

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  025036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/26/2024
NAME OF PROVIDER OR SUPPLIER  Providence Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE  920 Compassion Circle Anchorage, AK 99504	

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)
<p>F 0555</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to choose his or her attending physician.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40259</b></p> <p>Based on record review and interview, the facility failed to honor the rights to choose his/her attending physician for 1 Resident (#3), out of 1 resident reviewed. This failed practice denied the resident the right to choose his/her physician or provided the opportunity for the resident to work with the facility to seek alternate physician participation if his/her choice was unavailable.</p> <p>Findings:</p> <p>Record review on 11/25-26/24 revealed Resident #3 was admitted to the facility on [DATE] with diagnoses that included stage 3b chronic kidney disease (mild to moderate damage to the kidneys), hypertension (high blood pressure), and diabetes.</p> <p>During an interview on 11/25/24 at 9:55 AM, Resident #3 stated that he/she had, since admission to the facility, asked to be seen and work with a Medical Doctor (MD) instead of a Nurse Practitioner (NP). Resident #3 stated he/she had never worked with an NP and preferred an MD to address his/her care and treatments. Resident #3 stated that he/she had repeatedly asked the NP to change his/her care to an MD. Resident #3 stated his/her main concern was his/her kidney disease and the need to see a nephrologist regularly. Resident #3 stated he/she needed vascular assessments every three months to ensure his/her kidneys were functioning and to monitor for any decline.</p> <p>When asked if he/she had ever talked to any of the staff at the facility about this request to see an MD for all cares, Resident #3 stated he/she had asked the NP repeatedly to change care to an MD and he/she had also mentioned it to the Minimum Data Set (MDS -a federally mandated assessment) Nurse during care conferences. Resident #3 further stated that in October 2024 he/she had escalated his/her request, which may have been perceived as yelling, when his/her request was not being met. Resident #3 stated this was with a supervisor, who then asked the Director of Nursing (DON) to talk to him/her about his/her request. After this, Resident #3 stated he/she was seen by an MD in October 2024, who happened to be a nephrologist. Resident #3 stated he/she now had an appointment in January 2025 to see a nephrologist for further assessment and care concerning his/her kidneys.</p> <p>During an interview on 11/25/24 at 2:21 PM, when asked if Resident #3 had every requested to see an MD for his/her care, Nurse Practitioner (NP) #15 stated Resident #3 had been asking to see an MD since I have known [him/her]. When asked if NP #15 had made any attempt to honor that request, NP #15 stated he/she had not because it was not always clear what the request meant, and it was difficult to probe for more information with Resident #3 as he/she was not always cooperative.</p> <p>(continued on next page)</p>

