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	05/15/2026

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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review, observation, and interview, the facility failed to implement its abuse prevention screening process to ensure an employee with regular resident contact maintained a valid State of Alaska background check clearance before continuing to work in the facility. Specifically, the facility failed to ensure an individual who had direct contact with residents had a valid criminal history check conducted under 7 Alaska Administrative Code (AAC) 10.900-10.990. This resulted in 1 employee working (Assistant #3) at the facility without valid clearance from the Alaska Background Check program. This failed practice placed all residents (based on a census of 9) at risk for abuse, neglect or exploitation. Findings:Review of the State of Alaska background check clearance letter for Assistant #3, dated [DATE], revealed: .The Background Check Program has completed the background check for [Assistant #3] and the individual has been issued an Eligible Determination for association with Providence Health & Services Alaska (Main). The determination is valid from [DATE] to [DATE]. Review of two email correspondences sent from the State of Alaska Background Check Unit to the facility, sent on [DATE] and again on [DATE], revealed: The following individual(s) need a new background check within the next 0-60 days:. Provider: Providence Health & Services Alaska (Main). Applicant Name: [Assistant #3]. New Background Check Needed by: [DATE]. Review of the New Alaska Background Check System (NABCS) website revealed that a new background check application for Assistant #3 was started on [DATE], the day after Assistant #3's background check expired. The status of the application showed Assistant #3 was provisionally hired (meaning allowed to work until the background check application was completed) on [DATE]. Review of payroll records provided by the facility revealed that Assistant #3 worked a total of 164.38 hours from [DATE]-[DATE] without a valid background check. An observation on [DATE] at 5:02 PM, kitchen staff brought up the dinner meal from the facility's main kitchen to the Long-Term Care (LTC) unit for the LTC residents. Further observation revealed six residents (#'s 2, 4, 6, 7, 8, and 9) were at the dining room table for the meal. Three residents were in their rooms (#'s 1, 3, and 5). Further observation revealed the kitchen staff served meals to the residents at the table, as well as hand delivered trays of dinner to each resident who was in their room. An observation on [DATE] at 12: 35 PM, revealed kitchen staff hand delivered the lunch meal to Resident #1, who was in his/her room. During an interview on [DATE] at 11:33 AM, when asked what his/her job entailed, Assistant #3 stated that he/she helped prep and cook resident meals and also served lunch and dinner in person to the LTC residents on the unit. During an interview on [DATE] at 3:22 PM, the Human Resource Regulatory Assurance Analyst (HRRAA) stated that a system log was maintained with background check application numbers and expiration dates. Monthly audits were conducted to identify employees within 90 to 100 days of expiration. Renewal requests were then initiated for employees to complete new fingerprints, which were submitted to the state background check program. The Chief Administrative Officer added that the state background check process took a long time to complete. Review of the facility-provided policy Resident/Patient Abuse, Neglect and Exploitation, dated 12/2024, revealed: . All staff will be screened for records of reported abuse prior to hiring. Documentation will be kept in their personnel file. Review of the facility-provided policy Background (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Check Reverification and Fingerprints, undated, revealed: Caregivers who work in the state of Alaska. must have their background check renewed with the State of Alaska. In most cases, this occurs every five years. Caregivers can expect to start receiving notifications 90 days prior to their reverification deadline. After the fingerprints are submitted, RA [Regulatory Assurance] will monitor the State of Alaska site for results. Review of 7 AAC 10.900(b) at https://www.akleg.gov/basis/aac.asp#7.10.900, the 34th Legislature (2025-2026), revealed: . Each individual who is to be associated with a provider in a manner described in this subsection must have a valid background check conducted under 7 AAC 10.900 - 7 AAC 10.990 if that individual is 16 years or older and will be associated with the provider as (1) an administrator or operator; (2) an individual service provider; (3) An employee, an independent contractor, an apprentice, an unsupervised volunteer, or a board member if that individual as (A) regular contact with recipients of services; (B) access to personal or financial records maintained by the provider regarding recipients of services, including access to (i) personal identifying information, financial information, treatment information, or medical records .