STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025035	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Utuqqanaat Inaat	436 Mission Street Kotzebue, AK 99752

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41597 47929 Based on record review and interview, the facility failed to ensure a copy of 2 residents' (#8 and #12) transfer notices were sent to the Office of the State Long Term Care (LTC) Ombudsman. This failed practice had the potential to affect all residents, based on a census of 17, by: 1) denying residents the added protection from being inappropriately discharged ; 2) providing the residents with access to an advocate who can inform them of their options and rights; and 3) ensuring the Office of the State LTC Ombudsman was aware of facility practices and activities related to transfers and discharges. Findings: Resident #8: Record review from 4/22-25/24 revealed Resident #8 was admitted to the facility with diagnoses that included dementia, epilepsy, stroke, and a history of falls. Further review revealed Resident #8 was hospitalized and discharged from the facility on 12/12/23 with a return anticipated and readmitted on [DATE]; discharged and hospitalized on [DATE] with a return anticipated and readmitted on [DATE]; and discharged and hospitalized on [DATE] with a return anticipated and readmitted on [DATE]. During an interview on 4/23/24 at 4:00 PM, when asked about the process of notifying the Ombudsman for discharges or transfers to the hospital, the Director of Nursing (DON) stated the facility just became aware of the need to notify the Ombudsman this year. During an interview on 4/23/24 at 5:02 PM, when asked for the notification documentation for December 2023 and March 2024, the DON stated the facility just started the Ombudsman notification for hospital discharges in January (2024), so there were no notifications for the December hospitalization s. Review of Notification of Discharge: Month: March, 2024, revealed No Discharges for the Month of March. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON further stated the facility had not alerted the Ombudsman of Resident #8's hospitalization transfer in March because the resident was not admitted to the hospital, but remained in the Emergency Department in observation status. During an email correspondence with the Ombudsman on 4/25/24 at 11:30 AM, the Ombudsman wrote: A notice of transfer must be provided to the resident and resident representative as soon as practicable . Copies of notices for emergency transfers must also be sent to the Ombudsman when practicable such as on a monthly basis. Resident #12 Record review on 4/22-25/24 revealed Resident #12 was admitted to the facility with diagnoses that included dementia, mild cognitive impairment, chronic obstructive pulmonary disease (chronic lung disorders resulting in blocked air flow in the lungs), hypertension (high blood pressure), and a history of myocardial infarction (heart attack). Further review revealed Resident #12 was admitted to the hospital on 1/17-20/24 for sepsis (a life-threatening complication of an infection), pneumonia, and acute kidney injury. Review of the facility's Notification of Discharge, dated 1/2024, that was sent to the Ombudsman, revealed Resident #12's discharge to the hospital was not included. During an interview on 4/25/24 at 1:21 PM, the Administrator stated, in January 2024, the facility had implemented a new monthly process of notifying the Ombudsman, which included a form with every resident that was admitted to the hospital for the entire month. She further stated Resident #12 should have been on the Ombudsman's notification form, but it was missed somehow. Review of the facility's policy, Transfer or Discharge, dated 1/23/24, revealed: Upon receiving the provider [physician] order to transfer or discharge the patient, the Charge Nurse will notify the patient, their family and/or representative, and Social Services .The patient will be given written notice of the reason for the discharge or transfer .The transfer notice is to include an explanation of the right to appeal the transfer to the State as well as the name, address, and phone number of the State Long Term Care Ombudsman . .

