: unable . The resident can correctly state what each medication is for: unable . The resident can correctly state the time/frequency of medication are to be taken: unable . The resident can correctly state the correct dosage/quantity for each administration: unable . The resident can correctly administer inhalant medications according to proper procedure: unable . Review of Resident #11's Observation Tool for Self-Administration, dated 3/16/25, revealed a scoring matrix to assess whether a resident was appropriate to learn to self- administer their own medications. Further review revealed Resident #11 scored a 1 on Cognitive Skills, which indicated: Follows simple directions with 1 step prompting and encouragement. Further review revealed the rest of the assessment scored Resident #11 at mostly the highest score for: - Fine Motor Coordination: 3 - Able to pick up and/or manipulate small objects - Feeding: 3 - Fully independent - Behaviors: 3 - Reacts typically to daily life events - Vision: 3 - Normal vision with/without glasses - Communication: 3 - Communicates clearly - Colors: 3 - Constantly identifies and states color - Shapes: 3 - Constantly identifies shapes - Numbers: 3 - Understands number concepts and identifies and writes numbers - Time: 3 - Ability to tell time by clock or watch - Letters/Name: 3 - Writes name - Medication: 3 - Always takes medication well - Medication Recognition Side Effects: 1 - Able to say names of current medications, but not able to identify specific pill bottles or medication card - Side Effects: 0 - Unable to identify/understand possible side effects of current medications. From this 3/16/25 assessment the facility gave Resident #11 an . Average Score 2.3 . If Average Score is . Greater than 1.7 - Individual is appropriate to learn to self-administer to the full extent of his/her ability. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further assessment of this Observation Tool for Self-Administration had no documentation of witnessing Resident #11 manipulating his/her inhaler for appropriate use and administration of correct dosages of medication. The assessment also did not list out any medications Resident #11 was clinically cleared to self-administer. Review of the Symbicort Inhaler Quick Guide accessed at https://www.symbicorttouchpoints.com/content/dam/physician-services/us/526-rwd-symbicort-hcp/pdf/03_using_the_symbicort_inhaler.pdf, accessed on 4/10/25, revealed: . 3. Breathe out fully, then place the mouthpiece into your mouth and close your lips around it. Make sure that the inhaler is upright and that the opening of the mouthpiece is pointing towards the back of your throat. Inhale deeply and slowly while pressing down firmly on the top of the counter on the inhaler. 4. Continue to breathe in and hold your breath for about 10 seconds, or for as long as comfortable. Before you breathe out, release your finger from the top of the counter. Keep the inhaler upright and remove from your mouth. For your second puff, shake the SYMBICORT inhaler again for 5 seconds and repeat steps 3 and 4. After you finish taking SYMBICORT (two puffs), rinse your mouth with water.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 51615 Based on record review, observation and interview, the facility failed to revise the comprehensive care plans to include medication self-administration for two residents (#s 3 and 11), out of 5 residents reviewed for medication self-administration. This failed practice placed the residents at risk for not receiving appropriate care and services. Findings: Resident #3 Record review on 4/7-10/25 revealed Resident #3 was admitted to the facility with diagnoses that included Chronic Kidney Disease (a long-term condition where the kidneys do not work effectively), Anemia (a condition marked by a deficiency of red blood cells), and Cerebrovascular Disease (a group of conditions that affect blood flow and the blood vessels in the brain). Record review on 4/8/25 of Resident #3's medication orders found: Clotrimazole External Cream 1% . Apply to affected area topically two times a day. An observation on 4/8/25 at 9:40 AM, LN #4 asked Resident #3 if he/she had applied medical cream to his/her groin. Resident #3 stated that he/she had done it earlier in the morning. LN #4 then administered Resident #3's PO (by mouth) medications and exited his/her room. During an interview on 4/8/25 at 9:40 AM, when asked if Resident #3 was assessed for medication self-administration capability, Licensed Nurse (LN) #4 stated: We let [him/her] apply the medication on [his/her] own, because it is in a private area, and [he/she] would rather do it [himself/herself]. Review of Resident #3's care plan on 4/7/25 revealed no plan for medication self-administration. Resident #11 Record review on 4/7-10/25 revealed Resident #11 was admitted to the facility with diagnoses that included Vascular Dementia (a condition caused by reduced blood flow to the brain, resulting in cognitive impairment) and Asthma (a respiratory condition marked by spasms in the bronchi of the lungs, causing difficulty in breathing). Record review on 4/7/25 of Resident #11's medication orders revealed: Budesonide/Formoterol Fumarate (Symbicort 160-4.5 Mcg Inhaler) 2 puff IH BIDNP [inhaled twice daily at noon and nightly] . Problem . Pulmonary emphysema. An observation on 4/8/25 at 9:25 AM, revealed LN #2 gave Resident #11 a Budesonide/Formoterol Fumarate (medication used to treat Asthma) inhaler. Resident #11 self-administered the medication, taking three puffs in quick succession, without holding his/her breath in between puffs. LN #2 then took the inhaler away and stated: You were only supposed to take two puffs. LN #2 then exited the resident's room without having Resident #11 rinse his/her mouth with water. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/25 at 9:35 AM, when asked if Resident #11 was assessed for medication self-administration capability, LN #2 stated: Yes, [he/she] self-administers the inhaler. Review of Resident #11's care plan on 4/7/25 revealed no plan for medication self-administration. During an interview on 4/9/25 at 1:20 PM, when asked if a resident's care plan should include a plan for self-administering medications if they have been approved to self-administer, the Minimum Data Set (MDS) Nurse stated, Yes.

