

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  07/19/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>47929</p> <p>Based on interview, observation, and record review, the facility failed to: 1) ensure a dignified dining experience for all who received cooked meals in the Aniak Cottage (based on a census of 12); and 2) respond in a timely manner for assistance for two residents (#34 and #92), out of 20 sampled residents. These failed practices placed the residents at risk for psychological harm from loneliness, feelings of poor self-esteem and a potential for a poor quality of life.</p> <p>Findings:</p> <p>Aniak Cottage Dining</p> <p>During an interview on 7/8/24 at 9:27 AM, Certified Nurse Assistant (CNA) #10 stated that the cottage did not have a home keeper (cook) that day for the cottage. When the cooks are short staffed, the meals for the cottage were prepared in another cottage and placed in separate disposable Styrofoam clamshell food containers labeled with the resident's room number and brought over. The CNA and licensed nurse (LN) would serve the meals.</p> <p>During an observation on 7/8/24 at 11:59 AM, an open cart, containing disposable Styrofoam clamshell food containers, was brought into the cottage by [NAME] #1. [NAME] #1 placed all containers on the kitchen counter. At 12:02 PM [NAME] #1 left the cottage. The CNA and LN began serving the meals in the disposable Styrofoam clamshell food containers.</p> <p>During an observation and interview on 7/8/24 at 12:04 PM, Resident #34 was sitting in his/her room, at his/her bedside table with a disposable Styrofoam clamshell food container containing the resident's lunch. Resident #34 stated that the food was cold, but it was no use to call someone to warm it up as it might be forgotten in the microwave, or the staff would take a long time to come get it and to heat it up. The resident stated that he/she might as well eat it cold than bother the staff. Resident #34 stated he/she had been eating out of Styrofoam containers all weekend as well as that day. His/her meals were served this way when a cook would call out. When this happened, their meals would be prepared in another cottage and brought over. He/she stated the meals felt like he/she was eating take out and would rather eat off real dishes.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/9/24 at 9:07 AM, [NAME] #2 stated that the cottage did not have a cook for the last three days (7/6-8/24), and other cooks in the other cottages would rotate preparing meals for the day. [NAME] #2 stated that meals were served in the disposable Styrofoam clamshell food containers because when a cook was covering another cottage, there was no time to wash dishes for both cottages and complete other duties. If another cottage did not have a cook available for the day, [NAME] #2 would prepare meals for the other cottage first before working on the meals for his/her assigned cottage.</p> <p>During an interview on 7/10/24 at 4:39 PM, the Dietary Manager stated serving meals from disposable Styrofoam clamshell food containers was not ideal and needed to ask dietary why they are delivering food like that. She stated that it did not happen very often and did not know why the food could not be plated.</p> <p>Resident #34</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #34 was admitted to the facility with diagnoses that included Parkinson's disease (a chronic and progressive movement disorder that affects the nervous system and causes movement problems, such as tremors, stiffness and slowed movements), congestive heart failure (a chronic condition where the heart doesn't pump blood as effectively as it should) and weakness.</p> <p>During an interview on 7/15/24 at 11:43 AM, Resident #34 stated twice last week, he/she was not able to get out of bed until dinner time. He/she further stated he/she usually liked to be up and dressed by 8:00 AM daily. The resident expressed that it was very lonely waiting for the staff to come assist with getting him/her out of bed. The resident was unsure what activities he/she missed on those days and expressed that he/she felt that dining at the dining table with other residents at least once a week was important.</p> <p>During an interview on 7/15/24 at 12:39 PM, CNA #11 stated there were no limits on the frequency a resident could get up out of bed or have a shower but depended on the availability of staff.</p> <p>Review of Resident #34's Care Plan, entry dated 6/5/24, revealed: I LIKE: group activities of a social nature, bingo and discussion groups . An additional entry, dated 6/20/24, revealed: I NEED: help moving from one place to the other, help transferring, help repositioning .</p> <p>Review of Resident #34's Baseline Care Plan/RDCP, undated, revealed: I DRESS: with the help of 1 person, substantial assistance on upper body dressing and dependent assistance on lower body dressing .</p> <p>Resident #92</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #92 was admitted to the facility with diagnoses that included cerebral infarction (a stroke where clusters of brain cell die due to insufficient blood flow), hemiplegia (loss of strength or paralysis on one side of the body) and hemiparesis (mild to moderate muscular weakness on one side of the body), a history of traumatic brain injury, and nicotine dependence.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 7/15/24 at 11:49 AM, Resident #92 was seen in his/her room and the resident was in bed and had just finished his/her breakfast of pancakes and peanut butter. The resident said that he/she had waited to be served breakfast since 7:00 AM and had received it about an hour ago. He/she was going to skip lunch because it was so late in the day. The resident pressed his/her call light because he/she wanted nicotine gum. The surveyor left the resident's room.</p> <p>Continued observation on 7/15/24 at 12:38 PM, 46 min later, this surveyor walked over to the call light monitoring system in the common area and saw that Resident #92's call light had been on for 46 minutes. Further observation revealed Resident #92 called out from his/her room to [NAME] #2 in the kitchen. The cook was busy and stated that someone would be in shortly. This surveyor asked Resident #92 if anyone had been in to help, the resident stated no one had come.</p> <p>During an interview while continuing the observation on 7/15/24 at 12:39 PM, CNA #11 stated he/she was the only CNA in the cottage. CNA #11 then went into Resident #92's room and the call light was turned off. Resident #92 waited approximately 51 minutes for staff. At 1:17 PM Resident #92 was observed coming out of his/her room in his/her wheelchair. When asked if he/she received his/her nicotine gum, the resident stated, No and that he/she was headed out to go smoke.</p> <p>Review of Resident #92's Baseline Care Plan/RDCP, undated, revealed: I DRESS: MY UPPER BODY, MY LOWER BODY, MY FOOTWEAR with 1 helper providing more than half the effort . I TRANSFER: with the help of 1 person .</p> <p>Review of the facility's Your Rights. Our Responsibilities resident rights paperwork in the admission packet, effective date 4/1/21 revealed: As a Resident, you have the Right: . To be treated with dignity, respect, and consideration at all times . To receive services that meet your individual needs and preferences and choose healthcare, activities and schedules that are consistent with these . To equal access of care and services provided .</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>43792</p> <p>47929</p> <p>Based on record review, interview, and observation, the facility failed to ensure 2 residents (#34 and #39), out of 20 sampled residents, were able to make choices that were important to them. This failed practice had the potential to affect all residents by denying them the right to make choices that effect their care and quality of life.</p> <p>Findings:</p> <p>Resident #34</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #34 was admitted to the facility with diagnoses that included Parkinson's disease (a chronic and progressive movement disorder that affects the nervous system and causes movement problems, such as tremors, stiffness and slowed movements), congestive heart failure (a chronic condition where the heart doesn't pump blood as effectively as it should) and weakness.</p> <p>During an interview on 7/8/24 at 1:50 PM, Resident #34 stated that he/she was at the mercy of the staff. He/she stated that he/she would like to shower every night before bed but he/she was told the facility policy was to shower twice a week. The resident stated that his/her shower days were Wednesdays and Saturdays. The resident expressed concerns that he/she would not be able to get a shower if he/she had a bad episode of bowel incontinence.</p> <p>Review of Resident #34's Baseline Care Plan/RDCP, undated, revealed: I bathe with the help of 1 person doing more than half of the effort to help me wash. I prefer showers .</p> <p>Record review of the Resident Assessment Instrument 3.0 Minimum Data Set (MDS, a federally required nursing assessment for long term care residents) admission assessment, dated 3/12/24, revealed: Section F - Preferences for Customary Routine and Activities . F400. Interview for Daily Preferences . how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? [response] Very important.</p> <p>During an interview on 7/15/24 at 12:39 PM, Certified Nursing Assistant (CNA) #11 stated there were no limits on the frequency a resident could shower or when a resident was able to get up, but mainly depended on the availability of staff. Most of the time the staff were busy, and it was much harder to give showers outside of the resident's schedule.</p> <p>Resident #39</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #39 was admitted to the facility with diagnoses that included Quadriplegia (paralysis of all four limbs) and other chronic osteomyelitis (bone infection caused by bacteria or fungus).</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/9/24 at 9:01 AM, Resident #39 stated he/she was not able to choose more showers when she/he wished. Showers were scheduled two days a week. Resident #39 stated, I often miss showers due to there not being enough staff here.</p> <p>Review of Resident #39's medical record failed to reveal the resident was given showers twice weekly. The baseline care plan revealed the resident was to receive showers twice a week on Tuesdays and Fridays during the day. The showers or bed baths were not given twice a week in the weeks of 6/25-29/24 (resident refused on 6/25/24 since a male CNA was only available to give a shower); 6/30/24-7/6/24; and 7/7-13/24 with only one shower a week documented. A lack of Tuesday showers was noted on the dates of 7/2/24 and 7/9/24.</p> <p>During an observation on 7/12/24 at 10:10 AM, CNA #2 was observed to give Resident #39 a shower by using a ceiling lift device and a shower chair.</p> <p>During an interview on 7/17/24 at 3:31 PM, Licensed Nurse (LN) #1 stated the resident does not always get showered due to the need for a two-person assist and that sometimes there was a lack of staff at the facility. Resident #39 should have showers two times a week. LN #1 stated, [Resident #39] is particular, and sometimes there is no one here to give a shower. [He/she] does refuse a male caregiver.</p> <p>Review of the facility's Your Rights. Our Responsibilities resident rights paperwork in the admission packet, effective date 4/1/21, revealed: As a Resident, you have the Right: . To receive services that meet your individual needs and preferences and choose healthcare, activities and schedules that are consistent with these .</p>		

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<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>47929</p> <p>Based on observations, interviews, and record review, the facility failed to: 1) clearly post the location of available state survey reports in 3 out of 8 cottages due to digital displays being down for repairs; and 2) ensure state survey reports were readily accessible to all residents and resident representatives. This failed practice denied residents, resident representatives, and their families of knowing recent facility surveys were available for review and where they were located.</p> <p>Findings:</p> <p>Aniak, Dershka, and Matanuska Cottages</p> <p>During random observations on 7/8-12/24 revealed large flat screen televisions, that were not turned on, hanging on the wall by the kitchens of the Aniak, Dershka, and Matanuska cottages. Each TV had a sign taped to it that said, Digital Display Down for Repairs Please see posting in the book.</p> <p>During an interview on 7/8/24 at 9:27 AM, when asked about which book the sign taped to the TV was referring to, Certified Nurse Assistant (CNA) #10 did not know. When asked if he/she knew where the state survey results were, CNA #10 did not know.</p> <p>Further observations revealed a countertop by the entry way that contained a wooden grievance box, several unlabeled white three ring binders, a white three ring binder labeled Special Orders, a closed black horizontal three ring binder on a black stand, and various other objects. Once opened, the black horizontal three ring binder revealed a page that contained the following: GOOD THINGS TO KNOW. At Providence Extended Care, our most recent survey results are available for review in the Den.</p> <p>During an interview with the Resident Council on 7/12/24 at 11:47 AM, when asked if the residents knew where the state survey results were, Resident's #59 and #60 stated he/she had never known the state survey results existed. When asked if they knew what book the signs that were taped to the TV's by the kitchens were referring to, or if there was a sign posted in their cottages that directed them to the location of the state survey results, everyone stated that they did not know. Resident #45 stated that he/she had found the state survey results in the extra room with the computer in it (which was the den). Some of the residents replied that they did not use the facility's computer and were not sure where this room was. Resident #60 stated he/she was blind and had his/her own tablet set up to use and expressed concerns about those residents who were bed bound not having access to those results.</p> <p>During an interview on 7/15/24 at 11:43 AM, Resident #34 stated he/she did not know that the state survey results were located or available to read. The resident further stated he/she never noticed any signs posted in his/her cottage indicating the state survey results' location.</p> <p>(continued on next page)</p>		

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<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>An observation on 7/15/24 at 12:42 PM, revealed that the digital display in the Kenai Cottage was active and working appropriately. Further observation revealed the digital display indicated the most recent survey results were located in the dining rooms, and not the den as three-ring binders indicated in other cottages. Further observation revealed the most recent survey results were in the den of the Kenai Cottage.</p> <p>During an interview on 7/17/24 at 3:14 PM, the Senior Manager of Support Services (SMSS) stated that the cottages large TV's by the kitchens are frequently not working. These TV's would normally have facility postings broadcasted to them. The content of the broadcasts was made by the facility, but the feed was controlled by a third party, and they have had issues with the feed. When asked if he knew which book the signs taped to the TV's were referring to, he did not know.</p> <p>Review of Your Rights. Our Responsibilities. resident rights paperwork in the admission packet, effective date 4/1/21, revealed: As a Resident, you have the Right: . To examine results of facility surveys. Results from the past three years are available upon request .</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>43792</p> <p>47929</p> <p>Based on interview, observation, and record review, the facility failed to provide a homelike dining experience for all residents who received cooked meals in the Aniak cottage (based on a census of 12). This failed practice had the potential to cause a sense of being institutionalized, resulting in diminished self-worth and a reduced sense of well-being.</p> <p>Findings:</p> <p>During an interview on 7/8/24 at 9:27 AM, Certified Nurse Assistant (CNA) #10 stated that the cottage did not have a home keeper (cook) that day for the cottage. When the cooks were short staffed, the meals for the cottage were prepared in another cottage, placed in separate disposable Styrofoam clamshell food containers labeled with the resident's room number, and brought over. The CNA and licensed nurse (LN) would serve the meals.</p> <p>During an observation on 7/8/24 at 11:59 AM, an open cart, containing disposable Styrofoam clamshell food containers, was brought into the cottage by [NAME] #1. [NAME] #1 placed all containers on the kitchen counter. At 12:02 PM [NAME] #1 left the cottage. The CNA and LN began serving the meals in the disposable Styrofoam clamshell food containers.</p> <p>During an observation and interview on 7/8/24 at 12:04 PM, Resident #34 was sitting in his/her room, at his/her bedside table with a disposable Styrofoam clamshell food container containing the resident's lunch. Resident #34 stated that the food was cold, but it was no use to call someone to warm it up as it might be forgotten in the microwave, or the staff would take a long time to come get it and heat it up. The resident stated that he/she might as well eat it cold than bother the staff. Resident #34 stated he/she had been eating out of Styrofoam containers all weekend as well as that day. His/her meals were served this way when a cook would call out. When this happened, their meals would be prepared in another cottage and brought over. He/she stated the meals felt like he/she was eating take out and would rather eat off real dishes.</p> <p>During an interview on 7/8/24 at 3:44 PM, Resident #78 showed this surveyor a picture of a meal that was served to him/her on 7/6/24. The picture contained potatoes and carrots that had small traces of pot roast on the food (Resident #78 was a vegetarian) and was served in a disposable Styrofoam clamshell food container. The resident stated this was very upsetting.