(4) an officer, a director, a partner, a member, or a principal of the business organization that owns an entity, if that individual has (A) regular contact with recipients of services; (B) access to personal or financial records maintained by the provider regarding recipients of services, including access to (i) personal identifying information, financial information, treatment information, or medical records .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. .Based on record review and interview, the facility failed to: 1) Report an allegation of verbal intimidation/harassment, involving inappropriate sexual comments made by Certified Nursing Assistant (CNA) #4 to 1 Resident (#9), to the State Survey Agency immediately, or not later than 2 hours after the allegation was made/reported; and 2) Develop and implement an accurate reporting policy for allegations of abuse that aligned with regulatory requirements. Not reporting an allegation of abuse in an appropriate and timely manner placed all residents (based on a census of 9) at risk for future exposure to potential abuse. Findings:Resident #9 Record review on 5/11-15/26 revealed Resident #9 was admitted to the facility with diagnoses that included Alzheimer's disease with behavioral disturbance, decreased functional mobility, and anxiety. Review of Resident #9's Resident Daily Care Plan, last updated 4/23/26, revealed Resident #9 required a two-person assist with brief changes every two to three hours and staff were to provide personal hygiene. Review of Resident #9's Occupational Therapy Initial Assessment Addendum for POC [Plan of Care] Submission, dated 2/11/22, revealed: . [Resident #9] is not able to follow simple commands or participate in an interview. During interactions with [Resident #9], it was noted that [he/she] becomes agitation when removed from the group setting. with concerns from staff that [he/she] has a past history of trauma which impacts the provision of care during ADLs [activities of daily living, to include brief changes and personal hygiene]. 1) Allegation Reporting Staff Incident Report to Facility Leadership Review of an internal staff-submitted incident report, dated Tuesday, 10/28/25 at 12:00 AM, revealed the following report was submitted by a Licensed Nurse (LN) #2: . Describe the event in your own words: After shift change last night in LTC [long term care], a conversation was relayed to me by [CNA #8]. I was not a witness to the conversation and have no way to verifying its accuracy. [He/she] stated that one time while changing [Resident #9], [CNA #4] was staring at [Resident #9] and [CNA #4 made sexually explicit remarks directed toward Resident #9 during cares. The reported remarks included an implied sexual proposition and a personal statement by CNA #4 about sexual activity.] Further review of the occurrence report revealed the incident was categorized under workplace violence for verbal intimidation/harassment/bullying, and the type of verbal intimidation/harassment was Other bias/discriminatory language, unwanted sexual comments/gestures. It was documented that this incident occurred on Monday, 10/27/25 at 8:00 AM. Facility Initial Report to State Survey Agency Review of a Facility Reported Incident (FRI), received by the State Survey Agency on Thursday, 10/30/25 at 12:17 PM, revealed the facility's initial report regarding the incident between CNA #4 and Resident #9: . Caregiver working with another co worker, reported a disturbing conversation: ?. while conducting personal care and changing [Resident #9], [CNA #4] was staring at [Resident #9] and [CNA #4 made sexually explicit remarks directed toward Resident #9 during cares. The reported remarks included an implied sexual proposition and a personal statement by CNA #4 about sexual activity.]' . Initial Action: [CNA #8], made sure that the resident's needs were met, and the rest of the day carried on with [CNA #4] as if the conversation never happened. [CNA #8] indicated that Sunday there was no further conversation or incident. [CNA #8] was still disturbed by what was stated and decided on Monday evening when [he/she] came back to work, to speak with the Team Leader, who immediately submitted an Incident Report and Administration was notified. This initial FRI report documented that this incident actually occurred on Sunday, 10/26/25 at 11:00 AM. Further review of the FRI initial report revealed this report was completed by the facility's Chief Administrative Officer (CAO), who documented the date of notification to leadership of the allegation was Tuesday, 10/28/25. This initial report was sent to the State Survey Agency two days after leadership was made aware of the allegation. Further review revealed the CAO documented the incident as not abuse, No abuse, but reporting disturbing conversation under investigation. Review of the facility-provided policy Resident/Patient Abuse, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Neglect and Exploitation, effective 12/2024, revealed the facility defined abuse as: . ?Abuse' means the willful infliction of. intimidation. including a caretaker of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being. This presumes that instances of abuse of all residents/patients, even those in a coma, due to willful, intentional, or reckless non accidental, or non-therapeutic infliction of. mental distress that can cause. mental anguish. ?Sexual abuse' includes but is not limited to sexual harassment. During an interview on 5/15/26 at 12:21 PM, when asked why the report of intimidation/harassment, involving inappropriate sexual comments, made by CNA #4 to Resident #9 was not interpreted as intimidation or sexual harassment, a form of abuse per the facility policy, the CAO stated at the time she didn't interpret the comment as harassment, but in retrospect she could see how it could be interpreted as such, but we didn't see it that way. When asked why the report was not submitted immediately, but no later than two hours after leadership became aware of the allegation, the CAO stated she was trying to investigate the allegation prior to sending the initial report and understood now that she should have submitted the report and then initiated the investigation after. 