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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<p>F 0555</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When asked if NP #15 had ever brought Resident #3's request to be seen by an MD forward to the Medical Director or Leadership, NP #15 stated he/she had not.</p> <p>Review of Resident #3's medical records revealed NP #15 had seen Resident #3 on 6/20/24, 7/1/24, 8/29/24, 9/5/24, and 10/15/24. Further review revealed no documentation that Resident #3 had been requesting to see an MD. There was no documentation that those requests were forwarded to the Medical Director or leadership.</p> <p>Review of Resident #3's Provider Note, dated 10/30/24, revealed: . Patient is being seen today for follow up regarding [his/her] CKD [chronic kidney disease]. Patient also has been requesting to see a physician, not really clarifying the reason behind it . Patient also wants to follow-up with [his/her] nephrologist . It is also noted that patient prefers to talk with a physician . Further review revealed orders to make an appointment with nephrology. A nephrology appointment was scheduled for 1/21/25.</p> <p>During an interview on 11/25/24 at 3:41 PM, the Interim Administrator stated it was not made known to leadership that Resident #3 had been requesting to see an MD until October 2024, when Resident #3 escalated about not having his/her request to see an MD honored. When this was known, leadership facilitated a visit from an MD, and it was at this time that Resident #3's request to see a nephrologist was initiated.</p> <p>Review of the facility's policy Resident Rights, effective 7/2024, revealed: Scope . Procedures are implemented to ensure that these rights of the resident are protected and promoted and not violated . Residents shall have the following rights . To choose a physician and to be fully informed by a physician, in a language that he or she can understand, of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing and psychosocial needs and the planning of related services .</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40259</p> <p>Based on record review and interview, the facility failed to ensure regular follow up care by a nephrologist (medical doctor who specializes in kidneys) for 1 Resident (#3), out of 1 resident reviewed. This failed practice had the potential to cause the resident to miss needed kidney treatment and care, which had the potential to affect the resident's kidney function and overall health.</p> <p>Findings:</p> <p>Record review on 11/25-26/24 revealed Resident #3 was admitted to the facility on [DATE] with a diagnoses that included 3b chronic kidney disease ( mild to moderate damage to the kidneys), hypertension (high blood pressure), and diabetes.</p> <p>During an interview on 11/25/24 at 9:55 AM, Resident #3 stated, .from April [2024] I had been asking about going to my kidney doctor, but nothing was ever done .</p> <p>Review of Resident #3's Nephrology consultation report, dated 9/26/23, revealed a recommendation by the Nephrology provider stating .follow-up with Nephrology at least every 3 months.</p> <p>Review of Resident #3's medical record revealed his/her last nephrology appointment was 12/11/23. No other nephrology orders for continued nephrology care were found in the medical record.</p> <p>During an interview on 11/25/24 at 2:21 PM, when asked if he/she had been monitoring Resident #3's need for nephrologist care related to his/her chronic kidney disease, Nurse Practitioner (NP) #15 stated he/she hadn't been able to see any nephrology consult notes and had not requested any nephrology records since having Resident #3 in his/her care stating, I haven't gotten to that point yet.</p> <p>When asked if a resident with stage 3b chronic kidney disease should be seen and monitored by nephrology more than once a year, NP #15 stated he/she would imagine that a resident would need to be seen more than annually but he/she hadn't seen that in Resident #3's record.</p> <p>Record review revealed Resident #3 had been under the care of NP #15 since 6/20/24. NP #15 saw Resident #3 on 6/20/24, 7/1/24, 8/29/24, 9/5/24, and 10/15/24. Further review revealed no documentation that Resident #3's need for nephrology oversight was monitored, no request for nephrology records was ordered, nor was there any referral or consult orders to initiate nephrology care.</p> <p>Review of requested medical records from Resident #3's nephrology clinic, dated 12/11/23, revealed: . Patient is referred for CKD [chronic kidney disease] 3B in the setting of diabetes and hypertension . [He/she] has labs over the last year which show rising creatinine slowly and progressively . Patient educated on natural disease progression. Discussed follow up and orders indicated below . CKD 3B deteriorating slowly . High risk of developing ESRD [end stage renal disease - requiring dialysis] in lifetime . Return to office . on or around 1/18/24 .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/26/24 at 11:35 AM, the Supervisor of Health Information Management (HIM) stated that prior to a change in medical providers, Physician #8 was overseeing Resident #3's nephrology needs. From the point when the providers switched to a medical provider group, no documentation could be found in Resident #3's medical records to indicate Resident #3's nephrology care was being monitored.</p> <p>It was determined, through record review, the medical provider group came onboard to the facility on [DATE].</p> <p>During an interview on 11/26/24 at 11:35 AM, the Interim Administrator stated that the facility had become aware that Resident #3 needed to see a nephrologist when a medical doctor (MD) assessed Resident #3 on 10/30/24. It was at this time an order for a referral to nephrology was made. A nephrology appointment was scheduled for 1/21/25.</p> <p>Review of the facility's policy Resident Rights, effective 7/2024, revealed: Scope . Procedures are implemented to ensure that these rights of the resident are protected and promoted and not violated . Residents shall have the following rights . To choose a physician and to be fully informed by a physician, in a language that he or she can understand, of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing and psychosocial needs and the planning of related services .</p>