</p> <p>During an interview on 7/9/24 at 9:07 AM, [NAME] #2 stated that the cottage did not have a cook for the last three days (7/6-8/24), and other cooks in the other cottages would rotate preparing meals for the day. [NAME] #2 stated that meals were served in the disposable Styrofoam clamshell food containers because when a cook was covering another cottage, there was no time to wash dishes for both cottages and complete other duties. If another cottage did not have a cook available for the day, [NAME] #2 would prepare meals for the other cottage first before working on the meals for his/her assigned cottage.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/10/24 at 4:39 PM, the Dietary Manager stated serving meals from disposable Styrofoam clamshell food containers was not ideal and needed to ask dietary why they were delivering food like that. She stated that it did not happen very often and did not know why the food could not be plated.</p> <p>Review of the facility's Providence Extended Care: The Cottages A handbook for residents and their families, revised 7/2024, revealed: Our vision is to provide excellent care in a place that truly is a home to those who live here . Just like mealtime at home, mealtime in the Cottage is a cherished time .</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>40259</p> <p>Based on interview and record review, the facility failed to protect residents in response to allegations of abuse. Specifically, the facility failed to:</p> <p>1) ensure an alleged perpetrator, Licensed Nurse (LN) #6, was immediately removed from resident care, to prevent further potential abuse, while an active abuse investigation was in progress for 1 sampled resident (#83), out of 1 active abuse investigation reviewed; and</p> <p>2) ensure an alleged perpetrator, Certified Nurse Assistant (CNA) #2, was kept from 1 unsampled resident (#86), out of 1 past abuse investigation reviewed, after an investigation of abuse was completed.</p> <p>These failed practices caused psychosocial harm to Residents #'s 83 and 86; and placed all residents of the Susitna Cottage (based on a census of 12), and all residents of the Dshka Cottage (based on a census of 11) at risk for further potential abuse.</p> <p>Findings:</p> <p>Resident #83</p> <p>During an interview on 7/17/24 at 9:10 AM, Resident #83, who was a resident of the Susitna Cottage, stated that on 7/14/24 at 6:00 PM he/she was sitting in his/her wheelchair and felt short of breath. He/she wanted the fan on, and also felt the need for oxygen. Resident #83 stated he/she used his/her call light to call for assistance. Resident #83 stated he/she waited 3 1/2 hours, and since no one came, he/she began to yell for help. Resident #83 stated LN #6 arrived and placed oxygen on him/her. Resident #83 asked LN #6, .when will I get transferred to the bed . Resident #83 stated LN #6 got really out of control screaming. [LN #6] got behind me and hit me like a hammer on top of my head. It hurt really bad. Resident #83 further stated he/she asked LN #6, 'Why are you hitting me?' and [LN #6] was screaming loud. [LN #6] left and left me in my chair.</p> <p>Resident #83 further stated that Resident #32 arrived at Resident #83's room to check on him/her. Resident #83 further stated he/she reported the incident to CNA #9 and then Supervisor Long Term Care Nurse (SRN) #1 arrived in the resident's room on 7/14/24. Resident #83 stated he/she provided his/her report of the incident to SRN #1. Resident #83 further stated that after SRN #1 left, LN #6 remained in the cottage and completed his/her shift on 7/14/24.</p> <p>Resident #83 stated that the next day, 7/15/24, he/she had a headache and was dizzy. Resident #83 stated his/her head was still tender to the touch. Resident #83 stated, I don't want to see [LN #6] again, I am afraid, like a killer they won't stop. [He/She] will do this again. I can't control [him/her], [LN #6] is very strong, powerful.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Providence Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE  920 Compassion Circle Anchorage, AK 99504	
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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/17/24 at 10:30 AM, Resident #32 stated he/she, . heard people fussing and raising hell. Yelling voices loud enough to disturb and upset me. By the time I got to [Resident #83's] room, [LN #6] took off.I asked [Resident #83] what was going on? [Resident #83] stated '[LN #6] hit me on my head.' Resident #32 further stated . I don't want [LN #6] to know I am talking because I am afraid [LN #6] may poison me.</p> <p>Review of Resident #83's base line care plan, undated, revealed: . transfers . I need staff to do 100% of the effort using the overhead lift .</p> <p>Review of Resident #83's care plan, dated 6/11/24, revealed: . I am weak . tell my nurse when I am short of breath .</p> <p>Review of the facility's initial report, completed by SRN #1 on 7/14/24, revealed it was documented that SRN #1 was made aware of the incident at 6:50 PM, and the report was completed at 7:25 PM.</p> <p>Review of the LN #6's hours worked on 7/14/24, from the facility's kronos system (time keeping system that tracked working hours of an employee), revealed LN #6 remained on the clock and worked on the Susitna Cottage until 7:30 PM. LN #6 was allowed to work for 40 minutes after SRN #1 was made aware of the allegation of abuse.</p> <p>During an interview on 7/17/24 at 9:50 AM, SRN #1 stated on the evening of 7/14/24, he/she was informed by CNA #9 that Resident #83 wanted to talk to him/her right away. SRN #1 stated he/she went to the resident's room and Resident #83 reported the allegation of abuse. SRN #1 stated he/she completed the initial report and contacted the Administrator and Director of Nursing (DON) about the incident on 7/14/24 at 7:00 PM.</p> <p>When asked if he/she was aware of the facility's policy to remove staff from the facility, for resident safety, when a report of alleged abuse was given until the investigation was completed, SRN #1 stated he/she was aware of this policy however stated shift change was occurring and LN #6 stayed because he/she was leaving soon. SRN #1 stated he/she did report this incident to the nightshift nursing supervisor prior to him/her leaving for the night.</p> <p>When asked if LN #6 was taken off the schedule until the investigation was over, SRN #1 stated the DON had told him/her, when he/she made contact about the incident, that the Operations Director would intercept LN #6 in the morning to prevent him/her from working on 7/15/24.</p> <p>Review of the facility's staff schedule for 7/15/24, the day after this incident, revealed LN #6 was scheduled to work a full shift on the Deshka Cottage.</p> <p>Review of the LN #6's hours worked on 7/15/24, from the facility's kronos system, revealed LN #6 worked a full shift (7:00 AM to 7:30 PM) on the Deshka Cottage.</p> <p>During an interview on 7/18/24 at 11:15 AM, the Quality Director stated she was only informed of the allegation of abuse concerning LN #6 later in the day on 7/15/24, and LN #6 continued to work through 7/15/24. When told of the DON's plan to have the Operations Director to intercept LN #6 in the morning, the Quality Director stated there was a miscommunication, and that the Operations Director was on vacation on 7/15/24. The Quality Manager stated that LN #6 should have been placed on administrative leave as soon as the report of allegation was received, and the investigation was completed.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #86</p> <p>During an interview on 7/12/24 at 1:09 PM, Resident #86 stated he/she was involved in an incident with CNA #2 where Resident #86 requested assistance after having a urine incontinence accident which resulted in the need for his/her bedding and clothing be changed. Resident #86 stated CNA #2 came into the room frustrated over the situation. At one point, Resident #86 requested another nightshirt. Resident #86 stated CNA #2 retrieved a fresh nightshirt from Resident #86's dresser and threw it in Resident #86's face. Resident #86 stated it was thrown with force, which caused the nightshirt to strike Resident #86's open eyes. Resident #86 further stated that he/she did report the incident and the facility did investigate. The result of the investigation concluded that everyone was having a bad day and it was decided that CNA #2 would not work in Resident #86's Cottage anymore, which Resident #86 was satisfied with and felt the incident was addressed and concluded.</p> <p>Resident #86 stated that a couple of weeks later, CNA #2 returned to the cottage to work, despite the agreement that CNA #2 would no longer work in his/her cottage. As Resident #86 began to cry during the interview, he/she stated he/she felt fearful and reported the incident to a supervisor, although could not remember who it was. Resident #86 stated the supervisor stated CNA #2 had to work the cottage due to staffing shortages. Resident #86 tearfully stated he/she felt so unsafe, he/she didn't leave his/her room the entire day.</p> <p>Review of the facility's investigation of this incident revealed the date of incident was 2/25/24, and the final investigation concluded on 2/28/24. Further review revealed a corrective action plan of [CNA #2] is being moved to another cottage and there is to be no interaction between [CNA #2] and the resident [Resident #86].</p> <p>Review of the CNA #2's hours worked from the facility's kronos system, dated 2/25/24 to 4/30/24, revealed CNA #2 worked a full day in Resident #86's cottage on 3/3/24.</p> <p>During an interview on 7/18/24 at 11:15 AM, the Quality Director stated she could not speak to this incident, the investigation, or the outcome as the Director of Nursing (DON) handled this incident.</p> <p>The DON was not available to interview.</p> <p>Review of the facility's policy SNF [Skilled Nursing Facility]/AL [Assisted Living] Abuse Prohibition and Prevention, last revised 1/2024, revealed: . Protection: Resident will be protected from physical and psychological harm during and after the investigation. Protection measures include, but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation . increased supervision of the alleged victim and other residents at risk; room or staffing changes, if necessary, to protect the resident(s) from the accused; protect from retaliation .</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>40259</p> <p>Based on record review and interview, the facility failed to provide written notice which specified the duration of the bed-hold policy and the reserve bed payment policy for 3 residents (#s 13, 76, and 93), out of 20 sampled residents, who were transferred to the emergency department (ED) for medical treatment. This failed practice had the potential for residents to be uninformed of the facility's bed-hold and reserve bed payment policy, placing them at risk for losing their beds at the facility due to an extended stay at the hospital.</p> <p>Findings:</p> <p>Transfer Process</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed the facility utilized a form called Resident Transfer Form Emergency Department whenever a resident was transported to the ED for evaluation and/or treatment. The form had two parts: 1) the original form, which was white, to which nurses documented on and sent to the ED with the resident; and 2) a carbon copy page, which was yellow, that was torn off and kept at the facility, which was placed in the resident's hard chart (or paper only) medical record.</p> <p>Resident #13</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #13 was admitted to the facility with diagnoses that included hemiplegia and hemiparesis (weakness or paralysis of one side of the body) following a cerebral infarction affecting left non-dominant side and acute kidney failure.</p> <p>Review of Resident #13's medical record revealed the following transfers to the ED and/or hospitalization s:</p> <p>1.) Was transferred to the ED on 1/15/24 and was admitted to the hospital through 1/19/24 for severe sepsis.</p> <p>Further review of Resident #13's medical record revealed there was no yellow transfer form for 1/15/24. There was no documentation in Resident #13's medical record to indicate a notice of bed hold and reserve bed payment policy was provided to the resident.</p> <p>2.) Was transferred to the ED on 2/10/24 and was admitted to the hospital through 2/13/24 for altered mental status.</p> <p>Review of the yellow transfer form, dated 2/10/24, revealed the section Bed Hold Guidelines Enclosed in Transfer Packet was not marked. There was no documentation in Resident #13's medical record to indicate a notice of bed hold and reserve bed payment policy was provided to the resident.</p> <p>3.) Was transferred to the ED on 6/25/24 and was admitted to the hospital through 7/5/24 for lethargy and hypotension.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the yellow transfer form, dated 6/25/24, revealed the section Bed Hold Guidelines Enclosed in Transfer Packet was not marked. There was no documentation in Resident #13's medical record to indicate a notice of bed hold and reserve bed payment policy was provided to the resident.</p> <p>Resident #76</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #76 was admitted to the facility with diagnoses that included intracranial injury (traumatic brain injury) with level of consciousness more than 24 hours without return to consciousness, chronic respiratory failure with hypoxia (inadequate oxygen tension at the cellular level, characterized by increased heart rate, high blood pressure, dizziness, and mental confusion), functional quadriplegia (complete paralysis of the body from the neck down), and persistent vegetative state.</p> <p>Review of Resident #76's medical record revealed the following transfers to the ED and/or hospitalization s:</p> <ol style="list-style-type: none"> <li>1.) Was transferred to the ED on 12/18/23 for seizure activity and returned to the facility the same day.</li> <li>2.) Was transferred to the ED on 4/24/24 and was admitted to the hospital through 5/1/24 for fever and abdominal distention.</li> <li>3.) Was transferred to the ED on 7/14/24 and was admitted to the hospital due to new onset/change of condition due to respiratory status. Resident #76 remained in the hospital through 7/18/24.</li> </ol> <p>Further review of Resident #76's medical record revealed there were no yellow transfer forms for 12/18/23, 4/24/24, or 7/14/24. There was no documentation in Resident #76's medical record to indicate notices of bed hold and reserve bed payment policy were provided to the resident representative for any of these dates.</p> <p>Resident #93</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #93 was admitted to the facility with diagnoses that included vascular parkinsonism (clinical features Parkinson's, caused by cerebrovascular disease, also known as lower-body parkinsonism with gait unsteadiness and absence of tremors) and type 2 diabetes.</p> <p>Review of Resident #93's medical record revealed he/she was transferred to the ED on 3/24/24 for chest pain, however returned to the facility the same day.</p> <p>Further review of Resident #93's record revealed there was no yellow transfer form for 3/24/24. There was no documentation in Resident #93's medical record to indicate a notice of bed hold and reserve bed payment policy was provided to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/16/24 at 3:44 PM, when asked if residents or resident representatives received a notice of bed hold policy and reserve bed payment policy when they transfer to the ED, Licensed Nurse (LN) #8 stated bed hold notices were placed in the transfer packets that went with the residents to the hospital. LN #8 further stated this notice was communication for the hospital and it never came back to the facility to be placed in the resident's medical record.</p> <p>When asked if the nurses ever went over the notice of bed hold policy and reserve bed payment policy with residents prior to being transferred to the ED, LN #8 stated nurses did not.</p> <p>During an interview on 7/17/24 at 3:53 PM, the Medical Records Supervisor stated notice of bed hold policy and reserve bed payment policy was placed in the transfer packets so the nurses could complete them before the resident left the facility.</p> <p>When told of the absence of documentation of notice of bed hold policies and reserve bed payment policies in the resident records, and that the nurses were not completing the forms with the resident prior to leaving, the Medical Records Supervisor stated she was not aware the nurses were not completing the forms.</p> <p>When asked if there was any attempt by the facility to contact the resident, or resident representatives, to inform them of the notice of bed hold policy and reserve bed payment policy, the Medical Records Supervisor stated phone calls were made to these residents or representatives, however this was not documented in the resident's medical record.</p> <p>Review of the facility's Bed Hold Guidelines and Notification notice form, last reviewed 11/2018, revealed the notice included information about the bed hold and reserve bed payment information. Further review revealed a section at the bottom of the page for the date and signature of the resident and/or representative, as well as a place for a facility representative to sign.</p> <p>Review of the facility's policy Bed Hold Policy, dated 7/2024, revealed: . Notice of Bed-Hold Guidelines for Transfers: Before a non-emergency transfer to a hospital or a therapeutic leave, the facility will inform the resident and a family member or legal representative of the facilities guidelines of bed holds. This is accomplished using the Bed Hold Guidelines and Notice form. As soon as practical after an emergency hospital transfer the facility will inform the resident and resident representative of the facility's guidelines on bed holds. This is accomplished using the Bed Hold Guidelines and Notice form. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital . Procedure: Nurse Manager/Shift Supervisor: Completes Resident Transfer form indicating bed hold guidelines sent with resident to the hospital. Copy placed in Health Unit Coordinator box for filing. Health Unit Coordinator: Notifies the Business Office and Admissions Office within one day that a resident has been transferred. Files Resident Transfer form in medical record. Admissions Representative . communicates with hospital case manager on daily status of resident and determines length of any bed hold .</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility's policy SNF [skilled nursing facility] Bed Hold and Return To Facility, last revised 2/2022, revealed: . Bed Hold and Return Notice Upon Transfer: The facility will provide the resident and resident representative a written notice which specifies the duration of the bed hold policy at the time of transfer for hospitalization or therapeutic leave . In cases of emergency transfer, notice at the time of transfer means the facility will either send the notice along with the necessary paperwork to the receiving setting or the resident representative will receive a notice by phone at the time of or within 24 hours of the transfer. Documentation of bed hold notices will be completed in the resident's medical record .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40259</p> <p>47929</p> <p>Based on record review and interview, the facility failed to ensure the comprehensive care plan: 1) included the listing of potential serious side effects of medications used, to ensure monitoring was established for resident safety, for 1 resident (#13), out of 20 sampled residents; and 2) included smoking interventions, for resident and cottage safety, for 1 resident (#92), out of 20 sampled residents. These failed practices had the potential to: 1) place the resident #13 at risk for a delay in identifying serious side effects that could affect the resident's health and wellbeing; and 2) place the Aniak Cottage (based on a census of 11) at risk for potential smoke and fire exposure.</p> <p>Findings:</p> <p>Resident #13</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #13 was admitted to the facility with diagnoses that included hemiplegia and hemiparesis (weakness or paralysis of one side of the body) following a cerebral infarction affecting left non-dominant side and acute kidney failure.</p> <p>Review of Resident #13's care plan revealed an identified need/preference, dated 6/17/24, of I may experience side effects from my medications because I am on the following medications: narcotics, antihypertensive, beta-blocker, anticonvulsants, antispasmodic, antidepressants, anticoagulant and PRN [as needed] antihistamine.</p> <p>Further review revealed an approach, dated 6/17/24, of I need my nurses to give me my medications and evaluate effectiveness and adverse effects of medication. I need my aides to notify my nurse if I have dizziness, drowsiness, confusion, blurred vision, weakness, or change/decline in mental status or signs of bleeding/bruising.</p> <p>Review of Resident #13's Medication Administration Record (MAR), dated 7/1/24 to 7/17/24, revealed the following medications that had potential side effects that were not listed in the care plan:</p> <p>1) Buspirone (an anti-anxiety, or anxiolytic medication) 2.5mg by mouth twice a day given for anxiety.</p> <p>Review of [NAME] 2024 Pocket Drug Guide for Nurses, dated 2024, revealed Buspirone included side effects of abdominal distress, dry mouth, headaches, or insomnia.</p> <p>A serious adverse reaction for this medication could be serotonin syndrome (a serious drug reaction caused by medications that build up high levels of serotonin in the body: symptoms include fast heartbeat, hallucinations, loss of coordination, twitching muscles, severe dizziness, severe nausea/vomiting, unexplained fever, agitation/restlessness).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) Apixaban (Eliquis - an anticoagulant medication) 5mg by mouth twice a day for atrial fibrillation.</p> <p>Review of [NAME] 2024 Pocket Drug Guide for Nurses, dated 2024, revealed Apixaban came with a black box warning (a Food and Drug Administration [FDA] requirement for medications with serious safety risks or rate but dangerous side effects) which stated, premature discontinuation [of the medication] increased risk of thrombotic events [blood clots].</p> <p>Review of Resident # 13's MARs, revealed he/she has had a history of refusing medications, including Apixaban:</p> <ul style="list-style-type: none"> <li>- June 1 through 24, 2024 MAR: Resident refused Apixaban 20 out of the 48 times offered.</li> <li>- July 5 through 16, 2024 MAR: Resident refused Apixaban 4 out of the 23 times offered.</li> </ul> <p>3) Leflunomide (a medication to treat rheumatoid arthritis) 20mg by mouth every morning. This medication was identified as hazardous and required appropriate handling precautions in the MAR, however no instructions for this were visible on the MAR.</p> <p>Review of [NAME] 2024 Pocket Drug Guide for Nurses, dated 2024, revealed Leflunomide came with a black box warning which stated, Risk of severe liver injury, monitor liver function tests [LFTs - lab work].</p> <p>Other side effects listed were erythematous rashes (red, inflamed, bumpy skin rash), diarrhea, headaches, and alopecia (hair loss).</p> <p>4) Levetiracetam (Keppra - an anticonvulsant medication) 250mg by mouth twice a day for seizures.</p> <p>Review of [NAME] 2024 Pocket Drug Guide for Nurses, dated 2024, revealed side effects of behavior abnormalities, psychiatric reactions, dyspepsia (persistent or recurrent pain of the upper abdomen), and headache.</p> <p>5) Metoprolol Succinate ER (Extended Release) (a beta-blocker medication, used to treat chest pain, heart failure, and high blood pressure) 12.5mg by mouth daily in the morning for atrial fibrillation.</p> <p>Review of [NAME] 2024 Pocket Drug Guide for Nurses, dated 2024, revealed serious side effects of laryngospasm and bronchospasm (airway spasms that could affect breathing). Other side effects listed were cardiac arrhythmias, gastric pain, and paresthesia (tingling or prickling sensations).</p> <p>6) Megestrol acetate (a hormone medication used to treat breast cancer, endometrial cancer, and weight loss) 400mg by mouth daily in the morning. This medication was identified as hazardous and required appropriate handling precautions in the MAR, however no instructions for this were visible on the MAR.</p> <p>Review of [NAME] 2024 Pocket Drug Guide for Nurses, dated 2024, revealed Megestrol acetate came with a black box warning which stated, . risk of thromboembolic events [blood clots], stop drug at sx [signs or symptoms] of thrombosis.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Other side effects lists were edema, fluid retention, photosensitivity (sensitivity to ultraviolet rays from sun or other light source), and rash.</p> <p>7) Duloxetine (an antidepressant medication) 30mg by mouth daily at night.</p> <p>Review of [NAME] 2024 Pocket Drug Guide for Nurses, dated 2024, revealed Duloxetine came with a black box warning which stated, monitor for increased depression (agitation, irritability, increased suicidality), especially at start of treatment or dose change .</p> <p>A serious allergic reaction listed was hepatotoxicity (damage to liver). Other side effects listed were serotonin syndrome, sweating, and urinary hesitancy (unable to void).</p> <p>8) Methadone (medication used for relief of severe pain) HCl 5mg by mouth twice a day for pain.</p> <p>Review of [NAME] 2024 Pocket Drug Guide for Nurses, dated 2024, revealed Methadone came with a black box warning which stated, . carefully determine all drugs patient [is] taking, respiratory depression and death have occurred .</p> <p>Other serious side effects listed were apnea, cardiac arrest, circulatory depression, prolonged QT (hearth rhythm), respiratory arrest, respiratory depression, and shock.</p> <p>9) Oxycodone (an opioid narcotic pain medication) concentrate 5mg, or 0.25mL (milliliter), by mouth as needed three times a day for pain.</p> <p>Review of [NAME] 2024 Pocket Drug Guide for Nurses, dated 2024, revealed Oxycodone came with a black box warning which stated, Risk of addiction/abuse/misuse that can lead to overdose/death . other CNS [central nervous system] depressants may result in increased drug effect, potentially fatal respiratory depression, coma, death .</p> <p>During an interview on 7/16/24 at 3:08 PM, the MDS Nurse #1 stated he/she did not look at black box warnings when choosing which side effects were listed in the care plan. The MDS Nurse #1 stated in the electronic MAR, that the nurses work out of, there were drop down options to list side effects for medications, however these side effects were not listed in the care plans for residents. When asked how he/she was ensuring important side effects for each medication were listed in the care plan, the MDS Nurse #1 stated, that's a good question.</p> <p>Resident #92</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #92 was admitted to the facility with diagnoses that included cerebral infarction (a stroke where clusters of brain cell die due to insufficient blood flow), hemiplegia (loss of strength or paralysis on one side of the body) and hemiparesis (mild to moderate muscular weakness on one side of the body), a history of traumatic brain injury, and nicotine dependence.</p> <p>During an interview on 7/8/24 at 3:23 PM, Resident #92 stated he/she smoked cigarettes. The resident confirmed that the cigarettes and lighter are locked in a drawer in his/her room.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Resident Assessment Instrument 3.0 Minimum Data Set (MDS, a federally required nursing assessment for long term care residents) admission assessment dated [DATE] revealed: Section J .Current Tobacco Use . Yes [was checked] .</p> <p>Review of the Baseline Care Plan/RDCP,, undated and printed on 7/10/24 at 2:04 PM, did not document Resident #92's smoking.</p> <p>Review of Resident #92's Care Plan, undated and printed on 7/10/24 at 2:05 PM, did not document Resident #92's smoking.</p> <p>During an interview on 7/17/24 at 9:06 AM, MDS Nurse #1 stated that smoking was something that should be care planned for. When he/she reviewed Resident #92's care plan he/she was unable to locate it.</p> <p>Review of the facility's policy SNF [skilled nursing facility] Baseline Care Plans, revised 2/2022, revealed: The baseline care plan will be developed within 48 hours of a resident's admission and include the minimum healthcare information necessary to properly care for a resident including, but not limited to: Initial goals based on admission orders; physician orders . In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals or physical, mental or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes shall be incorporated into an updated summary .</p> <p>Review of the facility's policy Interdisciplinary Care Plan and Team Conference for Long Term Care Residents, revised 8/2023, revealed: . complete a full assessment of the resident and record problem areas and plan of treatment . any changes should be recorded on the new care plan . the assessment shall identify resident needs and problems . Identify an action plan including the care and services that must be provided to meet resident goals .</p> <p>Review of the facility's policy Smoke Free Environment, revised 12/2022, revealed: . Should a resident and/or a visitor wish to smoke they must be off of the [facility] campus. Resident will have a Smoking Safety Evaluation completed upon admission or when they identify as wanting to smoke, annually and with an identified change of condition. Resident should sign the LOA [leave of absence] book when they leave to facility to smoke. Residents will use a smoking blanket/apron if indicated. Residents should have a reflective flag or equipment on their wheelchair to increase visibility.</p> <p>Further review revealed no indication that smoking should be a part of the resident's care plan.</p>		

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<p>F 0675</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40259</p> <p>.</p> <p>Based on record review, interview, and observation, the facility failed to ensure residents received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.</p> <p>Specifically, the facility's failed to create and sustain an environment that humanizes and individualizes each resident's quality of life and ensuring that the care and services provided were person-centered, and honored and supported each resident's preferences, choices, and values. This failed practice resulted in psychosocial harm for 10 residents (#s 26, 34, 39, 47, 56, 61, 77, 78, 86, and 92).</p> <p>In addition, these failed practices placed the remaining 83 residents at risk for living and receiving care in a less than optimal environment.</p> <p>Findings:</p> <p>Resident Quality of Life</p> <p>During random interviews and observations, 7/8-10/24 and 7/15-18/24, revealed multiple residents expressed feelings of hopelessness, had sad-toned verbal expressions, tearfulness, and shared they experienced apathy, humiliation, frustration, and feelings of helplessness about the current staffing situation and how it has affected their livelihood at the facility.</p> <p>Resident #26</p> <p>During an interview on 7/8/24 at 4:01 PM, Resident #26 stated he/she had requested . no male caregivers for changing and showering. Resident #26 stated males providing hygiene to him/her bothered his/her spouse as well. Resident #26 further stated CNA #3 told him/her, . If your husband doesn't know it will be ok. Resident #26 stated . But it bothers me.</p> <p>During an interview on 7/15/24 at 11:10 AM, CNA #6 stated Resident #26 refused CNA #6 to provide personal cares because Resident # 26's spouse does not like it. CNA #6 stated a male CNA on nights showered resident.</p> <p>During an interview on 7/15/24 at 3:20 PM, LN #7 stated Resident #26 did not want male caregivers providing personal/pericare [cleaning of the genitalia and buttock area]. LN #7 stated, .It is more his/her [spouse] and his/her culture. I have talked to his/her [spouse] many times and explained we do not always have a [female] CNA .</p> <p>Review of the facility-provided ADL assistance documentation from resident's medical records, received 7/16-17/24, revealed Resident #26: I BATHE with 1 helper providing all of the effort. I use the shower chair. I prefer showers .</p> <p>(continued on next page)</p>

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<p>F 0675</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #34</p> <p>During an observation and interview on 7/8/24 at 12:04 PM, Resident #34 was sitting in his/her room, at his/her bedside table with a disposable Styrofoam clamshell food container containing the resident's lunch. Resident #34 stated that the food was cold, but it was no use to call someone to warm it up as it might be forgotten in the microwave, or the staff would take a long time to come get it to heat it up. The resident stated that he/she might as well eat it cold than bother the staff. Resident #34 stated he/she had been eating out of Styrofoam containers all weekend as well as that day. His/her meals were served this way when a cook would not come into work. When this happened, their meals would be prepared in another cottage and brought over. He/she stated the meals felt like he/she was eating take out and would rather eat off real dishes.</p> <p>During an interview on 7/8/24 at 1:50 PM, Resident #34 stated that he/she was at the mercy of the staff. He/she stated that he/she would like to shower every night before bed, but he/she was told the facility policy was to shower twice a week. The resident stated that his/her shower days were Wednesdays and Saturdays. The resident expressed concerns that he/she would not be able to get a shower if he/she had a bad episode of bowel incontinence.</p> <p>Review of Resident #34's MDS (Minimum Data Set - A federally required nursing assessment) annual assessment dated [DATE], revealed: . Section F0400. Interview for Daily Preferences: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Very important .</p> <p>During an interview on 7/15/24 at 11:43 AM, Resident #34 stated twice last week, he/she was not able to get out of bed until dinner time. He/she further stated he/she usually liked to be up and dressed by 8:00 AM daily. The resident expressed that it was very lonely waiting for the staff to come assist with getting him/her out of bed. The resident was unsure what activities he/she missed on those days and expressed that he/she felt that dining at the dining table with other residents at least once a week was important.</p> <p>Review of Resident #34's MDS annual assessment dated [DATE], revealed: . Section F0500. Interview for Daily Preferences: How important is it to you to do things with groups of people? Very important. How important is it to you to do your favorite activities? Very important .</p> <p>Resident #39</p> <p>During an interview on 7/8/24 at 10:58 AM, Resident #39 stated that his/her biggest complaint with the facility was the lack of staffing due to a new system which was one CNA per cottage. There were times when there was no cook, no nurse, or CNA. Resident #39 stated that the lack of staffing consequence was that he/she did not always get his/her shower. Resident #39 stated, when questioned about the lack of showers, stated, This is unacceptable. Resident #39 had concerns that his/her exercises were not always completed. Resident #39 stated, If we lack staff, the replacement has to come from a different cottage. The lack of CNAs has always a problem. The doctors are gone too. The [administrative leadership] are aware of this. We can't take care of ourselves. One CNA with 12 people is a lot.</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #39's Baseline Care Plan, printed on 7/17/24, revealed: Special Precautions . Assist me with ROM exercises to all extremities, 3-5 rep, BID [twice a day] with care as tolerated . I bathe with the help of 1-2 people doing 100% of the care, using the Carendo shower chair. Transfer me with the ceiling lift and blue sling. No Male CNAs during shower. Nails to be trimmed by PCN. Bath/shower: Tuesday (day); Friday (day).</p> <p>During an interview on 7/9/24 at 9:01 AM, Resident #39 stated he/she was not being able to choose more showers when she/he wished. Showers were scheduled two days a week. Resident #39 stated, I often miss showers due to there not being enough staff here.