2) Facility's Reporting Abuse Policy Procedures Review of State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Rev. 232; Issued 7/23/25, revealed the Code of Federal Regulations (CFR) 483.12(b) and (c) addressed the reporting requirements for LTC facilities when allegations of abuse are reported: - CFR 483.12(b): The facility must develop and implement written policies and procedures that: - CFR 483.12(c): In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: - 483.12(c)(1): Ensure that all alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, - or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Review of the facility-provided policy Resident/Patient Abuse, Neglect and Exploitation, effective 12/2024, revealed: . Reporting. The following is notified, as required by law, in the event that abuse occurs in the Long Term Care. Notification of the reportable event results in serious bodily injury, the staff member shall report the suspicion to the State Survey Agency and at least one local law enforcement entity, immediately, but no later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury but it is unclear as to the origin of injury, the staff member shall report the suspicion immediately to the LTC Team Leader/LTC Manager or LTC Administrator. A written report will be faxed to the State Survey Agency no later than 24 hours from time of knowledge of the injury. The facility's policy's verbiage does not align with CFR 483.12(c) and 483.12(c)(1) regulatory requirements to report allegations of abuse, neglect, exploitation or mistreatment immediately, but no later than two hours after the allegation was made, but instead, focused on reporting only abuse which resulted in serious bodily injuries within that required regulatory timeframe

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. .Based on record review, interview, and observation, the facility failed to clearly designate one registered nurse to serve as the full-time Director of Nursing (DON) for the long-term care (LTC) unit. Specifically, the facility's leadership documents, Human Resources (HR) records, payroll records, staff identification, and administrative interviews identified conflicting roles for the Director of Clinical Services (DCS), the LTC Manager, and the newly hired DON. As a result, the facility could not demonstrate that one RN was consistently designated to serve as the full-time DON responsible for LTC nursing leadership and oversight. This deficient practice placed all residents (based on a census of 9) at risk for more than minimal harm due to unclear nursing leadership accountability, including risk for delayed clinical oversight, delayed resident assessment, and failure to ensure consistent implementation of nursing services. Findings:Record review on 5/11-15/26, of the facility provided list of leadership personnel, undated, revealed the Key Contacts list identified the DCS as the LTC DON, RN/MDS [minimum data set - a federally required assessment], however the LTC Contact Resources list identified her as the LTC Manager (RN). During an interview on 5/14/26 at 1:35 PM, Licensed Nurse (LN) #1 stated the DCS was the LTC Manager and had always been the LTC Manager. LN #1 further stated that another person will be transitioned into the DON role soon. When asked if the DCS was ever the LTC DON, LN #1 stated, No. An observation on 5/14/26 at 1:48 PM, revealed the DCS wore a name badge that identified her as the Manager Long Term Care. The DCS's office door title and business card identified her as the Director of Clinical Services. Review of the facility provided LTC Quality Committee members list, undated, revealed the DCS attended this committee in the DCS role's capacity. Another staff member attended the meetings identified as the RN LTC DON. HR Review During an interview on 5/14/26 at 2:10 PM, personnel and staffing records were reviewed with facility administration and HR staff. Review of personnel records revealed the DCS was officially designated in the HR system as the DCS effective 4/6/26. The DCS held the Long Term Care Manager position prior to becoming the DCS. During the interview, the Chief Administrative Officer (CAO) stated the DCS continued performing DON duties because the newly hired DON was still transitioning into the role and had not fully assumed DON responsibilities. The CAO also stated that the DCS was still in the process of learning her role as the DCS. During the interview, the DCS stated, I'm officially in the payroll system as