STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025034	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Valdez Medical Center	911 Meals Avenue Valdez, AK 99686

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42377 Based on record review, observation, and interview, the facility failed to ensure one resident (#5) out of seven sampled residents was provided care in a manner that promoted dignity and respect. This failed practice placed the resident at risk of poor self-esteem and/or self-worth and a potential for poor quality of life. Findings: Record review on 3/3-6/25, revealed Resident #5 was admitted to the facility with diagnoses that included dementia (a decline in cognitive abilities), muscle weakness of right upper extremity, impaired ability to follow simple direction, and decreased functional mobility. Review of the Minimum Data Set (MDS- a federally required nursing assessment) Annual Assessment, dated 2/7/25, revealed in Section C- Cognitive Patterns C0100. Should Brief Interview of Mental Status be conducted? . the marked response was 0. No (resident is rarely/never understood). An observation on 3/5/25 at 9:54 AM, revealed Licensed Nurse (LN) #2 after the medication preparation at the nurses' station, the LN went to Resident #5's room. While LN #2 was outside the door with the door slightly opened, LN #2 asked the Certified Nurse Assistant (CNA) #2, who was inside the room, if Resident #5 was ready for medication administration. CNA #2 replied that Resident #5 was not yet ready. Since the Resident was not yet ready, LN #2 stated to the surveyor that he/she could keep the prepared medication in a locked cabinet inside the Resident's room. An observation on 3/5/25 at 9:55 AM revealed LN #2 opened the door and entered Resident #5's room followed by the surveyor. While in the room, it was observed that Resident #5 was out of the bathroom, seated in a shower chair naked with a towel on his/her back and a wet Hoyer (a lift device) sling underneath the Resident. Further observation revealed there were two CNAs inside the room. One male CNA (#1) and one female CNA (#2). An observation on 3/5/25 at 9:56 AM revealed LN #2 approached Resident #5 who was still seated in a shower chair, naked. The LN stated that he/she would administer the medication and gave the medication to the Resident. Then, LN #2 left the room. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same observation, while Resident #5 was still naked, exposing his/her anterior (front side) body, the CNAs transferred him/her to bed through the use of a mechanical lift. The Resident was laid in bed, anterior body still exposed. The CNAs inserted chucks (an absorbent pad) underneath Resident #5 by turning him/her from side to side. CNA #2 wiped the Resident's buttocks and applied cream to the skin. Then, both CNAs helped the Resident put on his/her brief, shirt, socks and pants. During a joint interview on 3/5/25 at 2:59 PM, when asked about the process on providing a shower to a resident, CNA #2 stated that one CNA would provide the shower and one CNA would prepare the bed, apply cream to the resident's skin, and would help the resident put on his/her clothes. When asked how the CNAs ensure that privacy was provided to the resident after shower, CNA #1 stated the door was kept closed, window blinds were kept closed, and when somebody knocked at the door, the CNAs would make sure the resident was covered with blankets so the person at the door would not see the resident naked. During the same joint interview, CNA #1 stated the expectation was to provide warm blanket after shower, especially when transporting the resident from the tub room (a shared tub room located outside the residents' room) to the resident's room. CNA #1 stated Resident #5 showered in his/her own bathroom inside his/her room. CNA #1 further stated the CNAs should have covered Resident #5 with a towel. During an interview on 3/6/25 at 3:23 PM, the Clinical Director (CD) stated, each individual was provided care according to resident's preference. When asked the expectation for CNAs in providing resident's privacy after shower, the CD stated if the resident was from the tub room, the resident would be covered up and kept warm while being escorted to the resident's room. The CD further stated if the resident had showered in their own room, the resident should have been covered and toweled down because the room was heated. Then, the resident should have been transferred to their bed quickly and made the resident comfortable. When asked if the resident should have been covered, the CD stated it was not mandatory, as long as the CNAs could transfer the resident as quickly as possible. When asked if the CD was agreeable that the resident should have been covered during the medication administration, with the presence of a male and female CNAs in the room, the CD agreed that the resident should have been covered. The CD further stated: It is not the best practice; we could have done better. Review of the facility's policy titled: Activities of Daily Living, dated 11/2023, revealed: PURPOSE/SCOPE To provide for the basic needs and promote dignity and well being of all Long Term Care Residents. Review of the facility's admission packet, that contained a document titled: THE RESIDENT'S BILL OF RIGHTS, dated 1/2021, revealed: As a Resident, you have the Right to receive notices orally or in writing. any of the following information.To personal privacy of not only your own personal body, but also of your personal space, including accommodations and personal care.