</p> <p>Review of Resident #39's MDS annual assessment, dated 3/14/24, revealed: . Section F0400. Interview for Daily Preferences: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Very important .</p> <p>Resident #47</p> <p>During an observation on 7/15/24 at 12:45 PM, Resident #47 was sitting at dining table and asked staff for help to the bathroom. Occupational Therapist (OT) #1 told Resident #47 that he/she would have to wait for staff. The Dietary Manager was serving food to residents at the dining table. It was observed that Licensed Nurse (LN) #4 was going room to room passing medications. Resident #47 started independently propelling his/her wheelchair (wc) with his/her feet to the nurse. LN #4 told Resident #47 he/she was trying to locate the CNA. It was observed CNA #7 came out of room [ROOM NUMBER] and went immediately towards room [ROOM NUMBER] as Resident #47 was looking towards CNA #7 saying he/she needed to go to the bathroom. CNA #7 ignored Resident #47 and entered room [ROOM NUMBER].</p> <p>At 1:05 PM, Resident #47 continued to request help to the bathroom propelling himself/herself in his/her wc throughout the common space in cottage. OT #1 told Resident #47 he/she would try and find staff to assist him/her. At 1:15 PM, CNA #7 told Resident #47 I have one more person to change first. CNA #7 then entered room [ROOM NUMBER]. At 1:27 PM, it was observed that CNA #7 walk up to the kitchen as OT #1 ask CNA #7 about another resident's meal. Resident #47 noted CNA #7 and started propelling him/herself toward the kitchen from the hallway and tried to get CNA #7's attention. Resident #47 stopped propelling and stopped trying to call out to CNA #7. Resident #47 started to frown and put his/her head down.</p> <p>During an interview on 7/15/24 at 1:28 PM, when asked if he/she still required assistance to the bathroom, Resident #47 frowned putting his/her head down stating they required assistance of toileting hygiene (because the resident had an accident). At 1:29 PM, CNA #7 took Resident #47 to his/her room.</p> <p>Resident #56</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 7/15/24 at 1:48 PM, no CNA, LN, or cook were visibly present in the Yukon cottage. Further observation in Resident #56's room revealed his/her had a breakfast tray to be picked up. Resident #59 used the call light and stated, They won't come, I always wait. Resident #59 stated the breakfast had been delivered around 11:00 AM. The breakfast tray was on his/her lap and the resident was in bed with the head of the bed raised 45 degrees. Observation of the open common areas of the cottage revealed no staff visible. CNA #8 arrived at 2:09 PM and asked Resident #56 what he/she wanted. When asked, why the call light had been delayed and no staff were present in the dayroom, CNA #8 stated he/she did not hear the call light because he/she was in the office charting since the other computer out on the floor did not work.</p> <p>Resident #61</p> <p>During an interview on 7/16/24 at 3:30 PM, Resident #61 stated he/she had to stay in bed for days because there is only one CNA, and they don't have time to get me up. Resident #61 stated he/she missed activities because [of] not enough staff. missed BINGO today .</p> <p>Review of the facility-provided ADL assistance documentation from resident's medical records, received 7/16-17/24, revealed Resident #61: I TRANSFER with the dependent assistance of 1 person, using the ceiling lift with green-trimmed bariatric sling .</p> <p>Resident #77</p> <p>During an interview on 7/10/24 at 9:30 AM, Resident #77's family stated the facility had reduced their CNAs dramatically. This family member stated he/she had witnessed residents in Deskha cottage crying out saying they needed help, however there was no one in the Deshka cottage to help because the CNA was busy with someone else. The family member further stated he/she had called and filed a grievance, however never received a response about it. The family member stated he/she turned the grievance into LN #14 on 6/13/24 and he/she had a copy of the grievance</p> <p>Resident #78</p> <p>During an interview on 7/15/24 at 11:53 AM, Resident #78 stated that the nursing staff do not ask her when she wants to get up, they just let her sleep. The resident stated that he/she is on a diuretic (a drug that helps remove excess water, salts, and other accumulated metabolic products from the body through urine), which increases his/her need to urinate. The resident stated he/she cannot wait long periods of time for staff to answer the call light, which resulted in the resident urinating in bed. This had happened regularly and as recent as two days ago.</p> <p>Review of Resident #78's Baseline Care Plan, printed on 7/12/24, revealed: I USE THE BATHROOM: with the help of 1 person doing less than half the effort. I am continent of bladder and bowel, but wear incontinence briefs in case I have an accident.</p> <p>Resident #86</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/12/24 at 1:09 PM, Resident #86 stated since the staffing change there has been a big problem getting showers because he/she required assistance. Resident #86 stated he/she rarely received a shower, unless he/she felt brave enough to try and take a shower by himself/herself. Resident #86 also stated there had been delays in obtaining a bedpan when needed because there were no staff to answer the request, and he/she had to wait 3 hours once just to relieve himself/herself.</p> <p>Review of the facility-provided ADL assistance documentation from resident's medical records, received 7/16-17/24, revealed Resident #86: I BATHE with 1 helper providing more than half the effort. I sit on the shower chair. I prefer showers .</p> <p>Review of Resident #86's MDS annual assessment, dated 1/23/24, revealed: . Section F0400. Interview for Daily Preferences: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Very important .</p> <p>Resident #86 further stated because nurses must go to other cottages now to help other residents, he/she has had to wait hours for as needed medications for shortness of breath. This had happened so often that he/she had resorted to calling the nurse supervisors for help when nurses weren't in the cottage.</p> <p>Resident #92</p> <p>During an observation and interview on 7/15/24 at 11:49 AM, Resident #92 was in bed and had just finished his/her breakfast of pancakes and peanut butter. The resident said that he/she had waited to be served breakfast since 7:00 AM and had received it about an hour ago. He/she was going to skip lunch because it was so late in the day. The resident pressed his/her call light because he/she wanted nicotine gum. The surveyor left the resident's room.</p> <p>Continued observation on 7/15/24 at 12:38 PM, 46 min later, this surveyor walked over to the call light monitoring system in the common area and saw that Resident #92's call light had been on for 46 minutes. Further observation revealed Resident #92 called out from his/her room to [NAME] #2 in the kitchen. The cook was busy and stated that someone would be in shortly. This surveyor asked Resident #92 if anyone had been in to help, the resident stated no one had come.</p> <p>During an interview while continuing the observation on 7/15/24 at 12:39 PM, CNA #11 stated he/she was the only CNA in the cottage. CNA #11 then went into Resident #92's room and the call light was turned off. Resident #92 waited approximately 51 minutes for staff. At 1:17 PM Resident #92 was observed coming out of his/her room in his/her wheelchair. When asked if he/she received his/her nicotine gum, the resident stated, No and that he/she was headed out to go smoke.</p> <p>Resident Council Meeting Minute Review</p> <p>Review of Resident Council meeting minutes, dated 1/17/24, revealed: . Resident shared concerns of the night CNA's leaving the cottage for an extended amount of time and not available to help with their own resident[s]. Resident believes it is a safety concern. Resident shared concerns that his call light is not being answered at nights due to caregivers not being available in the cottages. He feels this is escalating and not being addressed.</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident Council meeting minutes, dated 4/17/24, revealed: . Resident asked for clarification on toileting assistance with 1 C.N.A. in each cottage. Residents concern is waiting for assistance at night to get help to the toilet and will that also be a problem during the day?.</p> <p>Review of Resident Council meeting minutes, dated 6/20/24, revealed: . Residents' concerns as follows: Will we have someone on the weekends helping us get out of bed and help with getting ready for the day including church services on Sundays? Resident shared she has not been getting up daily as she should and having to wait to be put back to bed causing her pain on the weekend. [DON] acknowledged residents' complaint and explained that the weekend was very challenged with caregivers calling out and staffing being extremely short.</p> <p>Food/Dining</p> <p>During an interview on 7/8/24 at 9:27 AM, CNA #10 stated the Aniak cottage did not have a home keeper (cook) that day for the cottage. When the cooks were short staffed, the meals for the cottage were prepared in another cottage, placed in separate disposable Styrofoam clamshell food containers labeled with the resident's room number, and brought over. The CNA and LN would serve the meals.</p> <p>During an interview on 7/8/24 at 1:20 PM, LN #3 stated the lack of staff was a problem. Whenever a CNA was missing, that was a problem. If the cottage's cook was not working that day, the food came from a different cottage. LN #3 stated the housekeepers are often short staffed too.</p> <p>During an interview on 7/9/24 at 9:07 AM, [NAME] #2 stated that the Aniak cottage did not have a cook for the last three days (7/6-8/24), and other cooks in the other cottages would rotate preparing meals for the day. [NAME] #2 stated that meals were served in the disposable Styrofoam clamshell food containers because when a cook was covering another cottage, there was no time to wash dishes for both cottages and complete other duties. If another cottage did not have a cook available for the day, [NAME] #2 would prepare meals for the other cottage first before working on the meals for his/her assigned cottage.</p> <p>During an interview on 7/10/24 at 4:39 PM, the Dietary Manager stated serving meals from disposable Styrofoam clamshell food containers was not ideal and needed to ask dietary why they were delivering food like that.</p> <p>Staffing/Care Deficits</p> <p>During an interview on 7/10/24 at 3:26 PM, when asked to describe the current staffing situation in the cottages, the Administrator stated the facility traditionally would have had one nurse in every cottage (12 residents per cottage), and 16 CNAs (2 CNAs per cottage) scheduled on the dayshift, however since COVID they had not been able to meet that staffing level. The Administrator stated that the facility was currently running at crisis staffing level where there was one nurse for every 18 resident (one nurse per 1 and a half cottages) and one CNA for every 12 residents (one CNA per cottage), and there was a goal of having 4 support CNAs (1 support CNA per two cottages) to provide support and complete showers. However, when staff call out of work, the facility had only been able to provide about 3 support CNAs a day.</p> <p>During the same interview, when asked if the facility had received any calls or grievances about the staffing shortages, the Administrator stated there had been grievances from families.</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/11/24 at 1:25 PM, when asked if staff had voiced any concerns about the staffing levels, the Director of Nursing (DON) stated nurses had expressed concerns on having to pick up extra residents in a second cottage. The CNAs had expressed concerns that the home keepers, housekeepers, and activity staff weren't supporting them during the day because they were unsure on what they could or couldn't do.</p> <p>During an interview on 7/12/24 at 10:29 AM, the Lead CNA (LCNA) stated staffing shortage and crisis level staffing had affected resident care, the LCNA stated it was a challenge to meet the needs of residents as swiftly as they could have with a full complement of staff, and that staff were not able to give the residents the level of attention they used to.</p> <p>During the same interview the LCNA stated it was hard to meet the needs of the residents, and residents had voiced that their care had been delayed, to include not getting showers, and they didn't like the new staffing schedule. The LCNA further stated that if there weren't enough support CNAs, residents would get bed baths instead of showers because there were not enough staff to provide showers. The LCNA further stated that having only one CNA per cottage now meant that residents had to wait longer for their needs to be met and it may have impacted pressure ulcers because the CNAs were having trouble meeting the turning schedule of every 2 hours.</p> <p>During an interview on 7/16/24 at 4:35 PM, LN #8 stated staff shortages had affected the ability to spend time with the residents. LN #8 stated it was a struggle to complete turns every 2 hours and showers. When properly staffed it used to be enjoyable and staff could spend time with residents to put on lotion, however staff are now rushed due to the increased workload that resulted in the staff being less available. LN #8 further stated quality time with residents wasn't possible anymore.</p> <p>During an interview on 7/17/24 at 3:28 PM, CNA #11 stated the 4 person CNA support teams doesn't work and cottage CNAs end up doing everything on their own. CNA #11 further stated nurses would help, when they are available, but it wasn't easy for the nurses because they now had to cover other cottages.</p> <p>During an interview on 7/18/24 at 11:27 AM, the Quality Director stated she felt that the lack of staffing, and their inability to provide more one on one attention to residents, had attributed to and increase in pressure related injuries.</p> <p>During an interview on 7/17/24 at 8:17 AM, when asked if the concerns with low staffing had impacted the resident's care, the Medical Director stated residents did talk to her about how staff needed help. The Medical Director further stated low staffing was affecting the residents with higher acuity, who required heavier assistance in cares, more than the residents who were more independent.</p> <p>During an interview on 7/17/24, when asked if the number of staff currently working, based on the bed capacity of 96, was able to meet the needs of the resident acuity levels, the Administrator stated she felt they were able to meet the needs, but not at the standard we would want to meet them.</p> <p>Review of the facility's policy SNF [skilled nursing facility]/AL [assisted living] Abuse Prohibition and Prevention, revised 1/2024, revealed: . The purpose of this policy is to set forth the . policy regarding the prohibition and prevention of resident . neglect . Definitions . Neglect . means 'the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .</p>		

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  07/19/2024
NAME OF PROVIDER OR SUPPLIER  Providence Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE  920 Compassion Circle Anchorage, AK 99504	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40259</p> <p>Based on record review, interview, and observation, the facility failed to ensure appropriate treatment and services that includes all care provided to residents to maximize the resident's functional abilities.</p> <p>Specifically, the facility failed to ensure Activities of Daily Living (ADLs - the skills of bathing, dressing, toileting, transferring, bed mobility, and eating) were completed to meet the needs of 8 Residents (#s 26, 34, 39, 47, 61, 78, 86, and 92), out of 20 sampled residents, as determined by resident acuity [acuity is a measurement of the level of care a patient need based on the severity of either an illness or mental condition]. This failed practice resulted in psychosocial harm of these residents. In addition, this failed practice also resulted in two residents (#s 56 and 77) not having ADL needs met. The overall inability to provided ADL care had the potential to affect the other 83 residents placing them at risk for not receiving services to maintain the highest practicable physical, mental, and psychosocial wellbeing.</p> <p>Findings:</p> <p>Review of the facility-provided ADL [Activities of Daily Living] assistance documentation from resident's medical records, received 7/16-17/24, revealed the following need for assistance from staff:</p> <p>1) Bed Mobility (Turning or adjusting):</p> <ul style="list-style-type: none"> <li>- Independent: 4 residents</li> <li>- One-person assist: 62 residents</li> <li>- One to two person assist: 9 residents</li> <li>- Two-person assist: 15 residents</li> <li>- Information not provided: 3 residents (#s 8, 28, and 60)</li> </ul> <p>2) Transfer (from bed to wheelchair):</p> <ul style="list-style-type: none"> <li>- Independent: 2 residents</li> <li>- One-person assist: 62 residents</li> <li>- One to two person assist: 11 residents</li> <li>- Two-person assist: 15 residents</li> <li>- Information not provided: 3 residents (#s 8, 62, and 87)</li> </ul> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>3) Bathing:</p> <ul style="list-style-type: none"> <li>- Independent: 2 residents</li> <li>- One-person assist: 74 residents</li> <li>- One to two person assist: 6 residents</li> <li>- Two person assist: 8 residents</li> <li>- Information not provided: 3 residents (#s 8, 33, and 76)</li> </ul> <p>4) Eating:</p> <ul style="list-style-type: none"> <li>- Independent: 5 residents</li> <li>- Set Up Assistance: 40 residents</li> <li>- Dependent: 23 residents</li> <li>- Intermittent Supervision: 4 residents</li> <li>- Enteral feeding: 9 residents</li> <li>- Information not provided: 12 residents (#s 8, 12, 33, 49, 51, 57, 66, 76, 77, 79, 82, and 91)</li> </ul> <p>5) Toileting:</p> <ul style="list-style-type: none"> <li>- Independent: 2 residents</li> <li>- One-person assist: 65 residents</li> <li>- One to two person assist: 13 residents</li> <li>- Two-person assist: 10 residents</li> <li>- Information not provided: 3 residents (#s 8, 61, and 76)</li> </ul> <p>Staffing:</p> <p>During an interview on 7/11/24 at 1:25 PM, when asked if staff had voiced any concerns about the staffing levels, the DON stated nurses had expressed concerns on having to pick up extra residents in a second cottage. The CNAs had expressed concerns that the home keepers, housekeepers, and activity staff weren't supporting them during the day because they were unsure on what they could or couldn't do.