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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** 50031 Based on record review, observation, and interview, the facility failed to provide adequate supervision to ensure the environment remains as free of accident hazards as is possible for one resident (#16) out of six residents who attended an activity. Specifically, the facility failed to ensure Resident #16 had limited opportunity to access an unsafe equipment for cutting his/her hospital wrist band off during a baking activity. This failed practice placed the resident at risk of self-harm and a potential of harming other residents. Findings: Record review on 4/7-10/25, revealed Resident #16 was admitted to the facility on [DATE] with diagnoses that included Parkinson's (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination) disease with dyskinesia (involuntary movement disorder) and low back pain. Further review revealed Resident #16 was diagnosed with Post-Traumatic Stress Disorder (PTSD) on 3/5/25. Review of Resident #16's Pre-Admission Screening and Resident Review (PASRR) Level 1, dated 11/22/24, revealed: . Functional and Adaptive Needs . Harmful to Self or Others . suicidal ideation/attempt past history . Review of Resident #16's, Brief Interview for Mental Status (BIMS), dated 1/14/25 revealed; . Score: 11, Category: Moderately Impaired [difficulty with cognitive task and may require assistance with activities of daily living] . Mood and Behavior: Review of the Physician Progress Note, dated 2/11/25, revealed: . Depression and PTSD related to military service . I will still place a referral to behavioral health. Review of the Behavior Note, dated 2/20/25, revealed resident stated, they are going to kill me. Review of the Behavior Note, dated 2/21/25, revealed: Resident reporting to staff and other residents during a resident council meeting, 'Somone with a gun was shooting at our building last night and security came to my room and asked if I was alright.' . Attempts to reorientation [Resident #16] was successful with the announcement of BINGO was starting. Review of the Behavior Note, dated 3/4/25, revealed: [Resident #16] requested to lay down in bed. Once resident entered [his/her] room [he/she] began yelling at the female staff members, calling them crude names . Resident transferred to bed and attempted [to] hit a female staff member. The resident's agitation continued to increase even with staff's attempts to calm . Son notified and advised staff to take [him/her] to the ED [emergency room] if agitations continues . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Behavior Note, dated 3/5/25, revealed Resident #16 grabbed staff wrist and would not let go when asked. Resident #16 was yelling at staff and agitated. Review of the Physician Progress Note, dated 3/6/25, revealed: Chief Complaint: Parkinson's dementia and PTSD with increasing agitation and paranoia . Apparently has a history of 'going into blind rages' related to PTSD. According to [his/her] son . I was asked to see [him/her] today because of multiple daily outbursts of agitation or otherwise inappropriate behavior such as climbing out of [his/her] bed . [he/she] complains of the sitter outside of [his/her] room . [Resident #16] states as far as the food and [his/her] medications 'I feel like it is doing something to me' that staff here is trying to poison [him/her] . Record review on 4/7-10/25, Nurse Note, dated 3/23/25, revealed: . [he/she] became very agitated . grabbing at staff with nails digging into their skin . verbally abusive [with staff] . An observation in the resident dining room on 4/7/25 at 12:40 PM, revealed Resident #16 stated Don't let them take me, they will lock me up. Resident #16 looked over at the Director of Nursing (DON) during his/her statement. Certified Nurse Assistant (CNA) #1 approached Resident #16 and Resident #16 followed CNA #1 and left the area. Review of the Resident #16's care plan, LTC [Long Term Care] (PTSD) Post Traumatic Stress Disorder, dated 3/17/25 at 2:22 PM, revealed: Administer medications as ordered. Monitor/document for side effects and effectiveness. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Give the resident as many choices as possible about care and activities. Monitor every shift. Document observed behavior and attempted interventions in behavior log. Monitor/document/report PRN any s/sx [signs and symptoms] of resident posing danger to self and others. [Resident #16] triggers for physical aggression are telling [Resident #16] 'no' without allowing [Resident #16] time to process the reasoning, medications changes. [Resident #16's] behaviors is [are] deescalated by provided phone time with [his/her] family, outings with family, anti-anxiety medication. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Medication: Review on 4/10/25 of the eMAR [electronic medication administration record] Administration Report, revealed on: 4/6/25, .Lorazepam 2mg/Ml Inj 0.25 ML . PRN [as needed] Reason: Agitation Label Comments: DOSE = 0.5MG = 0.25ML. GIVE IF UNABLE TO GIVE PO [by mouth].Lorazepam 0.5 mg tab . dose 0.5mg PO . PRN Reason: Agitation Label Comments: ATTEMPT PO FIRST BEFORE GIVING IM [intramuscular] . no doses were provided. 