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 51615 Based on record review and interview, the facility failed to ensure physicians consistently assessed residents in person at least once every 60 days for all residents (based on a census of 7). This failed practice placed all residents at risk for delayed identification of changes in medical condition and unmet medical care needs. Findings: Record review on 3/5/25 at 10:00 AM of the facility's Physician Visits Non-compliance Flowsheets, undated, revealed multiple instances where residents exceeded the 60-day interval between physician visits: Resident #1 had a gap of 73 days between physician visits (7/9/24 to 9/20/24) and another gap of 109 days between physician visits (9/20/24 to 1/7/25). Resident #2 had a gap of 128 days between physician visits (7/9/24 to 11/14/24). Resident #3 had a gap of 104 days between physician visits (10/23/24 to 2/4/25). Resident #4 had a gap of 368 days between physician visits (12/1/23 to 12/4/24). Resident #5 had a gap of 75 days between physician visits (8/22/24 to 11/5/24) and another gap of 71 days between physician visits (12/25/24 to 3/5/25). Resident #7 had a gap of 97 days between physician visits (7/31/24 to 11/5/24). Resident #8 had a gap of 82 days between physician visits (11/14/24 to 2/4/25). During an interview on 3/6/25 at 1:03 PM, the Long-Term Care Manager (LTCM) stated, Tracking physician visits has been a significant challenge. Nurses keep logs, but there's no reliable system for follow-up if physicians miss appointments. The LTCM further explained, We created the flowsheet because we knew it was a problem. However, even with the flowsheet, some residents are still not being seen timely because physicians rely on us for reminders, and sometimes those reminders aren't communicated effectively. During an interview on 3/6/25 at 2:00 PM, the Medical Director (MD) stated: I depend on my staff to keep track. I don't have time or a way to track that myself. The MD further explained, If someone misses a visit, the nursing staff or medical records department usually reminds us. But the system doesn't always work, especially if physicians are on vacation or busy. During the same interview, the MD acknowledged awareness of missed visits, stating, I'm probably one of the people who missed visits, especially when I'm busy or on vacation. Review of the facility's policy titled: Physician's Visits in Long Term Care, effective date 11/2023, revealed: (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Long Term Care staff will make appointments with the Primary Care Clinic for physicians to see residents in Long Term Care. The Team Leader on duty on day of the appointment is responsible for notifying Physician's office staff of missed appointments promptly and rescheduling if necessary. Notify LTC Manager of any barriers to make these appointments.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 51615 Based on observation and interview, the facility failed to ensure daily nurse staffing information posted in the facility was maintained for 18 months. This failed practice had the potential to provide limited transparency regarding staffing levels, affecting all residents (based on a census of 7 residents) and visitors' ability to evaluate the adequacy of nursing care provided. Findings: An observation on 3/6/25 at 12:45 PM revealed the facility had a staffing board posted that displayed the facility name, current date, total number and actual hours worked by staff, and resident census. During an interview on 3/6/25 at 12:45 PM, when asked where the previous 18 months of staffing information was located, the Long-Term Care Manager (LTCM) responded: We don't take pictures of the staffing board every day. When asked if the facility retained records of previously posted staffing information, the LTCM said: We do not . we didn't know it was required.