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>When asked specifically what the home keepers, housekeepers, and activity staff could do to support the CNAs, the DON stated they could assist only with bed mobility or transfers of resident when the CNAs were present, however they could not assist by themselves, and they could not assist with toileting. Also, for dining assistance, they could help with cuing and support resident's hands or arms to allow the residents to feed themselves, however they could not feed residents.</p> <p>Random observations on 7/8-10/24 and 7/15-18/24 revealed no home keepers, housekeepers, or activity staff assisted CNAs with bed mobility, transfers, or dining assistance.</p> <p>During an interview on 7/12/24 at 10:29 AM, when asked how the staffing shortage and crisis level staffing had affected resident care, the Lead CNA (LCNA) stated it was a challenge to meet the needs of residents as swiftly as they could have with a full complement of staff, and that staff were not able to give the residents the level of attention they used to. The LCNA stated it was hard to meet the needs of the residents, and residents had voiced that their care had been delayed, to include not getting showers, and they didn't like the new staffing schedule. The LCNA further stated that if there weren't enough support CNAs, residents would get bed baths instead of showers because there were not enough staff to provide showers.</p> <p>Resident Review</p> <p>Resident #26</p> <p>During an interview on 7/8/24 at 4:01 PM, Resident #26 stated he/she had requested . no male caregivers for changing and showering. Resident #26 stated males providing hygiene to him/her bothered his/her spouse as well. Resident #26 further stated CNA #3 told him/her, . If your husband doesn't know it will be ok. Resident #26 stated . But it bothers me.</p> <p>During an interview on 7/15/24 at 11:10 AM, CNA #6 stated Resident #26 refused CNA #6 to provide personal cares because Resident # 26's spouse does not like it. CNA #6 stated a male CNA on nights showered resident.</p> <p>During an interview on 7/15/24 at 3:20 PM, LN #7 stated Resident #26 did not want male caregivers providing personal/pericare [cleaning of the genitalia and buttock area]. LN #7 stated, .It is more his/her [spouse] and his/her culture. I have talked to his/her [spouse] many times and explained we do not always have a [female] CNA .</p> <p>Review of the facility-provided ADL assistance documentation from resident's medical records, received 7/16-17/24, revealed Resident #26: I BATHE with 1 helper providing all of the effort. I use the shower chair. I prefer showers .</p> <p>The LCNA further stated that having only one CNA per cottage now meant that residents had to wait longer for their needs to be met and it may have impacted pressure ulcers because the CNAs were having trouble meeting the turning schedule of every 2 hours.</p> <p>Resident #34</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/8/24 at 1:50 PM, Resident #34 stated that he/she was at the mercy of the staff. He/she stated that he/she would like to shower every night before bed, but he/she was told the facility policy was to shower twice a week. The resident stated that his/her shower days were Wednesdays and Saturdays. The resident expressed concerns that he/she would not be able to get a shower if he/she had a bad episode of bowel incontinence.</p> <p>Review of Resident #34's MDS (Minimum Data Set - A federally required nursing assessment) annual assessment dated [DATE], revealed: . Section F0400. Interview for Daily Preferences: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Very important .</p> <p>During an interview on 7/15/24 at 11:43 AM, Resident #34 stated twice last week, he/she was not able to get out of bed until dinner time. He/she further stated he/she usually liked to be up and dressed by 8:00 AM daily. The resident expressed that it was very lonely waiting for the staff to come assist with getting him/her out of bed. The resident was unsure what activities he/she missed on those days and expressed that he/she felt that dining at the dining table with other residents at least once a week was important.</p> <p>Review of Resident #34's MDS annual assessment dated [DATE], revealed: . Section F0500. Interview for Daily Preferences: How important is it to you to do things with groups of people? Very important. How important is it to you to do your favorite activities? Very important .</p> <p>Resident #39</p> <p>During an interview on 7/8/24 at 10:58 AM, Resident #39 stated that his/her biggest complaint with the facility was the lack of staffing due to a new system which was one CNA per cottage. There were times when there was no cook, no nurse, or CNA. Resident #39 stated that the lack of staffing consequence was that he/she did not always get his/her shower. Resident #39 stated, when questioned about the lack of showers, stated, This is unacceptable. Resident #39 had concerns that his/her exercises were not always completed. Resident #39 stated, If we lack staff, the replacement has to come from a different cottage. The lack of CNAs has always a problem. The doctors are gone too. The [administrative leadership] are aware of this. We can't take care of ourselves. One CNA with 12 people is a lot.</p> <p>Review of Resident #39's Baseline Care Plan, printed on 7/17/24, revealed: Special Precautions . Assist me with ROM exercises to all extremities, 3-5 rep, BID [twice a day] with care as tolerated . I bathe with the help of 1-2 people doing 100% of the care, using the Carendo shower chair. Transfer me with the ceiling lift and blue sling. No Male CNAs during shower. Nails to be trimmed by PCN. Bath/shower: Tuesday (day); Friday (day).</p> <p>During an interview on 7/9/24 at 9:01 AM, Resident #39 stated he/she was not being able to choose more showers when she/he wished. Showers were scheduled two days a week. Resident #39 stated, I often miss showers due to there not being enough staff here.</p> <p>Review of Resident #39's MDS annual assessment, dated 3/14/24, revealed: . Section F0400. Interview for Daily Preferences: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Very important .</p> <p>Resident #47</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 7/15/24 at 12:45 PM, Resident #47 was sitting at dining table and asked staff for help to the bathroom. Occupational Therapist (OT) #1 told Resident #47 that he/she would have to wait for staff. The Dietary Manager was serving food to residents at the dining table. It was observed that Licensed Nurse (LN) #4 was going room to room passing medications. Resident #47 started independently propelling his/her wheelchair (wc) with his/her feet to the nurse. LN #4 told Resident #47 he/she was trying to locate the CNA. It was observed CNA #7 came out of room [ROOM NUMBER] and went immediately towards room [ROOM NUMBER] as Resident #47 was looking towards CNA #7 saying he/she needed to go to the bathroom. CNA #7 ignored Resident #47 and entered room [ROOM NUMBER].</p> <p>At 1:05 PM, Resident #47 continued to request help to the bathroom propelling himself/herself in his/her wc throughout the common space in cottage. OT #1 told Resident #47 he/she would try and find staff to assist him/her. At 1:15 PM, CNA #7 told Resident #47 I have one more person to change first. CNA #7 then entered room [ROOM NUMBER]. At 1:27 PM, it was observed that CNA #7 walk up to the kitchen as OT #1 ask CNA #7 about another resident's meal. Resident #47 noted CNA #7 and started propelling him/herself toward the kitchen from the hallway and tried to get CNA #7's attention. Resident #47 stopped propelling and stopped trying to call out to CNA #7. Resident #47 started to frown and put his/her head down.</p> <p>During an interview on 7/15/24 at 1:28 PM, when asked if he/she still required assistance to the bathroom, Resident #47 frowned putting his/her head down stating they required assistance of toileting hygiene (because the resident had an accident). At 1:29 PM, CNA #7 took Resident #47 to his/her room.</p> <p>Resident #56</p> <p>During an observation and interview on 7/15/24 at 1:48 PM, no CNA, LN, or cook were visibly present in the Yukon cottage. Further observation in Resident #56's room revealed his/her had a breakfast tray to be picked up. Resident #59 used the call light and stated, They won't come, I always wait. Resident #59 stated the breakfast had been delivered around 11:00 AM. The breakfast tray was on his/her lap and the resident was in bed with the head of the bed raised 45 degrees. Observation of the open common areas of the cottage revealed no staff visible. CNA #8 arrived at 2:09 PM and asked Resident #56 what he/she wanted. When asked, why the call light had been delayed and no staff were present in the dayroom, CNA #8 stated he/she did not hear the call light because he/she was in the office charting since the other computer out on the floor did not work.</p> <p>Resident #61</p> <p>During an interview on 7/16/24 at 3:30 PM, Resident #61 stated he/she had to stay in bed for days because there is only one CNA, and they don't have time to get me up. Resident #61 stated he/she missed activities because [of] not enough staff. missed BINGO today .</p> <p>Review of the facility-provided ADL assistance documentation from resident's medical records, received 7/16-17/24, revealed Resident #61: I TRANSFER with the dependent assistance of 1 person, using the ceiling lift with green-trimmed bariatric sling .</p> <p>Resident #77</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/10/24 at 9:30 AM, Resident #77's family stated the facility had reduced their CNAs dramatically. This family member stated he/she had witnessed residents in Deskha cottage crying out saying they needed help, however there was no one in the Deshka cottage to help because the CNA was busy with someone else.</p> <p>Resident #78</p> <p>During an interview on 7/15/24 at 11:53 AM, Resident #78 stated that the nursing staff do not ask her when she wants to get up, they just let her sleep. The resident stated that he/she is on a diuretic (a drug that helps remove excess water, salts, and other accumulated metabolic products from the body through urine), which increases his/her need to urinate. The resident stated he/she cannot wait long periods of time for staff to answer the call light, which resulted in the resident urinating in bed. This had happened regularly and as recent as two days ago.</p> <p>Review of Resident #78's Baseline Care Plan, printed on 7/12/24, revealed: I USE THE BATHROOM: with the help of 1 person doing less than half the effort. I am continent of bladder and bowel, but wear incontinence briefs in case I have an accident.</p> <p>Resident #86</p> <p>During an interview on 7/12/24 at 1:09 PM, Resident #86 stated since the staffing change there has been a big problem getting showers because he/she required assistance. Resident #86 stated he/she rarely received a shower, unless he/she felt brave enough to try and take a shower by himself/herself. Resident #86 also stated there had been delays in obtaining a bedpan when needed because there were no staff to answer the request, and he/she had to wait 3 hours once just to relieve himself/herself.</p> <p>Review of the facility-provided ADL assistance documentation from resident's medical records, received 7/16-17/24, revealed Resident #86: I BATHE with 1 helper providing more than half the effort. I sit on the shower chair. I prefer showers .</p> <p>Review of Resident #86's MDS annual assessment, dated 1/23/24, revealed: . Section F0400. Interview for Daily Preferences: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Very important .</p> <p>Resident #86 further stated because nurses must go to other cottages now to help other residents, he/she has had to wait hours for as needed medications for shortness of breath. This had happened so often that he/she had resorted to calling the nurse supervisors for help when nurses weren't in the cottage.</p> <p>Resident #92</p> <p>During an observation and interview on 7/15/24 at 11:49 AM, Resident #92 was in bed and had just finished his/her breakfast of pancakes and peanut butter. The resident said that he/she had waited to be served breakfast since 7:00 AM and had received it about an hour ago. He/she was going to skip lunch because it was so late in the day. The resident pressed his/her call light because he/she wanted nicotine gum. The surveyor left the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Continued observation on 7/15/24 at 12:38 PM, 46 min later, this surveyor walked over to the call light monitoring system in the common area and saw that Resident #92's call light had been on for 46 minutes. Further observation revealed Resident #92 called out from his/her room to [NAME] #2 in the kitchen. The cook was busy and stated that someone would be in shortly. This surveyor asked Resident #92 if anyone had been in to help, the resident stated no one had come.</p> <p>During an interview while continuing the observation on 7/15/24 at 12:39 PM, CNA #11 stated he/she was the only CNA in the cottage. CNA #11 then went into Resident #92's room and the call light was turned off. Resident #92 waited approximately 51 minutes for staff. At 1:17 PM Resident #92 was observed coming out of his/her room in his/her wheelchair. When asked if he/she received his/her nicotine gum, the resident stated, No and that he/she was headed out to go smoke.</p> <p>Staff Interview</p> <p>During an interview on 7/15/24 at 12:39 PM, CNA #11 stated there were no limits on the frequency a resident can get up out of bed or have a shower but depended on the availability of staff. Most of the time the staff were busy, and it was much harder to give showers outside of the residents' schedule.</p> <p>During an interview on 7/16/24 at 4:35 PM, LN #8 stated staff shortages had affected the ability to spend time with the residents. LN #8 stated it was a struggle to complete turns every 2 hours and showers. When properly staffed it used to be enjoyable and staff could spend time with residents to put on lotion, however staff are now rushed due to the increased workload that resulted in the staff being less available. LN #8 further stated quality time with residents wasn't possible anymore.</p> <p>During an interview on 7/17/24 at 3:28 PM, CNA #11 stated the 4 person CNA support teams doesn't work and cottage CNAs end up doing everything on their own. CNA #11 further stated nurses would help, when they are available, but it wasn't easy for the nurses because they now had to cover other cottages.</p> <p>Administration</p> <p>During an interview on 7/17/24 at 8:17 AM, when asked if the concerns with low staffing had impacted the resident's care, the Medical Director stated residents did talk to her about how staff needed help. The Medical Director further stated low staffing was affecting the residents with higher acuity, who required heavier assistance in cares, more than the residents who were more independent. The Medical Director further stated If turning residents isn't getting completed, I would say we need to find avenues to get it done.</p> <p>During an interview on 7/17/24, the Administrator stated she felt they were able to meet the needs, but not at the standard we would want to meet them.</p> <p>Review of the facility's Providence Anchorage Long Term Care Standards of Care, revised 5/2023, revealed: . These standards are established as daily expectations for care of resident unless otherwise directed on the plan of care. The RDCP [baseline care plan] builds on this standard of care .</p> <p>-A.M. Care (every morning) . Toilet [and] pericare . completely groomed and dressed . ROM [range of motion] as per care plan with 3-5 reps [repetitions] or to tolerance .</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>- H.S. [nighttime] Care (every HS at bedtime) . Toileted [and] peri care . ROM as per care plan with 3-5 reps or to tolerance .</p> <p>- Periodic Care: shower/bath as scheduled. Provide complete bed bath if scheduled shower cannot be given .</p> <p>- Ongoing Care: call lights: work as team to meet the goal of answering regular within 5-10 minutes . Provide peri care after voids, BM [bowel movement] . Turning/reposition [ever] 2 hours for residents with dependent mobility . Follow toileting schedules ([every] 2 hours means even hours) .</p> <p>- Approaches: Listen to resident - affirm self-worth [and] dignity . Promote resident choice and personal preference whenever possible.</p> <p>Review of the facility's policy SNF [skilled nursing facility]/AL [assisted living] Abuse Prohibition and Prevention, revised 1/2024, revealed: . The purpose of this policy is to set forth the . policy regarding the prohibition and prevention of resident . neglect . Definitions . Neglect . means 'the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>43792</p> <p>Based on record review, interview, and observation, the facility failed to ensure all treatments and care were provided for 4 Residents (#s 35, 39, 48 and 82), out of 20 sampled residents. This failed practice placed the residents at risk of decreased overall health and wellbeing.</p> <p>Findings:</p> <p>Resident #35</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #35 was admitted to the facility with diagnoses that included other paralytic syndrome following subarachnoid hemorrhage, bilateral (a paralysis after a brain hemorrhage) and essential hypertension (high blood pressure).</p> <p>Further review revealed the resident was verbal, confused about time, had a short attention span, and needed assist with transferring. A double-sided padded mitten had been placed on the right hand to prevent the resident from injuring him/herself.