4/7/25, .Lorazepam 2mg/Ml Inj 0.25 ML . PRN Reason: Agitation Label Comments: DOSE = 0.5MG = 0.25ML. GIVE IF UNABLE TO GIVE PO.Lorazepam 0.5 mg tab . dose 0.5mg PO . PRN Reason: Agitation Label Comments: ATTEMPT PO FIRST BEFORE GIVING IM . no doses were provided. Incident: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's documentation of the Group Baking Social, dated 4/7/25, revealed Resident #'s 4, 6, 9, 11, 14 and16 attended the baking activity. During a joint interview on 4/7/25 at 4:35 PM, Activities Aide (AA), DON, Social Worker (SW) and Administrator stated from 1:30-3:00 PM a baking activity was conducted with the residents. The AA stated during the activity Resident #16 requested to have his/her hospital wrist band removed that had been placed on 4/3/25 at his/her emergency room (ER) visit. The AA further stated the DON approached Resident #16 to cut off the wrist band and Resident #16 grabbed the scissors from the DON. The AA stated Resident #16 threatened to harm himself with the scissors. The AA further stated a code grey was activated quietly since Resident #16 does not do well with a lot of people. The AA stated the hospital security department, police department, and emergency medical services (EMS) were notified of the incident as well. The AA stated the staff tried to deescalate the resident but were unsuccessful. When asked what the de-escalation techniques were used, AA stated we asked the resident to return the scissors. The AA further stated the residents in attendance of the activity were removed from the unit kitchen. The SW and Administrator stayed with Resident #16 while the AA assisted in taking other residents out of the room. During the same interview, the DON was asked about the surveyors' observations upon entrance of Resident #16 agitation and paranoia of being locked up and behaviors increased as the DON approached the resident. The DON stated Resident #16 had PTSD with delirium and when [he/she] gets in these states we try to remove [him/her] from others. The DON was asked if the resident was appropriate for the activity related to his/her observed behaviors that day. The DON stated, sometimes activities calm [him or her] down, [he/she] does like outings. When the DON was asked if she had any concern with Resident #16 being around other residents with the observed agitation and paranoia, the DON stated, it was just [AA] and residents but when I came into the room I noticed [Resident #16] backing up. When the DON was asked if Resident #16 was triggered when she approached, the DON stated, yes [he/she] gets aggressive with me. When the DON was asked if Resident #16 had had any prior episodes of being a danger to self or others, the DON stated, [Resident #16] became delusional, aggressive and threatened staff stated 'I am going to kill you. The DON stated the event happened in February 2025. The DON stated after the incident the provider was notified, and a behavioral health referral was requested. The DON further stated the facility was still learning the triggers of Resident #16's PTSD. When the DON was asked why the scissors were provided to Resident #16, the DON stated she had noticed Resident #16 was still wearing the hospital identification band from 4/3/25 ER visit and was pulling on it. The DON then asked Resident #16 if he/she wanted the ID band removed and Resident #16 stated I want it off. The DON further stated she went to her office and retrieved her desk scissors. The DON stated she approached Resident #16 to remove the ID band and had her fingers in the loops of the handle. The DON stated, Resident #16 grabbed the scissors from the pointed end and opened the blades of the scissors. The DON stated she released the scissors because she did not want Resident #16 to get hurt. The DON further stated Resident #16 pressed the open blades against his/her chest. The Administrator stated [Resident #16] will have scratches from them (scissors). The Administrator further stated the more she talked with Resident #16, the more he/she pushed the Administrator away with use of his/her elbows. The Administrator stated during this time Resident #16 continued making threats he/she wanted to kill his/herself. When the Administrator was asked how long the event took place, she stated from 2:30 to 3:45 PM. The Administrator stated the police were finally able to remove the scissors after they took Resident #16 down to the ground and EMS took Resident #16 to the ER for an evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 4/9/25 at 3:03 PM, with the DON and Minimum Data Set (MDS) Nurse, when asked about 4/7/25 incident with Resident #16, the MDS stated she asked Resident #16 for the scissors, but he/she wouldn't release them and continued to be agitated. The MDS Nurse stated the AA had a good relationship with Resident #16 but too, was unable to get Resident #16 to return the scissors. During the same interview, the DON was asked why the decision was made to remove the ID band during the baking activity. The DON stated Resident #16 wanted it removed and stated, I probably didn't make the best choice. When the DON was further asked why safety scissors were not used instead of desk scissors with a pointed end, the DON stated none were available. emergency room Visit: Record review on 4/10/25, Emergency Department Note, dated 4/7/25, revealed: . Delirium due to medical condition with behavioral disturbance . Presented with concerns for attempted self-harm with scissors . 1:1 sitter, suicide precautions .admitted as Inpatient . Chief Complaint: Psychiatric Symptoms . Review of the facility's policy Difficult behavior management, long-term care, dated 2/23/25, revealed: . Confirm your willingness to work with the resident . Ask the resident what you can do to make the situation better. Be alert for signs of escalating behavior . agitation .