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42377 Based on observation, record review, and interview, the facility failed to ensure correct medication labeling for two residents (#s 5 and 7) out of seven sampled residents. Specifically, the facility failed to ensure: 1) medications were labeled according to physician's order and 2) contained an expiration date. These failed practices placed all residents at risk of adverse effects and complications from receiving incorrect dosage and an expired medication. Findings: Medication Labelling: a. Glipizide tablet (a diabetes medicine that helps control blood sugar levels) An observation on [DATE] at 12:26 PM revealed during the medication preparation for Resident #7, one pack of Glipizide tablet 10 mg was labelled three times daily with meals. Record review of the medication administration record (MAR) on [DATE] revealed Glipizide tablet 10 mg was to be administered two times daily before meals. Review of the physician's order, dated [DATE], revealed GlipiZIDE (GLUCOTROL) Tablet 10 mg, Frequency: 2 TIMES DAILY BEFORE MEALS. During an interview on [DATE] at 2:49 PM, Licensed Nurse (LN) #1 stated the label for Glipizide 10 mg should have been changed by the pharmacist to one tablet twice a day before meals. b. Famotidine tablet (a medicine that reduces stomach acid) An observation and concurrent interview on [DATE] at 9:32 AM, at the nurses' station, during the medication preparation for Resident #5, LN #2 prepared Famotidine 20 mg morning dose because the evening dose was on hold. Record review of the MAR on [DATE], revealed Famotidine 20 mg one tablet every evening was on hold. During the same observation, a pack of Famotidine 20 mg label read: take 1 tablet by mouth every evening, dated [DATE]. Further observation of the label revealed a time: 0900, handwritten in black marker. LN #2 stated the label should have been changed. LN #2 further stated he/she would contact the pharmacist to provide the correct label. Review of the physician's order, dated [DATE], revealed: famotidine (PEPCID) tablet 20 mg DAILY. evening dose on hold. No order for the morning dose. During a follow-up interview and observation on [DATE] at 12:34 PM, LN #2 stated the label had been changed [by showing the new label] and the physician's order was changed to daily. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:37 PM, the Clinical Director (CD) stated that the facility had been struggling with the pharmacy provider, the way the pharmacy had packaged the medication was not ideal. Expired medication: An observation on [DATE] at 12:26 PM, during the medication preparation for Resident #7, revealed one bottle of Cholicalciferol (Vitamin D) capsule 5,000 units had no expiration date. During an interview on [DATE] at 2:43 PM, LN #1 stated the expiration date on the Cholicalciferol capsule [Vitamin D] 5,000 units was erased because the nurses had been using Avagard (alcohol-based hand sanitizer) during medication preparation. When asked how he/she would determine that the medication was not expired, LN #1 stated he/she knew the expiration date was printed in the label before and the nurses checked the expiration date of the medications monthly. Review of the facility's policy titled: Labeling Standards for Medications and Chemicals, dated ,d+[DATE], revealed: . ensure all medication containers are labeled to i[e]nsure safe and effective patient care. Medication label must be clear, consistent, legible and in compliance with state and federal requirements . Dispensing label requirements.the label also includes .g. directions for use and any applicable accessory label.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 51615 Based on observation, interview, and record review, the facility failed to ensure one resident (#3) out of seven sampled residents, with a known food allergy, received a diet free of identified allergens. Specifically, the facility failed to verify ingredients in a newly introduced menu item, resulting in Resident #3 being served and consuming pineapple, an identified allergen. This failed practice placed Resident #3 at risk for allergic reactions and adverse health outcomes. Findings: An observation on 3/5/25 at 1:10 PM revealed [NAME] #3 approached Licensed Nurse (LN) #2, stating Resident #3 had eaten a sweet and sour sauce containing pineapple and that Resident #3 had an allergy to pineapple. During an interview on 3/5/25 at 2:30 PM, when asked if he/she had consumed pineapple at lunch, Resident #3 confirmed, I could taste pineapple in the food I ate at lunch. During an interview on 3/5/25 at 2:10 PM, the Kitchen Manager (KM) stated, We have a KARDEX (paper card containing concise, easily accessible patient care information) card for all the residents, which contains food allergy information. The KM further explained, Before plating a resident's meal, we check the KARDEX to ensure residents are not given food which contains allergens. The KM further stated, Because we are using a new menu, the sweet and sour sauce we used is new to me, and I was unaware it contained pineapple. Review of the sweet and sour sauce ingredient list revealed: .Ingredients.Pineapple. Review of Resident #3's dietary KARDEX, undated, revealed, .Allergies: Pineapple. Review of the facility policy titled: Cycle Menu, effective date 6/2023, revealed: Food and Nutrition Services will accommodate resident allergies, intolerances, and preferences.