</p> <p>Review of Resident #35's physician orders, dated 2/8/24, revealed the double-sided padded mitten was to be removed and the resident was to be checked every 2 hours for adverse effects.</p> <p>Review of Resident #35's treatment record revealed no documentation of these checks on 6/28/24 at 12:00 AM, 2:00 AM, 4:00 AM, and 6:00 AM; and on 7/9/24 and 7/10/24 at 8:00 PM and 10:00 PM.</p> <p>Review of Resident #35's physician orders, dated 2/8/24, revealed an order for daily wound care to a neurotic excoriation (a wound associated with a resident repetitively picking one's own skin to the point of causing open sores) on the right buttock.</p> <p>Review of Resident #35's treatment record revealed no documentation of this wound care on 6/21/24.</p> <p>During an interview on 7/18/24 at 11:00 AM, the Quality Director stated agreement that there were holes on the treatment records.</p> <p>Review of the facility's protocol Safety and Positioning Interventions including Restraints, dated 4/2024, revealed: . Resident will not experience adverse effects of intervention/restraint (e.g., injury from device, decreased mobility, impaired skin integrity, impaired self-esteem, etc.[]). Safety correct intervention/restraint is in use. Check every 2 hours .</p> <p>Resident #39</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #39 was admitted to the facility with diagnoses that included Quadriplegia, C5-C7 Complete (paralysis of the body from the neck down) and Neurogenic Bowel (loss of normal bowel function due to a nerve or spinal cord problem).</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 - Some</p>	<p>Further review revealed resident was verbal, had a suprapubic catheter (a surgically placed drain for urine to flow out of the bladder through the abdominal wall), had a colostomy (a surgical opening through the abdominal wall for bowel movement removal), and needed one or two assist with all activities of daily living.</p> <p>Review of Resident #39's MDS (Minimum Data Set - A federally mandated nursing assessment), a Quarterly review dated 6/11/24, was coded at risk of developing pressure ulcers. The resident had a Stage 1 or higher-pressure ulcer, which was coded as an unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar.</p> <p>Review of Resident #39's Braden Scale [a tool used to assess risk for pressure ulcers] assessment, dated 6/25/24, revealed: Mobility very limited - makes occasional slight changes in body/extremity position, can't make frequent/significant changes alone (requires dependent assistance 1-2 staff for repositioning), Friction/shear problem - moderate/maximum assistance to move, can't lift without sliding on sheets, slides in bed/chair, constant friction (requires dependent assistance 1-2 staff for all mobility).</p> <p>Care Plan Review</p> <p>Review of Resident #39's Care Plan, dated 6/26/24, revealed: I have a current pressure injury and I have a history of skin injuries. I need my nurses to reduce pressure and friction between myself and my bed or chair, keep my bed at 30 degrees to my comfort level . monitor my nutrition or hydration intake, monitor my turning and repositioning, check my skin with cares . administer prophylactic wound care.</p> <p>Review of Resident #39's in-room Baseline Care Plan, printed on 7/17/24, revealed: I have a pressure injury (Stage 4, reopened on my right ischium [curved bone to base of hip]). I have a history of healed pressure ulcers on my buttocks. Reposition me every 2 hours- see turning schedule. Use pillows to reposition me comfortably. Notify nurse if prophylactic dressings are soiled or have come off. Make sure my mattress is always on and in good working condition. Make sure that my Roho cushion is adequately inflated when in use. Use lifting sheet when moving me in bed to prevent skin shearing. Apply barrier cream to non-open area on my buttocks/peri-area with each peri-care. Keep head of bed less than 30 degrees except for brief periods as tolerated. Limit my time up in wheelchair X 2 hours at a time.</p> <p>Turning/Repositioning Documentation Review</p> <p>Review of Resident #39's Certified Nursing Assistant (CNA) documentation, dated 7/1-12/24, revealed the CNAs did not document repositioning of the resident every 2 hours as was care planned for:</p> <ul style="list-style-type: none"> <li>- 7/1/24 at 1:44 AM;</li> <li>- 7/1/24 at 12:56 PM (11 hours and 54 minutes later);</li> <li>- 7/2/24 at 3:24 AM (14 hours and 28 minutes later);</li> <li>- 7/2/24 at 11:46 AM (8 hours and 22 minutes later);</li> </ul> <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 - Some</p>	<ul style="list-style-type: none"> <li>- 7/3/24 at 1:41 AM (13 hours and 55 minutes later);</li> <li>- 7/3/24 at 1:36 PM (11 hours and 55 minutes later);</li> <li>- 7/4/24 at 2:01PM (24 hours and 25 minutes later);</li> <li>- 7/5/25 at 1:57 AM (11 hours and 56 minutes later);</li> <li>- 7/5/24 at 11:51 AM (9 hours and 54 minutes later);</li> <li>- 7/6/24 at 12:42 AM (12 hours and 51 minutes later);</li> <li>- 7/6/24 at 7:42 PM (19 hours later);</li> <li>- 7/7/24 at 1:21 AM (5 hours and 39 minutes later);</li> <li>- 7/7/24 at 8:10 PM (18 hours and 49 minutes later);</li> <li>- 7/8/24 at 12:48 AM (4 hours and 38 minutes later);</li> <li>- 7/8/24 at 3:30 PM (14 hours and 42 minutes later);</li> <li>- 7/9/24 at 12:45 AM (9 hours and 15 minutes later);</li> <li>- 7/9/24 at 6:12 PM (17 hours and 27 minutes later);</li> <li>- 7/10/24 at 12:37 AM (6 hours and 25 minutes later);</li> <li>- 7/10/24 at 10:29 AM (9 hours and 52 minutes later);</li> <li>- 7/11/24 at 12:37 AM (14 hours and 8 minutes later);</li> <li>- 7/11/24 at 3:10 PM (14 hours and 33 minutes later);</li> <li>- 7/12/24 at 12:47 PM (21 hours and 37 minutes later); and</li> <li>- 7/12/24 at 1:34 PM (47 minutes later).</li> </ul> <p>Further review revealed no documented proof that repositioning had occurred every 2 hours.</p> <p>Wound Care Documentation Review</p> <p>Review of Resident #39's treatment administration record (TAR), for July 2024, revealed an order, dated 5/24/24 and discontinued on 7/9/24, for wound care for a stage 4 pressure injury that had reopened on his/her right ischium and buttock area.</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 - Some</p>	<p>The order was for the nurse to cleanse the wound with Vashe cleanser (a wound cleanser), apply skin prep to intact skin surrounding wound, apply to open or red areas: honey gel (inhibits bacterial growth protecting the wound), pack or cover wound with calcium alginate (a dressing to soak up any fluids), cut strip to cover open and macerated (liquid saturated skin or wound) areas, cover wound with foam dressing (Allevyn Life) border sacrum, and change the dressing 2 times a week on Tuesdays and Fridays and as needed if soiled or soaked.</p> <p>Review of Resident #39's treatment record revealed no documentation of this wound care on 7/2/24 and 7/5/24.</p> <p>Further review of Resident #39's TAR, for July 2024, revealed a new order with updated wound treatment, dated 7/9/24, for the wound care of the stage 4 pressure injury that had reopened on his/her right ischium/buttock area.</p> <p>The order was for the nurse to cleanse with Vashe cleanser, apply skin prep to intact skin surrounding wound, pack or cover wound with Silver coated Mesh [Acticoat - a dressing that provides a barrier to protect wounds], cover wound with foam dressing (Allevyn Life) border sacrum, and change the dressing two times a week on Tuesdays and Fridays in the morning and as needed if soiled or soaked.</p> <p>Review of Resident #39's treatment record revealed no documentation of this wound care on 7/9/24 and 7/12/24.</p> <p>During an interview on 7/17/24 at 5:00 PM, Wound Care Nurse (WRN) #1 agreed that the treatments should have been documented on the treatment record as completed when asked why the treatment record was not completed.</p> <p>Resident #48</p> <p>Record review from 7/8-12/24 and 7/15-19/24 revealed Resident #48 was admitted to the facility with diagnoses that included diabetes mellitus, multiple cerebrovascular accidents (CVA's), severe expressive aphasia (defect or loss of the power of expression by speech, writing, or signs, or of comprehending spoken or written language, due to injury or disease of the brain centers), severe dysphagia (difficulty swallowing), right sided hemiparesis (partial paralysis of one side of the body), and failure to thrive (weight loss of more than 5%, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction, and low cholesterol).</p> <p>Resident #48 was also being treated for a pressure injury of the left heel, which was unstageable (when stage of wound is not clear), and multiple venous stasis ulcers of lower extremities.</p> <p>Record review on 7/17/24 at 9:29 AM, revealed the following laboratory test results for Resident #48:</p> <p>1) 7/5/24 Hematology Report:</p> <p>- Red Blood Cell (RBC - the number of red blood cells in your blood) 2.88 million/(per) microliter (mCL) (normal value: 4.7 to 6.1 million/mCL);</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 - Some</p>	<p>-Total Hemoglobin (the amount of hemoglobin in your blood) 8.0 grams (g)/deciliter (dL), (normal value: 13 to 17 g/dL);</p> <p>- Hematocrit (the percentage of your blood made up of red blood cells) 26.0% (normal value: 40% to 55%); and</p> <p>- C-Reactive Protein (CRP- a protein made by the liver. The level increases when there's inflammation in the body) 24.3 milligrams (mg)/liter (L) (normal value: less than 0.9 mg/L),</p> <p>2) 7/8/24 Hematology Report:</p> <p>- RBC 2.55 million/mcL;</p> <p>- Total Hemoglobin 7.3 g/dL;</p> <p>- Hematocrit 22.9%; and</p> <p>- CRP 71.3 mg/L (more than 50mg/dL is considered a severe elevation, usually associated with acute bacterial infections about 90% of the time)</p> <p>3) 7/15/24 Hematology Report:</p> <p>- RBC 2.41 million/mcL;</p> <p>- Total Hemoglobin 6.8 g/dL;</p> <p>- Hematocrit 21.0%; and</p> <p>- CRP 141.0 mg/L</p> <p>Review of Resident #48's physician's notes revealed the last note written by Medical Provider #4 was for the date of service 6/14/24.</p> <p>Review of Resident #48's orders revealed a lab order, dated 6/24/24 from Medical Provider #4, for Comprehensive Metabolic Panel [CMP -a blood test that measures 14 different substance in your blood], CBC and differential [a complete blood count test], CRP, Recurring lab, 1 time per week, Mondays, diagnosis; wounds.</p> <p>Review of Resident #48's wound assessment notes, a late entry documented on 6/30/24, for a 6/24/24 weekly wound assessment revealed: . top of right foot . 100% black necrotic tissue. Peri wound with blanchable redness and puffy appearance, infectious process. open area in peri wound dripping serous fluid. talked with nurse practitioner, and labs are ordered to monitor for infection .</p> <p>Review of Resident #48's wound assessment note, a late entry documented on 7/7/24, for a 7/1/24 weekly wound assessment revealed: . right outer ankle . Discussed with NP [nurse practitioner] the need for checking labs for sign of infection.</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 - Some</p>	<p>During an interview on 7/17/24 at 11:15 AM, WRN #1 stated she monitored the labs for Resident #48 because there was a concern for osteomyelitis (a bone infection caused by bacteria or fungi) of the right foot and ankle. WRN #1 further stated that she had requested that Medical Provider #4 monitor the CRP level, and changes in Resident #48's wound bed as she was concerned for deterioration. WRN #1 stated she had not discussed Resident #48's; 7/5/24, 7/8/24, 7/15/24 lab results with provider at this time.</p> <p>During an interview on 7/17/24 at 12:30 PM, Medical Provider #4 stated when lab results were available for review, EPIC (Electronic Health Record) will send a notification to the ordering provider, and the results were reviewed daily by going through each one of the lab results. When asked if she had reviewed Resident #48's lab results, Medical Provider #4 stated, I may have missed them.</p> <p>When asked about what a hemoglobin level less than 7 would generally mean, Medical Provider #4 stated the resident would be sent for a blood transfusion. Medical Provider #4 further stated an elevated CRP results were concerning for infection. Medical Provider #4 stated if the CRP was elevated wound cultures would be ordered. When asked if Resident #48 had pending wound cultures, Medical Provider #4 stated no, as she hadn't seen [Resident #48] yet.</p> <p>When presented with Resident #48's lab results from 7/5/24, 7/8/24, and 7/15/24, Medical Provider #4 stated there was a concern with the CRP level going from 24.3 to 141.0 in 10 days. Medical Provider #4 agreed, Progress Note, 6/14/24 was last visit with resident. Provider #4 stated, I must have missed [Resident #48] . I will see [him/her] today.</p> <p>Review of the facility's policy Pressure Ulcer Prevention and Treatment, last revised 03/2022, revealed: . Wound Care Team provider will visit/assess chronic non-healing pressure injury wounds at least monthly or sooner if PCN notes interval worsening.</p> <p>Resident #82</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #82 was admitted to the facility with diagnoses that included Chronic Respiratory Failure with hypoxia (low level of oxygen in the body tissue), Chronic Respiratory Failure with hypercapnia (high level of carbon dioxide in the blood), and Chronic Obstructive Pulmonary Disease (an obstructive lung disease causing restrictive airflow and breathing problems).</p> <p>Further review revealed the resident was nonverbal, had a tracheostomy, and suprapubic catheter. The resident required one assist with all activities of daily living.</p> <p>Review of Resident #82's MDS assessment, a Quarterly review dated 5/31/24, revealed the resident was coded as being at risk for pressure ulcers with no pressure ulcers.</p> <p>Review of Resident #82's Braden Scale assessment dated [DATE], revealed: Mobility very limited - makes occasional slight changes in body/extremity position, can't make frequent/significant changes alone [1 person does 100% of the effort for bed mobility and transfers].</p> <p>Care Plan Review</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 - Some</p>	<p>Review of Resident #82's Care Plan, dated 6/14/24 revealed: I need to reduce pressure and friction between myself and my bed or chair . monitor my turning and repositioning . check my skin with cares . check my skin weekly. I need my aides to help me with hygiene and general skin care . help me reposition at least every 1-2 hours while I'm in bed . use a lift sheet when moving me in bed.</p> <p>Review of Resident #82's in-room Baseline Care plan, printed on 7/16/24, revealed: reposition at least every 2 hours and use pillows to position comfortably, position in bed with help of 1 person doing more than half effort, raise bilateral upper 1/4 siderails during care to allow resident to assist with positioning, use lifting sheet to prevent skin shearing, specialty bed: Synergy Air Elite with alternating pressure cycles every 15 minutes.</p> <p>Turning/Repositioning Documentation Review</p> <p>Review of Resident #82's CNA documentation, dated 6/17/24 - 6/25/24, revealed the CNAs did not document repositioning of the resident every 2 hours as was care planned for:</p> <ul style="list-style-type: none"> <li>- 6/17/24 at 12:26 AM;</li> <li>- 6/17/24 at 1:55 PM (13 hours and 29 minutes later);</li> <li>- 6/18/24 at 12:59 AM (11 hours and 4 minutes later);</li> <li>- 6/18/24 at 9:13 AM (8 hours and 14 minutes later);</li> <li>- 6/19/24 at 1:23 AM (16 hours and 10 minutes later);</li> <li>- 6/19/24 at 9:40 AM (8 hours and 17 minutes later);</li> <li>- 6/20/24 at 1:35 AM (15 hours and 55 minutes later);</li> <li>- 6/20/24 at 9:44 AM (8 hours and 9 minutes later);</li> <li>- 6/21/24 at 1:16 AM (15 hours and 31 minutes later);</li> <li>- 6/21/24 at 5:12 PM (15 hours and 56 minutes later);</li> <li>- 6/22/24 at 1:04 AM (7 hours and 52 minutes later);</li> <li>- 6/22/24 at 6:15 PM (17 hours and 11 minutes later);</li> <li>- 6/23/24 at 12:27 AM (6 hours and 12 minutes later);</li> <li>- 6/23/24 at 7:01 PM (18 hours and 34 minutes later);</li> <li>- 6/24/24 at 1:46 AM (6 hours and 45 minutes later);</li> <li>- 6/24/24 at 6:21 PM (16 hours and 35 minutes later);</li> </ul> <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 - Some</p>	<p>- 6/25/24 at 2:05 AM (7 hours and 43 minutes later); and</p> <p>- 6/25/24 9:57 AM (7 hours and 52 minutes later).</p> <p>Further review revealed no documented proof that repositioning had occurred every 2 hours.</p> <p>Wound Care Documentation Review</p> <p>Review of Resident #82's medical record revealed the following skin assessments:</p> <p>- 6/21/24: Licensed Nurse (LN) #5 documented, I have examined the Resident's skin head to toe and have noticed no wounds, abrasions, rashes, or skin conditions of concern. No new skin issues noted/reported during day shift.</p> <p>- 6/22-26/24: CNA skin assessments were documented at no new skin issues.</p> <p>Further review of Resident #82's medical record notes revealed a late entry wound assessment note, dated 7/1/24 and completed by WRN #1, for an assessment that occurred 6/24/24: : Wound assessment, wound #1 sacrum . initial assessment 6/24/24, onset 6/25/24 origin noted after admission, Wound type Pressure, Stage 4, length 2.5 X width 2.2 depth 0.2, Wound bed is 80 % adherent soft slough., 20 % pink tissue. Small amount of serous drainage, no odor. Resident continues on Envella bed (An Air-fluidized therapy bed); however, resident has been asking staff to pull [him/her] up so that . sacrum is on the top part of bed which is alternating air. Pulled resident down into air fluidized portion of bed, and [Resident #82] agreed to not ask staff to pull [him/her] up. Wound team notified; dietician did review. Weight is stable. Provider notified .</p> <p>Review of Resident #82's sacrum wound photo, dated 6/26/24, included a measuring tape on the wound bed with a width of approximately 3 centimeters.</p> <p>These dates of these documentations were not clear, as to when the date of onset actually was, and when this initial assessment actually occurred, based on the dates of the photos.</p> <p>This wound was not documented in the CNA skin assessments. No nurse skin assessment was documented for 6/24-26/24.