DCS, but I'm still doing all of the Director of Nursing and long-term care manager work. During the interview, the CAO stated, She has not assumed the DCS functions, and acknowledged there was no documentation differentiating the hours or duties being performed under the DON role versus the DCS role. Review of the DCS's offer letter, dated 1/13/26, revealed the DCS was to assume her role as DCS effective 4/6/26. Review of the newly hired DON's offer letter, dated 2/5/26, revealed the new DON was to assume his role as the DON effective 4/5/26. Review of the DCS's most recent annual evaluation, dated 3/11/26, revealed that the evaluation pertained to her role as the LTC Manager for the evaluation period of 1/1/25 through 12/31/25. Review of a facility-provided internal memo, addressed to the LTC Manager/DCS from the CAO, dated 11/16/25, revealed: . Interim Assignment. We are pleased to offer you the Interim Director of Nursing role. This interim assignment will begin on November 16th 2025, and will continue until the position is filled permanently. There was no reference on the memo that this was sent to HR. During an interview on 5/15/26 at 10:18 AM, when asked who was on the Quality Assurance Performance Improvement (QAPI), or LTC Quality committee, the Senior Quality Program Manager stated the Administrator, the DCS, the newly hired DON, the Resource Coordinator, and Physicians were on the committee. Business office, the Infection Preventionist, and Environment of Care department were also invited and would attend if available. Payroll Review Review of the DCS's payroll records, from 11/1/25 through 5/15/26, did not reveal any time designated specifically to the LTC's DON role. According to the payroll records, the DCS worked Monday through Friday, forty hours a week. Review of the new (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DON's payroll records, from 3/1/26 through 5/15/26, revealed that his time was coded as Acute RN on 5/7/26, 5/14/26, and 5/15/26, indicating that he worked in the acute care unit rather than in the long-term care unit. Prior to that, his time was coded to Director of Nursing which began on 4/6/26. Job Descriptions Review of the facility-provided Director of Clinical Services Job Description, original creation date 2/1/08, revealed: . Reports To: Administrator. This position has direct full responsibility, authority, and accountability for the provision of administrative direction and control of the resident and nursing services in regards to the Alaska state-licensed and federally-certified Nursing Home and Critical Access Hospital. Review of the facility-provided Manager Long Term Care RN Job Description, original creation date 5/1/14, revealed: . Reports To: Director of Clinical Services. Under general supervision works in collaboration with the Director of Nursing and other members of the multidisciplinary team to deliver elder centered care in a compassionate and ethical manner according to the standards of practice. Review of the facility-provided Director Long Term Care RN Job Description, original creation date 6/1/08, revealed: . Reports To: Director of Administrative Services LTC. The Director LTC RN provides clinical leadership, day-to-day clinical management and direction at the Long-Term Care facility. delivered in accordance with Providence philosophy, Federal and State regulatory standards ensuring the delivery of high quality, cost effective health care consistent with the mission.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. .Based on record review and interview, the facility failed to ensure residents, or resident representatives, had the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options, and to choose the alternative or option he or she preferred. Specifically, the facility failed to document that the resident or resident representative was able to accept or decline the initiation or continued use of the psychotropic medication (any chemical substances that affect brain function, altering a person's mood, thought, perceptions, or behavior) after receiving information about the risks, benefits, and alternatives for 3 residents (#'s 2, 6, and 9), out of 5 residents reviewed for unnecessary medications. This failed practice, of not documenting that the resident or resident representative was able to accept or decline the initiation or continued use of the psychotropic medication use, violated the resident's right to participate in their treatment decisions. Findings:Resident #2 Record review on 5/11-15/26 revealed Resident #2 was admitted to the facility with diagnoses that included vascular dementia, moderate with mood disturbance (dementia resulting from impaired blood flow to the brain, with associated aggressive or agitated behavior), Alzheimer's disease (a progressive mental deterioration characterized by confusion, memory failure, disorientation, restlessness, speech disturbances, and the inability to carry out purposeful movement), and depression. Review of Resident #2's Medication Administration Record (MAR), dated 5/2026, revealed he/she was taking the following psychotropic medications: 1- Duloxetine (Cymbalta - an antidepressant, used to treat depression and pain) DR (delayed release) 30mg (milligrams) capsule by mouth daily - scheduled every morning for