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 42377 Based on record review and interview, the facility failed to ensure the Medical Director(MD) fulfilled responsibilities for oversight and coordination of medical care in the facility. Specifically, the MD did not provide adequate oversight to ensure physician compliance with required visits. This failed practice placed residents at risk for unmet medical needs, delayed medical treatment, and diminished quality of care. Findings: Review of the facility's document titled Description of Medical Director Duties, undated, revealed: .Duties and Responsibilities: .The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility. Medical director responsibilities must include their participation in: Administrative decisions including recommending, developing and approving facility policies related to residents' care. Resident care includes the resident's physical, mental and psychosocial well-being; Issues related to the coordination of medical care identified through the facility's quality assessment and assurance committee and other activities related to the coordination of care; Organizing and coordinating physician services and services provided by other professionals as they relate to resident care; Participate in the Quality Assessment and Assurance (QAA) committee or assign a designee to represent him/her. Review of the facility's policy titled Physician's Visits in Long Term Care [LTC], effective date 11/2023, revealed: Residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Long Term Care staff will make appointments with the Primary Care Clinic for physicians to see residents in Long Term Care. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Team Leader on duty on day of the appointment is responsible for notifying Physician's office staff of missed appointments promptly and rescheduling if necessary. Notify LTC Manager of any barriers to make these appointments. Review on 3/5/25 at 1:00 PM of the facility's Physician Visits Non-compliance Flowsheets, undated, revealed multiple instances where residents exceeded the 60-day interval between physician visits: Resident #1 had a gap of 73 days between physician visits (7/9/24 to 9/20/24) and another gap of 109 days between physician visits (9/20/24 to 1/7/25). Resident #2 had a gap of 128 days between physician visits (7/9/24 to 11/14/24). Resident #3 had a gap of 104 days between physician visits (10/23/24 to 2/4/25). Resident #4 had a gap of 368 days between physician visits (12/1/23 to 12/4/24). Resident #5 had a gap of 75 days between physician visits (8/22/24 to 11/5/24) and another gap of 71 days between physician visits (12/25/24 to 3/5/25). Resident #7 had a gap of 97 days between physician visits (7/31/24 to 11/5/24). Resident #8 had a gap of 82 days between physician visits (11/14/24 to 2/4/25). During an interview with the MD on 3/6/25 at 2:00 PM, when asked how the MD ensured compliance with physician visits, she stated, I depend on my staff to keep track. I don't have time or a way to keep track of that. She further stated, .Obviously it's all going to hell in a hand basket, but it can't be just me. During an interview on 3/6/25 at 4:31 PM, when asked about the MD participation in the QAPI (Quality Assurance and Performance Improvement) meetings, the Regional Quality Manager (RQM) stated: The Medical Director doesn't bring up issues to QAPI; she listens and asks questions. During the same interview, when informed about physician's noncompliance with visits, including one resident who had not received a physician visit in over a year, the RQM stated: I didn't know about that, but I agree-this issue would be ideally addressed in QAPI. I'll put it on my radar to ensure more accountability and ownership by the Medical Director.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 42377 . Based on record review and interview, the facility failed to ensure the medical record included documentation of the education provided to the resident or resident representative (RR) regarding the Influenza and Pneumococcal immunizations benefits and potential side effects before signing or declining the vaccine administration for five residents (#s 3; 4; 5; 7; and 8) out of five residents reviewed. This failed practice had the potential to affect all residents (based on census of seven) who were residing in the facility. Findings: Record review on 3/6/25 at 4:00 PM of the facility's list of residents' immunization information, untitled and undated, revealed the following Residents received immunizations: Resident #3 received Influenza immunization on 10/28/24 and Pneumococcal 20 immunization on 11/21/24. Resident #5 received Influenza immunization on 10/28/24. Resident #7 received Influenza immunization on 10/28/24. Resident #8 received Influenza immunization on 10/28/24. Further review of the list revealed Resident #4 declined Influenza immunization (no date). Review of the nurse's progress notes, dated 10/15/24, revealed Resident #4's representative declined influenza immunization for him/her on 10/11/24. Review on 3/3-6/25 of all the Residents' electronic health record (EHR), revealed no documentation that Residents #3, #4, #5, #7 and #8 or their RRs were provided education of the benefits and potential side