</p> <p>Review of Resident #82's wound care orders revealed:</p> <p>- 12/28/23 to 7/1/24: A prophylaxis treatment (treatment to prevent further injury) to the sacrum was ordered: apply skin prep to intact skin surrounding wound, Cover wound with foam dressing (Allevyn Life) Border, square size 10 cm (centimeters), and change dressing every 72 hours and as needed if soiled or soaked.</p> <p>This order was discontinued on 7/1/24, 6 days after the documented 6/24/24 initial assessment of the open wound to the resident's sacrum, and new wound treatment orders were placed.</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 - Some</p>	<p>-7/1-5/24: Wound #1, Stage 4, Reopened, Cleanse with Vashe Cleanser and apply skin prep to intact skin surrounding wound, pack or cover wound loosely with pomogran prisma (sterilized dressing) to wound bed, cover wound with foam dressing (Allewyn Life Border) square size 10 cm, change dressing every 48 hours and as needed if soiled or soaked. This order was discontinued by WRN #1 on 7/5/24.</p> <p>Further review of this order on the TAR, dated July 2024, revealed a treatment had been completed on 7/1/24 but not on 7/3/24.</p> <p>- 7/5/24: A current order for the sacral wound was placed: Wound #1, stage 4 reopened, Location: Sacrum, cleanse with Vashe cleanser, apply skin prep to intact skin surrounding wound, Pack or cover loosely with Puracol Plus (collagen wound dressing) to wound bed; cover wound with foam dressing (Allewyn Life) Border. Square size 10 cm. Change dressing every 48 hours and as needed if soiled or soaked.</p> <p>During an observation and interview on 7/12/24 at 11:10 AM, WRN #1 was observed to change the sacral wound dressing of Resident #82. WRN #1 was observed to remove the dressing from the sacral region. WRN #1 stated this was a facility-acquired wound and was a Stage 4 pressure ulcer. Bone was present in the wound bed and had epithelized (covered with epithelial tissue, stages of healing).</p> <p>Review of Resident #82' MDS Nurse #1 note, dated 7/17/24, revealed, On 7/1/24 [Resident #82] developed a reopened pressure ulcer on [his/her] sacrum. This wound was actually discovered on 6/24/24, based on the medical record documented initial assessment.</p> <p>During an interview on 7/17/24 at 12:05 PM, WRN #1 stated the wound was three weeks old and has decreased in size. A nurse found it on the skin integrity report and called. WRN #1 stated this occurred on 6/26/24, and the provider was notified on 6/25/24. When asked why the dates on the medical record documentation didn't match the chronological order WRN #1 was verbally expressing, of the wound discovery, WRN #1 stated, I must have looked at the calendar wrong. The wound care treatment order was written on 7/1/24. WRN #1 agreed a delay occurred and that this should have been written immediately. WRN #1 stated the first treatment occurred on 6/26/24; the second treatment occurred on 6/27/24, and there was no documentation of this treatment. The third treatment occurred on 7/1/24. WRN #1 stated that he/she should write on the MAR and TAR to record treatments completed.</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 - Some</p>	<p>Review of the facility's policy Pressure Ulcer Prevention and Treatment, last revised 3/2022, revealed: A Resident who enters [the facility] without pressure ulcers will not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable and, a Resident having pressure ulcers will receive necessary treatment and services to promote healing, prevent infections and prevent new ulcers from [from] developing. Risk factors include: . e. DM, f. Serum albumin &lt; 3.4g/dl,. l. pain,. n. Edema, . d. Weekly assessment of pressure injury wound by Wound RN (or Wound NP [nurse practitioner]) to include documentation of stage, characteristics, measurements, and pain along with overall impression of healing trend. e. Provide comprehensive weekly wound assessments documented in the medical record until healed or determined chronic non-healing and not worsening. f. Wound Care Team provider will visit/assess chronic non-healing pressure injury wounds at least monthly or sooner if PCN notes interval worsening. g. Meets weekly with Skin IDT and adjust treatment plan if no improvement after 2 weeks and sooner if worsening.7. Wound Care Team will: a. Evaluate resident and wound on same day or 1st weekday, if not present at admission Skin Assessment. b. Document complete assessment including photo-documentation and diagnosis and initiate and/or adjust treatment orders as indicated. c. Collaborate with PCP and Other interdisciplinary team . to individualize care plan. d. Weekly assessment of pressure injury wound by Wound RN (or Wound NP) to include documentation of stage, characteristics, measurements, and pain along with overall impression of healing trend. e. Provide comprehensive weekly wound assessments documented in the medical record until healed .</p> <p>Review of the Providence Extended Care: The Cottages Handbook, revised July 2024, revealed, . CNAs use the Care Plan when assisting with activities of daily living in order to help residents achieve their goals. Cottage Nurses are licensed nurses who coordinate care during a specific shift, provide medications and treatments, and communicate care needs so that . issues are addressed.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40259</p> <p>43792</p> <p>50031</p> <p>Based on record review, interview, and observation, the facility failed to facilitate the necessary treatment and services to promote healing, prevent infections, and prevent new pressure ulcers for 3 residents (#s 39, 48, and 82), out of 9 sampled residents with pressure ulcer wounds. This failed practice caused pressure injuries for Residents #39 and #82 and impaired Resident #39, #48, and #82's overall health and wellbeing, which had the potential to create the need for hospitalization .</p> <p>Findings:</p> <p>Resident #39</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #39 was admitted to the facility with diagnoses that included Quadriplegia, C5-C7 Complete (paralysis of the body from the neck down) and Neurogenic Bowel (loss of normal bowel function due to a nerve or spinal cord problem).</p> <p>Further review revealed the resident was verbal, had a suprapubic catheter (medical device that helps drain urine from your bladder through a surgical opening in abdomen), had a colostomy (a surgical opening through the abdominal wall for bowel movement removal), and needed one or two person assists with all activities of daily living.</p> <p>2023 Wound History Review</p> <p>Review of an Admission and Readmission Body Check, dated 1/5/23 and completed by Licensed Nurse (LN) #13, revealed no open areas on Resident #39's body except for the presence of a suprapubic catheter and colostomy in the lower abdominal regions. There were two prophylactic dressings (treatment to prevent further injury) placed on the right and left buttock regions on this resident to prevent further skin breakdown.</p> <p>Review of Resident #39's physician progress note, dated 10/27/23, revealed the resident had a history of osteomyelitis (bone infection) throughout the pelvis and hips related to history of pressure ulcers which had since healed.</p> <p>Review of skin observation documentation, dated 11/14/23 and completed by LN #12, revealed a reddened area - dry ulcer/wound - full/partial thickness on the right pubic bone and right ischium (hip bone) area. The wound was measured at 2 centimeters (cm) round. The resident had been placed on an Envella (air fluidized therapy bed) bed and mattress with a plastic, hard surface on the upper side of bed, contributing factors: pressure-device/equipment, pressure-immobility, shear: Resident preferred to be pulled up past the head railing and he/she tended to sit approximately 45 degrees on the plastic area, pressing onto his/her buttocks. The scars were opening. The resident had an order for a prophylactic dressing to protect the right buttocks every 72 hours. This note documented, Dressing cover gets rolled out and scars were irritated during repositioning.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #39's physician progress note, dated 11/15/23, revealed the following statement, Resident concerns: obtaining a bed [he/she] finds comfortable, Nursing concerns: Right ischium stage IV Pressure Injury-reopened.</p> <p>Review of a skin observation, dated 11/19/23 and completed by Wound Care Nurse (WRN) #1, revealed: Late charting for 11/14/23: Wound #1 Right ischium, photo in Epic [electronic medical record], onset or discovery 11/13/23, origin noted after admission, pressure stage 4 reopened, length 1.0 cm length X 1.8 cm width, undetermined depth, color: 80% slough, 20 % red, peri wound blanchable red scar tissue, scant drainage, provider notified.</p> <p>Review of a skin observation, dated 11/21/23 and completed by WRN #1, revealed: Length 1.0 cm and 1.4 width, no depth noted, description: primary wound is yellow slough, 100%. Scant amount of drainage with no odor. Peri wound pink scar tissue, dry skin, two small partially open areas medially and an area of single thickness skin loss that is 2.0, 2.8 X 0.1 which may be considered a separate wound at some point but is now being considered a peri wound because it is in the scar tissue from the original stage 4. Seen with wound consultant. Resident's bed broke in July and was no longer being serviced, so [he/she] has now been in an Envella since that time. Envella is considered a bed for worse wounds and a top bed for prevention, but the change is likely the reason for breakdown, as very little has changed. [Resident #39] has lost some weight in the last year, but it is not significant weight loss. Wound is unchanged, peri wound is worse.</p> <p>Review of a Request for Repair or Maintenance, dated 11/28/23, revealed: [Supervisor] . to have . Envella bed changed to Synergy Air Elite.</p> <p>A new bed had been obtained for Resident #39 on 11/29/23. This last bed change occurred after the wound developed. This wound had not healed and had increased in size since its discovery on 11/14/23.</p> <p>Review of Wound Assessment note, dated 12/1/23 and completed by WRN #1, revealed: Order was written for Kin Aire [bed], which [Resident #39] did not like when . tried it in July.</p> <p>Review of Wound Assessment note, dated 12/12/23 and completed by the WRN #1, revealed: In previous note, incorrect bed was documented . in Synergy Aire Elite and is not happy.</p> <p>2024 Wound History Review</p> <p>Review of Resident #39's physician order, dated 1/19/24, revealed Resident #39 had a new treatment wound order for an unstageable pressure injury to the right ischium to cleanse with wound cleanser, apply skin prep to intact skin surrounding wound, apply to open or red areas, honey gel (inhibits bacterial growth protecting the wound), cover wound with foam dressing (Allevyn Life) Border, change dressing every 48 hours and as needed if soiled or soaked.</p> <p>Review skin assessment documentation, completed by WRN #1 since 5/1/24, revealed multiple late entry notes:</p> <ul style="list-style-type: none"> <li>- 5/9/24, late charting for 4/29/24;</li> <li>- 5/9/24, late charting for 5/7/24;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 5/19/24, late charting for 5/14/24;</p> <p>- 5/26/24, late charting for 5/24/24;</p> <p>- 6/2/24, late charting for 5/28/24;</p> <p>- 6/11/24, late charting for 6/7/24;</p> <p>- 6/20/24, late charting for 6/18/24;</p> <p>- 7/9/24 for wound assessment completed 6/28/24; and</p> <p>- 7/9/24 for wound assessment completed 7/5/24.</p> <p>Review of Resident #39's wound/skin care order, dated 5/24/24 and completed by WRN #1, revealed the wound was to be cleansed with Vashe Cleanser (a wound cleanser), honey gel applied to open areas, packed with calcium alginate (a dressing to soak up any fluids), cover with border flex (dressing) on the sacrum, Change dressing every 48 hours on Tuesdays and Fridays.</p> <p>June 2024 Assessments</p> <p>Review of Resident #39's MDS (Minimum Data Set - A federally mandated nursing assessment) assessment, a Quarterly review dated 6/11/24, was coded at risk of developing pressure ulcers. The resident had a Stage 1 or higher-pressure ulcer, which was coded at as an unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar.</p> <p>Review of Resident #39's Braden Scale [a tool used to assess risk for pressure ulcers] assessment, dated 6/25/24 revealed: Mobility very limited - makes occasional slight changes in body/extremity position, can't make frequent/significant changes alone (requires dependent assistance 1-2 staff for repositioning), Friction/shear problem - moderate/maximum assistance to move, can't lift without sliding on sheets, slides in bed/chair, constant friction (requires dependent assistance 1-2 staff for all mobility).</p> <p>Review of Resident #39's Care Plan, dated 6/26/24, revealed: I have a current pressure injury and I have a history of skin injuries. I need my nurses to reduce pressure and friction between myself and my bed or chair, keep my bed at 30 degrees to my comfort level . monitor my nutrition or hydration intake, monitor my turning and repositioning, check my skin with cares .administer prophylactic wound care.</p> <p>July 2024 Wound Treatment Review</p> <p>Review of Resident #39's treatment administration record (TAR), for July 2024, revealed an order, dated 5/24/24 and discontinued on 7/9/24, for wound care for a stage 4 pressure injury that had reopened on his/her right ischium and buttock area.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The order was for the nurse to cleanse the wound with Vashe cleanser, apply skin prep to intact skin surrounding wound, apply to open or red areas: honey gel, pack or cover wound with calcium alginate, cut strip to cover open and macerated (liquid saturated skin or wound) areas, cover wound with foam dressing (Allevyn Life) border sacrum, and change the dressing 2 times a week on Tuesdays and Fridays and as needed if soiled or soaked.</p> <p>Review of Resident #39's treatment record revealed no documentation of this wound care on 7/2/24 and 7/5/24.</p> <p>Further review of Resident #39's TAR, for July 2024, revealed a new order with updated wound treatment, dated 7/9/24, for the wound care of the stage 4 pressure injury that had reopened on his/her right ischium/buttock area.</p> <p>The order was for the nurse to cleanse with Vashe cleanser, apply skin prep to intact skin surrounding wound, pack or cover wound with Silver coated Mesh (Acticoat - a dressing that provides a barrier to protect wounds), cover wound with foam dressing (Allevyn Life) border sacrum, and change the dressing two times a week on Tuesdays and Fridays in the morning and as needed if soiled or soaked.</p> <p>Review of Resident #39's treatment record revealed no documentation of this wound care on 7/9/24 and 7/12/24.</p> <p>Review of Resident #39's Certified Nursing Assistant (CNA) documentation, dated 7/1-12/24, revealed the CNAs did not document repositioning of the resident every 2 hours as was care planned for:</p> <ul style="list-style-type: none"> <li>- 7/1/24 at 1:44 AM;</li> <li>- 7/1/24 at 12:56 PM (11 hours and 54 minutes later);</li> <li>- 7/2/24 at 3:24 AM (14 hours and 28 minutes later);</li> <li>- 7/2/24 at 11:46 AM (8 hours and 22 minutes later);</li> <li>- 7/3/24 at 1:41 AM (13 hours and 55 minutes later);</li> <li>- 7/3/24 at 1:36 PM (11 hours and 55 minutes later);</li> <li>- 7/4/24 at 2:01PM (24 hours and 25 minutes later);</li> <li>- 7/5/25 at 1:57 AM (11 hours and 56 minutes later);</li> <li>- 7/5/24 at 11:51 AM (9 hours and 54 minutes later);</li> <li>- 7/6/24 at 12:42 AM (12 hours and 51 minutes later);</li> <li>- 7/6/24 at 7:42 PM (19 hours later);</li> <li>- 7/7/24 at 1:21 AM (5 hours and 39 minutes later);</li> </ul> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 7/7/24 at 8:10 PM (18 hours and 49 minutes later);</p> <p>- 7/8/24 at 12:48 AM (4 hours and 38 minutes later);</p> <p>- 7/8/24 at 3:30 PM (14 hours and 42 minutes later);</p> <p>- 7/9/24 at 12:45 AM (9 hours and 15 minutes later);</p> <p>- 7/9/24 at 6:12 PM (17 hours and 27 minutes later);</p> <p>- 7/10/24 at 12:37 AM (6 hours and 25 minutes later);</p> <p>- 7/10/24 at 10:29 AM (9 hours and 52 minutes later);</p> <p>- 7/11/24 at 12:37 AM (14 hours and 8 minutes later);</p> <p>- 7/11/24 at 3:10 PM (14 hours and 33 minutes later);</p> <p>- 7/12/24 at 12:47 PM (21 hours and 37 minutes later); and</p> <p>- 7/12/24 at 1:34 PM (47 minutes later).</p> <p>Further review revealed no documented proof that repositioning had occurred every 2 hours.</p> <p>Review of Medical Provider #4's progress note, dated 7/5/24, revealed the Resident had a stage 3 pressure ulcer on the right ischium.</p> <p>Review of Resident #39's wound/skin care order, dated 7/9/24 and completed by WRN #1, revealed the wound to be cleansed with Vashe Cleanser, skin prep applied to intact skin surrounding the wound, packed with silver coated mesh (Acticoat), covered with border flex on the sacrum area two times a week on Tuesdays and Fridays and as needed if soiled or soaked.</p> <p>Review of a follow-up note, dated 7/9/24 and completed by WRN #1, revealed: Wound #1 Right buttock . follow-up note 7/5/24 Stage 3 . Visualized stage 3 Dimensions: A. Length (cm) 4.0: width 1.6 (cm): Depth 0.1 cm., C 2.5 X 2.5 X 0.3 . macerated tissue continues between A and C. This description revealed the increased size of this wound since its beginning in November 2023.</p> <p>During an observation and interview on 7/12/24 at 10:18 AM, WRN #1 explained to Resident #39 the new ordered wound care treatment and then commenced to complete wound care on the right buttocks wound. WRN #1 stated this wound had reopened and was a facility-acquired wound. WRN #1 explained that since the resident had acquired a new bed the wounds had reopened. Wound care was completed by the WRN #1.