depression and back pain, with an order start date of 2/16/26; 2- Duloxetine DR 60mg capsule by mouth daily - scheduled for every morning for depression and back pain, with an order start date of 2/16/26; 3- Hydroxyzine hydrochloride (Atarax - an antihistamine to treat itching and a psychotropic medication used to treat anxiety) 25mg tablet by mouth nightly for agitation and to reduce itching, with an order start date of 2/15/26; 4- Quetiapine (Seroquel - an antipsychotic, used to treat mood and depression) 25mg tablet - 1 1/2 tablets (37.5mg total dose) by mouth every morning and 1 tablet (25mg) in the afternoon for agitation, impaired emotional outbursts, and difficulty controlling anger, with an order start date of 4/1/26; and 5- Memantine (Namenda - used to treat moderate to severe Alzheimer's disease) 10mg tablet by mouth twice a day for impairing emotional outbursts, with an order start date of 6/10/23. Review of Resident #2's Psychotropic Risk/Benefit Form Verification of Informed Consent paper document, dated 12/18/25, revealed this consent form was for the Duloxetine DR 30mg and 60mg doses, Memantine 10mg dose, and a past Quetiapine 25mg twice a day dose. This form documented an explanation of the risks and benefits were discussed with Resident #2's family member, and no additional information was requested by the family. The form also had the following statement: . The resident or their surrogate decision maker has the right to accept or refuse the proposed medication treatment and if he/she consents, has the right to revoke his/her consent for any reason, at any time. Further review of the Psychotropic Risk/Benefit Form Verification of Informed Consent paper document revealed no documentation that the family accepted or declined the initiation or continued use of these psychotropic medications. Review of Resident #2's Psychotropic Risk and Benefits Note electronic document for psychotropic medication consent, dated 4/1/26, and completed by Provider #20, revealed this consent was for the Seroquel 37.5mg and the 25mg doses. This form documented an explanation of the risks and benefits were discussed with Resident #2 and his/her POA (power of attorney), and no additional information was requested by the resident or POA. The form also had the following statement: . This note is indicative of informed consent of the provider recommending the need to order a psychotropic medication. The resident, POA, surrogate decision maker has the right to accept or refuse the proposed medication treatment and if he/she consent, has the right to revoke his/her consent for any reason, at any time. Further review of the Psychotropic Risk and Benefits (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Note electronic document revealed no documentation that the family accepted or declined the initiation or continued use of this psychotropic medication. Review of Resident #2's Psychotropic Risk/Benefit Form Verification of Informed Consent paper document, dated 8/25/25, revealed this consent form was for the hydroxyzine hydrochloride 25mg dose, and additional past medications and doses that had been since changed. This form documented an explanation of the risks and benefits were discussed with Resident #2's family member, and no additional information was requested by the family. The form also had the following statement: . The resident or their surrogate decision maker has the right to accept or refuse the proposed medication treatment and if he/she consents, has the right to revoke his/her consent for any reason, at any time. Further review of the Psychotropic Risk/Benefit Form Verification of Informed Consent paper document revealed no documentation that the family accepted or declined the initiation or continued use of these psychotropic medications. Resident #6 Record review on 5/11-15/26 revealed Resident #6 was admitted to the facility with diagnoses that included vascular dementia (dementia resulting from impaired blood flow to the brain) and depression. Review of Resident #6's MAR, dated 5/2026, revealed he/she was taking Sertraline (Zoloft - an antidepressant used to treat depression) 100mg tablet by mouth daily for depression, with an order start date of 4/19/26. Review of Resident #6's Psychotropic Risk/Benefit Form Verification of Informed Consent paper document, dated 8/27/25, revealed this consent form was for the Sertraline 100mg dose. This form documented an explanation of the risks and benefits were discussed with Resident #6's family member and no additional information was requested by the family. The form also had the following statement: . The resident or their surrogate decision maker has the right to accept or refuse the proposed medication treatment and if he/she consents, has the right to revoke his/her consent for any reason, at any time. Further review of the Psychotropic Risk/Benefit Form Verification of Informed Consent paper document revealed no documentation that the family accepted or declined the initiation or continued use of this psychotropic medication. Resident #9 Record review on 5/11-15/26 revealed Resident #9 was admitted to the facility with diagnoses that included Alzheimer's disease with behavioral disturbance and agitation due to dementia. Review of Resident #9's MAR, dated 5/2026, revealed he/she was taking the following psychotropic medications: 1- Hydroxyzine hydrochloride 12.5mg tablet by mouth daily at 2:30 PM for reduced itching, with an order start date of 6/13/24; 2- Hydroxyzine hydrochloride 25mg tablet by mouth nightly for reduced itching, with an order start date of 6/4/24; 3- Sertraline 75mg tablet by mouth daily for dementia with behavioral disturbance, mood disturbance, and anxiety, with an order start date of 7/29/23. 