effects of the vaccines before offering the Influenza and Pneumococcal immunizations. During an interview on 3/6/25 at 4:10 PM, the Long-Term Care Manager (LTCM) stated the residents' vaccination was scheduled with the State of Alaska Public Health (SOAPH). When asked if education was provided to the residents, she stated the facility asked the residents and/or RRs for immunization consent and the SOAPH provided the education before administration of vaccination. When asked if the education provided to the residents and/or RRs was documented, the LTCM showed the SOAPH vaccination documents of Residents #3; #5; #7; and #8 and stated according to SOAPH, the vaccination record would show that the immunization was given and that indicate that education was provided. The LTCM also stated that Resident #4's RR declined immunization for him/her. The LTCM further stated there was no education documentation provided to Resident #4's RR. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/25 at 5:14 PM, the Clinical Director (CD) stated that staff were educating the residents and their POA (Power of Attorney) before offering the vaccination, but that was not documented. Review of the facility's PVEC[unknown acronym] Pneumococcal, COVID-19, RSV [Respiratory Syncytial Virus] & Influenza Vaccination, dated 12/2024, revealed: PURPOSE/SCOPE All Long Term Care .residents, regardless of age and/or medical condition, will be offered vaccination when clinically indicated/recommended by the US Centers for Disease Control & Prevention (CDC), unless it is contraindicated or otherwise declined by the physician, or resident' legal representative. Education will be provided to all residents & resident's legal representative regarding individual vaccination risks and benefits.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 42377 . Based on record review and interview, the facility failed to ensure the medical record included documentation of education provided to the resident or resident representative (RR) regarding the COVID-19 immunization benefits and potential side effects before signing or declining the vaccine administration for four residents (#s 3; 4; 5; and 7) out of five residents reviewed. This failed practice had the potential to affect all residents (based on census of seven) who were residing in the facility. Findings: Record review on 3/6/25 at 4:00 PM of facility's list of residents' immunization information, undated, revealed the following residents received immunization: Resident #3 received COVID-19 immunizations on 6/3/24 and 10/28/24. Resident #5 received COVID-19 immunizations on 6/3/24 and 10/28/24; and Resident #7 received COVID-19 immunizations on 6/3/24 and 10/28/24. Further review of the list revealed Resident #4 declined COVID-19 immunization (no date). Review of the nurse's progress notes, dated 10/15/24, revealed Resident #4's RR declined COVID-19 immunization for him/her on 10/11/24. Review on 3/3-6/25 of the residents' electronic health record (EHR), revealed no documentation that Residents #3, #4, #5, and #7 or their RRs were provided education of the benefits and potential side effects of the vaccines before offering COVID-19 immunization. During an interview on 3/6/25 at 4:10 PM, the Long-Term Care Manager (LTCM) stated the residents' vaccination was scheduled with the State of Alaska Public Health (SOAPH). When asked if education was provided to the residents, she stated the facility asked the resident or RR for immunization consent and the SOAPH provided the education before administration of vaccination. When asked if the education provided to the resident and RR was documented, the LTCM showed the SOAPH vaccination documents of Residents #3; #5; and #7 and stated according to SOAPH, the vaccination record would show that the immunization was given and that would indicate education was provided. The LTCM also stated that Resident #4's RR declined COVID-19 immunization for him/her. LTCM further stated there was no education documentation provided to Resident #4's RR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025034	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Valdez Medical Center	911 Meals Avenue Valdez, AK 99686

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/25 at 5:14 PM, the Clinical Director (CD) stated that staff were educating the residents and their POA (Power of Attorney) before offering the vaccination, but that it was not documented. Review of the facility's PVEC[unknown acronym] Pneumococcal, COVID-19, RSV [Respiratory Syncytial Virus] & Influenza Vaccination, dated 12/2024, revealed: PURPOSE/SCOPE All Long Term Care .residents, regardless of age and/or medical condition, will be offered vaccination when clinically indicated/recommended by the US Centers for Disease Control & Prevention (CDC), unless it is contraindicated or otherwise declined by the physician, or resident' legal representative. Education will be provided to all residents & resident's legal representative regarding individual vaccination risks and benefits.