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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. 41597 Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed and implemented with specific medical care needs for 1 resident (#8), out of 9 sampled residents. Specially, the facility failed to address risk factors or include specific information concerning the resident's prescribed anti-platelet medication (that inhibits the ability of platelets to clump together as part of a blood clot and could cause the risk of bleeding) in the resident's care plan. This failed practice had the potential to place the resident at risk for inconsistent care that could result from the many risk factors of the anti-platelet medication. Findings: Record review from 4/22-25/24 revealed Resident #8 was admitted to the facility with diagnoses that included dementia, epilepsy, stroke, and anemia. Further review revealed the resident had a history of falls. Review of Resident #8's Skin/Wound Note, dated 12/10/23, revealed: When Elder came to lunch, noticed left eye to be black and swollen. Palpated [felt] eye and around eye, Elder denies any pain or discomfort. When asked Elder denies any fall or injury. Noted both of Elders eyes watering and Elder aggressively wiping them with tissue . During an interview on 4/23/24 at 2:35 PM, Licensed Nurse (LN) #1 recalled the incident and stated the facility alerted the physician who assessed Resident #8's eye and thought the blood thinners and aggressive rubbing of the eyes caused the bruising. LN #1 further stated the physician concluded since the Resident was taking blood thinners, he/she had busted a capillary under the skin around his/her eye, which was black, and looked like a hematoma (an abnormal pooling of blood under the skin that results from a broken or ruptured blood vessel). Review of Resident #8's current Physician's orders, active as of 4/23/24, revealed the Resident was prescribed Clopidogrel Bisulfate (Plavix- an anti-platelet medication) once a day, with a start date of 3/11/23. Review of Resident #8's current Care Plan revealed no documentation of the Resident taking the Clopidogrel medication, nor interventions regarding the medication and the potential side effects or risks, such as bleeding. During an interview on 4/23/24 at 5:19 PM, when asked about the Resident's injury, the Director of Nursing (DON) stated the facility reviewed the resident's medical record which included the note about the resident aggressively wiping his/her eyes, and the physician was notified. When asked if the blood-thinning medication should have been included on the Resident's care plan, the DON stated it was not included because that medication was discontinued. When shown Resident #8's physician's orders which included the medication, the DON further stated, yes, the Resident's care plan should have included the blood thinning medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy CARE PLANNING, dated 11/2023, revealed: It is the policy of Manillaq Health Center to provide an individualized nursing care plan for all patients to provide continuous, consistent care . The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 43792 Based on record review, observation, and interview, the facility failed to ensure insulin (a medication for blood sugar maintenance) orders were followed for 2 residents (#5 and #10), out of 3 residents reviewed who received insulin. Specifically, the insulin orders were written to be administered before meals, and the insulin was administered after meals. This failed practice placed these residents at risk for experiencing potential adverse effects for not receiving insulin per the physician's orders. Findings: Resident #5: Resident #5 was admitted with diagnoses that included Type 2 Diabetes Mellitus with unspecified complications and essential hypertension (high blood pressure). Record review on 4/22/24 of Resident #5's insulin order, dated 2/14/24, revealed: Novolog Flex Pen [insulin] Subcutaneous [injection under the skin] Solution Pen-Injector 100 unit/ml [milliliter] (insulin aspart). Inject 8 unit subcutaneously before meals related to Type 2 Diabetes Mellitus with unspecified complications . (This medication is a rapid-acting anti-diabetic medication to help regulate blood sugar needs in the body. Type 2 Diabetes is a condition because of a problem the way the body regulates and uses sugar as a fuel). An observation on 4/22/24 at 11:30 AM, revealed Licensed Nurse (LN) #1 checked Resident #5's blood sugar. The blood sugar result was 290 (normal blood sugar results are about 70-100). An observation on 4/22/24 at 12:42 PM, revealed LN #1 administered the insulin injection into the Resident's abdomen after the resident had finished eating lunch. During an interview and concurrent observation on 4/24/24 at 1:03 PM, LN #1 stated Resident #5's blood sugar was 225. LN #1 was observed to administer insulin to Resident #5 after the resident had finished eating lunch. Resident #10: Resident #10 was admitted with diagnoses that included Type 2 Diabetes Mellitus without complications and essential hypertension. Record review on 4/22/24 revealed Resident #10's insulin order, dated 4/19/24, revealed: Novolog Flex Pen Subcutaneous Solution Pen-Injector 100 unit/ml (insulin aspart). Inject 8 unit subcutaneously before meals related to Type 2 Diabetes Mellitus without complications . During an interview on 4/22/24 at 11:50 AM, LN #1 stated Resident #10's blood sugar was 153. LN #1 further stated insulin would be administered after the resident was finished eating. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 4/22/24 at 1:01 PM, revealed LN #1 administered the insulin injection into Resident #10's abdomen after the resident had finished eating lunch. During an interview on 4/22/24 at 1:05 PM, LN #1 stated the insulin order had been written to administer the insulin before meals. During an interview on 4/24/24 at 4:00 PM, when asked about Resident #5 and #10's insulins being given after lunch and not before lunch, the Director of Nursing (DON) stated Residents #5 and #10 blood sugars would bottom out and so the insulin was given after the meals instead of before. During an interview on 4/25/24 at 9:45 AM, when asked if giving Resident #5 and Resident #10 the insulin after lunch instead of before was a medication error, the Administrator stated these were medication errors. She further stated the reason for the late administration of the insulin had been discussed with the physician, and this was due to the bottoming out of the blood sugars if the insulin was given before meals. During an interview on 4/25/24 at 12:20 PM, the Physician stated the late administration of these insulins was a timing issue. He also stated, I have told nursing they can give the insulins before, during, or after meals. The nurses can use their own judgement with how the patient is eating. We could have written after meals. If that is difficult to interpret, then this should be written differently. The expectation is for the nurse to follow their nursing judgement with the order. We want to prevent hypoglycemic (low blood sugar) episodes. I talk to [the DON] three times a month about blood sugar levels. Review of the facility's policy Medication Administration, dated 10/27/23, revealed: Medications are administered by Registered Nurses and Licensed Practical Nurses in accordance with the State and Federal regulations and the Alaska Board of Nursing .the nurse will follow up and check the 'eight rights' before administering medications, right medication, time, resident, dose, route, documentation, reason, and response.