4- Trazadone (Desyrel - an antidepressant used to treat depression) 25mg tablet by mouth nightly for agitation, with an order start date of 11/26/25. Review of Resident #9's Psychotropic Risk/Benefit Form Verification of Informed Consent paper document, dated 12/15/25, revealed this consent form was for the Hydroxyzine Hydrochloride 12.5mg and 25mg doses, Sertraline 100mg dose, and the Trazadone 25mg dose. This form documented an explanation of the risks and benefits were discussed with Resident #9's family member, and no additional information was requested by the family. The form also had the following statement: . The resident or their surrogate decision maker has the right to accept or refuse the proposed medication treatment and if he/she consents, has the right to revoke his/her consent for any reason, at any time. Further review of the Psychotropic Risk/Benefit Form Verification of Informed Consent paper document revealed no documentation that the family accepted or declined the initiation or continued use of these psychotropic medications. During an interview on 5/15/26 at 11:40 AM, the Director of Clinical Services (DCS) stated psychotropic medication consent was documented using either the paper Psychotropic Risk/Benefit Form Verification of Informed Consent or the electronic Psychotropic Risk and Benefits Note. When asked how the resident's or representative's decision was documented, the DCS stated the response to education was typically placed in a note. When asked to locate notes documenting the resident's or representative's acceptance or refusal for Residents #2, #6, and #9, the DCS stated she could not locate any notes documenting consent. When asked to review the paper and (continued on next page)

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	025034	A. Building B. Wing	05/15/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	electronic forms for language showing acceptance or refusal, the DCS stated the forms did not contain language showing the families or POAs accepted or refused the psychotropic medications. Review of the resident right's posted on the resident's unit, undated, revealed: . Your Rights. You have rights as a nursing home resident under Federal Law. Those rights include: The right to participate in your own care. The right to make independent choices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to ensure the MDS (Minimum Data Set, a federally required nursing assessment) quarterly review requirements for 2 residents (#'s 6 and 7), out of 5 residents were followed. Specifically, the facility failed to complete quarterly review assessments at least every 92 days from the last assessment of any type. This failed practice placed the residents at an increased risk for improper monitoring of decline and/or progress over time and inadequate care and services to maintain their highest practicable well-being. Findings:Resident #6 Record review on 5/11-15/26 revealed Resident #6 was admitted to the facility with diagnoses that included vascular dementia (dementia resulting from impaired blood flow to the brain) with behavioral disturbance, depression, dysphasia (difficulty swallowing), dehydration, and a history of falls. Review of Resident #6's most recent MDS data, dated 11/29/25, revealed this assessment was an annual review. The facility was 75 days past the 92-day timeline for the next quarterly review assessment. Resident #7 Record review on 5/11-15/26 revealed Resident #7 was admitted to the facility with diagnoses that included dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking), subarachnoid hemorrhage due to ruptured aneurysm (a type of stroke in which a ballooned blood vessel in the brain bursts, causing bleeding into the brain), cardiomyopathy (abnormal enlargement of the heart muscle), congestive heart failure (a condition in which the heart cannot pump efficiently enough to meet the body's need for blood), and chronic hip pain after a total replacement of the left hip joint. Review of Resident #7's most recent MDS data, dated 11/26/25, revealed this assessment was an annual review. The facility was 78 days past the 92-day timeline for the next quarterly review assessment. During an interview on 5/13/26 at 4:45 PM, the Director of Clinical Services (DCS) stated the most current assessments for Residents #6 and #7 were completed in 11/2025. Their quarterly assessments were due in 2/2026, however, they were not completed. Review of the facility-provided policy Resident MDS Assessment, effective date 10/2025, revealed: . In keeping with the philosophy. Providence [NAME] Medical Center (PVMC) Long Term Care Unit will complete initial, annual and quarterly comprehensive assessments of the Resident's needs. Quarterly Assessment.When Form is Completed. No later than the ARD [Assessment Reference Date] of prior assessment + 92 calendar days.