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #39's in-room Baseline Care Plan, printed on 7/17/24, revealed: I have a pressure injury (Stage 4, reopened on my right ischium). I have a history of healed pressure ulcers on my buttocks. Reposition me every 2 hours- see turning schedule. Use pillows to reposition me comfortably. Notify nurse if prophylactic dressings are soiled or have come off. Make sure my mattress is always on and in good working condition. Make sure that my Roho cushion is adequately inflated when in use. Use lifting sheet when moving me in bed to prevent skin shearing. Apply barrier cream to non-open area on my buttocks/peri-area with each peri-care. Keep head of bed less than 30 degrees except for brief periods as tolerated. Limit my time up in wheelchair X 2 hours at a time.</p> <p>During an interview on 7/12/24 at 10:30 AM, Lead CNA (LCNA) stated the current staffing ratio is impacting resident cares. Not as quick to provide, not getting cares done are impacting pressure ulcers. Residents not getting turned as often, every 2 hours as resident should be.</p> <p>During an interview on 7/12/24 at 2:30 PM, WRN #1 stated there were currently 18 residents with pressure ulcers. When asked if limited staffing concerns contributed to the pressure ulcer numbers, the WRN #1 stated residents needed to be turned every 2 hours to relieve pressure. When asked if she felt residents were being turned every 2 hours, the WRN #1 stated, no. When asked if she felt this contributed the deterioration of the resident's pressure ulcers, WRN #1 stated, yes.</p> <p>During an interview on 7/17/24 at 3:11 PM, the Senior Manager of Support Services stated the resident was on a Synergy Air Elite that was obtained 11/28/23.</p> <p>During an interview on 7/17/24 at 5:00 PM, WRN #1 agreed that the treatments should have been documented on the treatment record as completed when asked why the treatment record was not completed.</p> <p>Resident #48</p> <p>Record review from 7/8-12/24 and 7/15-19/24 revealed Resident #48 was admitted with diagnoses that included diabetes mellitus, multiple cerebrovascular accidents (CVA's), severe expressive aphasia (defect or loss of the power of expression by speech, writing, or signs, or of comprehending spoken or written language, due to injury or disease of the brain centers), severe dysphagia (difficulty swallowing), right sided hemiparesis (partial paralysis of one side of the body), and failure to thrive (weight loss of more than 5%, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction, and low cholesterol) .</p> <p>Resident #48 was also being treated for a pressure injury of the left heel, which was unstageable (when stage of wound is not clear because is obscured by slough or eschar), and multiple venous stasis ulcers of lower extremities.</p> <p>Resident #48 required one person assist for all activities of daily living as he/she was totally dependent for cares.</p> <p>Review of Resident #48's wound assessment note, a late entry documented on 5/13/24 for a 5/7/24 weekly wound assessment, revealed: . bottom of left heel . Stage: stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is exposed) . length (cm): 1.8 width (cm): 1.0 depth 0.2 . wound bed 70% light yellow slough, 30% pink tissue. wound is smaller, but bed continues with slough. status: improved, provider notified: No.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #48's wound assessment note, a late entry documented on 5/22/24 for a 5/14/24 weekly wound assessment, revealed: . bottom of left heel. Stage: Unstageable. 1.8 length (cm): 1.0 depth: UTD, description: wound bed is 70% dark purple, 30% white slough . wound is different shape and size than last week. feet with increased edema, several new open areas on legs. Sent SBAR to ANP previously, will send another one. status: worse, provider notified: no.</p> <p>Review of Resident #48's wound assessment note, a late entry documented on 5/22/24 for a 5/21/24 weekly wound assessment, revealed: . bottom of left heel . Stage: Unstageable . length (cm) 2.4 width (cm) 2.0 depth: 0.2, description: wound bed is 70% light red, 30% light slough. status: same, provider notified: no.</p> <p>Review of Resident #48's wound assessment note, a late entry documented on 6/7/24 for a 5/28/24 weekly wound assessment, revealed: . bottom of left heel . Stage: Unstageable . 3.5 length (cm): 3.5 width (cm): 3.0 depth: UTD, description: wound bed is 50% adherent yellow slough, 50% red non-granulating tissue. purulent drainage . Status from prior week/visit: worse, provider notified: Yes-conversation.</p> <p>Review of Resident #48's wound assessment note, a late entry documented on 6/10/24 for a 6/4/24 weekly wound assessment, revealed: . bottom of left heel .Stage: Unstageable: length (cm) 3.5 width (cm): 3.5 depth: UTD, description: wound bed is 50% soft black eschar, 50% mixed red and white tissue . peri wound medial area with reported purulence . Discussed with nurse practitioner . Status from prior week/visit: worse, provider notified: Yes, 6/4/24.</p> <p>Review of Resident #48's wound assessment note, a late entry documented on 6/12/24 for a 6/10/24 weekly wound assessment, revealed: . bottom of L heel . Stage: Unstageable: length (cm): 4.0 width (cm): 4.0 depth: UTD, description: wound bed is 50% soft eschar, 50% yellow missed with red tissue . Discussed with PT possible reasons for this open area to expand . Wound is larger . Status from prior week/visit: worse, provider notified: Yes, 6/12/24.</p> <p>Review of Resident #48's wound assessment note, a late entry documented on 6/21/24 for a 6/17/24 weekly wound assessment, revealed: . bottom of left heel . Stage: Unstageable: length (cm): 5.0 width (cm): 4.0 depth: UTD, description: 50% black eschar, 50% pale pink tissue with pale yellow . Podus boot was changed and it is now apparent that the old boot had flattened out, and there was possible pressure on the heel from the old boot . Status from prior week/visit: Same, Provider notified: No.</p> <p>Review of Resident #48's wound assessment note, a late entry documented on 6/30/24 for a 6/24/24 weekly wound assessment, revealed: . bottom of left heel . Stage: Unstageable: length (cm) 4.0 width (cm): 3.5 depth: Unstageable, description: wound bed is 50% black eschar, 30% red tissue, 20% white/tan . size change is mostly due to difficulty measuring . and poor ROM . L leg with forefoot edema . Status from prior week/visit: Same, Provider notified: No.</p> <p>Review of Resident #48's wound assessment note, a late entry documented on 7/7/24 for a 7/1/24 weekly wound assessment, revealed: . bottom of left heel. Stage: Unstageable: length (cm) 4.0 width (cm): 4.0 depth: UTD, description: wound bed is 60% black eschar, 20% white and brown slough, 20% red tissue . wound appears to be same size as last week, change being related to technique.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #48's Progress Note, dated 6/14/24, revealed: . Patient seen today for follow up for worsening wound . Edema to left lower leg . Left lower extremity is followed by wound nurse . Continue Podus boot at all times . strongly encourage offloading heel . anemia may be impairing wound healing . On 7/17/24, this was the last noted Progress Note in resident 48's electronic medical record or hard chart.</p> <p>Review of Resident #48's orders revealed a lab order, dated 6/24/24 from Medical Provider #4, for Comprehensive Metabolic Panel (CMP) [a blood test that measures 14 different substance in your blood], CBC and differential [a complete blood count test], CRP [C-Reactive Protein - a protein made by the liver. The level increases when there's inflammation in the body], Recurring lab, 1 time per week, Mondays, diagnosis; wounds.</p> <p>During wound observation on 7/12/24 at 1:15 PM, WRN #1 performed donning and doffing of personal protective equipment (PPE) without compromising. WRN #1 stated Resident #48's pressure injury to left heel has closed twice and reopened. WRN #1 stated the wounds had deteriorated over the last couple of months. After WRN #1 completed wound care for Resident #48, she stated she was going to discuss current wound assessment with the facilities nurse practitioner.</p> <p>Record review on 7/17/24 at 9:29 AM, revealed the following laboratory test results for Resident #48:</p> <p>1) 7/5/24 Hematology Report:</p> <ul style="list-style-type: none"> <li>- Red Blood Cell (RBC - the number of red blood cells in your blood) 2.88 million/(per) microliter (mcL) (normal value: 4.7 to 6.1 million/mcL);</li> <li>-Total Hemoglobin (the amount of hemoglobin in your blood) 8.0 grams (g)/deciliter (dL), (normal value: 13 to 17 g/dL);</li> <li>- Hematocrit (the percentage of your blood made up of red blood cells) 26.0% (normal value: 40% to 55%); and</li> <li>- C-Reactive Protein 24.3 milligrams (mg)/liter (L) (normal value: less than 0.9 mg/L),</li> <li>-Albumin 2.6g/dL</li> </ul> <p>2) 7/8/24 Hematology Report:</p> <ul style="list-style-type: none"> <li>- RBC 2.55 million/mcL;</li> <li>- Total Hemoglobin 7.3 g/dL;</li> <li>- Hematocrit 22.9%; and</li> <li>- CRP 71.3 mg/L (more than 50mg/dL is considered a severe elevation, usually associated with acute bacterial infections about 90% of the time)</li> <li>-Albumin 2.5g/dL</li> </ul> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3) 7/15/24 Hematology Report:</p> <ul style="list-style-type: none"> <li>- RBC 2.41 million/mcL;</li> <li>- Total Hemoglobin 6.8 g/dL;</li> <li>- Albumin 2.5g/dL</li> </ul> <p>During an interview on 7/17/24 at 11:15 AM, WRN #1 discussed Resident #48's left heel ulcer. She noted the wound bed deterioration between 5/21/24 - 6/14/24. WRN #1 stated the treatment was not changed at that time as the left heel pressure ulcer hadn't responded to order changes in the past. WRN #1 stated, I can consider changing it. WRN #1 stated if she had any concerns with a resident's wounds, he/she informed the provider.</p> <p>When WRN #1 was asked if any notes were documented on communication to the provider regarding Resident #48's wound concerns, she stated, I could do a better job of documentation.</p> <p>WRN #1 stated, Resident #48 had been ordered to wear a left foot Podus boot (manages heel pressure) and about a month ago she changed left Podus boot for concern it may not have been preventing pressure relief. WRN #1 stated on 6/17/24 while Resident #48 was wearing the left Podus boot, the pressure ulcer had been touching surfaces. WRN#1 stated the plastic support in the boot had flattened out and no longer provided pressure relief.</p> <p>When presented with the resident's in-room Baseline Care Plan/RDCP which documented Apply MultiBoot [Podus boot] to left foot to float heel when in and out of bed. Remove boot twice daily for at least 30 minutes to perform skin check, WRN #1 stated the monitoring of the Podus boot was documented on the TAR and performed by the cottage nurses.</p> <p>When asked to review the June and July 2024 TARs, WRN #1 was unable to locate the monitoring of the Podus boot. WRN #1 stated he/she would review and update the TAR.</p> <p>During the review of the TAR, WRN #1 stated she monitored the wound labs because of a concern for osteomyelitis of the right foot and ankle. WRN #1 further stated that she had requested that Medical Provider #4 monitor the CRP level, and changes in Resident #48's wound bed as she was concerned for deterioration. WRN #1 stated she had not discussed Resident #48's; 7/5/24, 7/8/24, 7/15/24 lab results with provider at this time.</p> <p>During an interview on 7/17/24 at 12:30 PM, Medical Provider #4 stated when lab results were available for review, EPIC will send a notification to the ordering provider, and the results were reviewed daily by going through each one of the lab results. When asked if she had reviewed Resident #48's lab results, Medical Provider #4 stated, I may have missed them.</p> <p>When asked about what a hemoglobin level less than 7 would generally mean, Medical Provider #4 stated the resident would be sent for a blood transfusion. Medical Provider #4 further stated an elevated CRP results were concerning for infection. Medical Provider #4 stated if the CRP was elevated, wound cultures would be ordered. When asked if Resident #48 had pending wound cultures, Medical Provider #4 stated no, as she hadn't seen [Resident #48] yet.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>When presented with Resident #48's lab results from 7/5/24, 7/8/24, and 7/15/24, Medical Provider #4 stated there was a concern with the CRP level going from 24.3 to 141.0 in 10 days. Medical Provider #4 agreed, Progress Note, 6/14/24 was last visit with resident. Provider #4 stated, I must have missed [Resident #48] . I will see [him/her] today.</p> <p>Resident #82</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #82 was admitted to the facility with diagnoses that included Chronic Respiratory Failure with hypoxia (low level of oxygen in the body tissue), Chronic Respiratory Failure with hypercapnia (high level of carbon dioxide in the blood), and Chronic Obstructive Pulmonary Disease (an obstructive lung disease causing restrictive airflow and breathing problems).</p> <p>Further review revealed the resident was nonverbal, had a tracheostomy, and suprapubic catheter. The resident required one person assist with all activities of daily living.</p> <p>Review of Resident #82's MDS assessment, a Quarterly review dated 5/31/24, revealed the resident was coded as being at risk for pressure ulcers with no pressure ulcers.</p> <p>Review of Resident #82's Braden Scale assessment dated [DATE], revealed: Mobility very limited - makes occasional slight changes in body/extremity position, can't make frequent/significant changes alone [1 person does 100% of the effort for bed mobility and transfers].</p> <p>Care Plan Review</p> <p>Review of Resident #82's Care Plan, dated 6/14/24 revealed: I need to reduce pressure and friction between myself and my bed or chair . monitor my turning and repositioning . check my skin with cares . check my skin weekly. I need my aides to help me with hygiene and general skin care . help me reposition at least every 1-2 hours while I'm in bed . use a lift sheet when moving me in bed.</p> <p>Review of Resident #82's in-room Baseline Care plan, printed on 7/16/24, revealed: reposition at least every 2 hours and use pillows to position comfortably, position in bed with help of 1 person doing more than half effort, raise bilateral upper 1/4 siderails during care to allow resident to assist with positioning, use lifting sheet to prevent skin shearing, specialty bed: Synergy Air Elite with alternating pressure cycles every 15 minutes.</p> <p>Turning/Repositioning Documentation Review</p> <p>Review of Resident #82's CNA documentation, dated 6/17-25/24, revealed the CNAs did not document repositioning of the resident every 2 hours as was care planned for:</p> <ul style="list-style-type: none"> <li>- 6/17/24 at 12:26 AM;</li> <li>- 6/17/24 at 1:55 PM (13 hours and 29 minutes later);</li> <li>- 6/18/24 at 12:59 AM (11 hours and 4 minutes later);</li> <li>- 6/18/24 at 9:13 AM (8 hours and 14 minutes later);</li> </ul> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 6/19/24 at 1:23 AM (16 hours and 10 minutes later);</p> <p>- 6/19/24 at 9:40 AM (8 hours and 17 minutes later);</p> <p>- 6/20/24 at 1:35 AM (15 hours and 55 minutes later);</p> <p>- 6/20/24 at 9:44 AM (8 hours and 9 minutes later);</p> <p>- 6/21/24 at 1:16 AM (15 hours and 31 minutes later);</p> <p>- 6/21/24 at 5:12 PM (15 hours and 56 minutes later);</p> <p>- 6/22/24 at 1:04 AM (7 hours and 52 minutes later);</p> <p>- 6/22/24 at 6:15 PM (17 hours and 11 minutes later);</p> <p>- 6/23/24 at 12:27 AM (6 hours and 12 minutes later);</p> <p>- 6/23/24 at 7:01 PM (18 hours and 34 minutes later);</p> <p>- 6/24/24 at 1:46 AM (6 hours and 45 minutes later);</p> <p>- 6/24/24 at 6:21 PM (16 hours and 35 minutes later);</p> <p>- 6/25/24 at 2:05 AM (7 hours and 43 minutes later); and</p> <p>- 6/25/24 9:57 AM (7 hours and 52 minutes later).</p> <p>Further review revealed no documented proof that repositioning had occurred every 2 hours.</p> <p>Wound Care Documentation Review</p> <p>Review of Resident #82's medical record revealed the following skin assessments:</p> <p>- 6/21/24: Licensed Nurse (LN) #5 documented, I have examined the Resident's skin head to toe and have noticed no wounds, abrasions, rashes, or skin conditions of concern. No new skin issues noted/reported during day shift.</p> <p>- 6/22-26/24: CNA skin assessments were documented at no new skin issues.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident #82's medical record notes revealed a late entry wound assessment note, dated 7/1/24 and completed by WRN #1, for an assessment that occurred 6/24/24: : Wound assessment, wound #1 sacrum . initial assessment 6/24/24, onset 6/25/24 origin noted after admission, Wound type Pressure, Stage 4, length 2.5 X width 2.2 depth 0.2, Wound bed is 80 % adherent soft slough., 20 % pink tissue. Small amount of serous drainage, no odor. Resident continues on Envella bed (An Air-fluidized therapy bed); however, resident has been asking staff to pull [him/her] up so that . sacrum is on the top part of bed which is alternating air. Pulled resident down into air fluidized portion of bed, and [Resident #82] agreed to not ask staff to pull [him/her] up. Wound team notified; dietician did review. Weight is stable. Provider notified .</p> <p>Review of Resident #82's sacrum wound photo, dated 6/26/24, included a measuring tape on the wound bed with a width of approximately 3 centimeters.</p> <p>These dates of these documentations were not clear, as to when the date of onset actually was, and when this initial assessment actually occurred, based on the dates of the photos.</p> <p>This wound was not documented in the CNA skin assessments. No nurse skin assessment was documented for 6/24-26/24.</p> <p>Review of Resident #82's wound care orders revealed:</p> <ul style="list-style-type: none"> <li>- 12/28/23 to 7/1/24: A prophylaxis treatment to the sacrum was ordered: apply skin prep to intact skin surrounding wound, Cover wound with foam dressing (Allevyn Life) Border, square size 10 cm, and change dressing every 72 hours and as needed if soiled or soaked.</li> </ul> <p>This order was discontinued on 7/1/24, 6 days after the documented 6/24/24 initial assessment of the open wound to the resident's sacrum, and new wound treatment orders were placed.</p> <ul style="list-style-type: none"> <li>-7/1-5/24: Wound #1, Stage 4, Reopened, Cleanse with Vashe Cleanser and apply skin prep to intact skin surrounding wound, pack or cover wound loosely with pomogran prisma (sterilized dressing) to wound bed, cover wound with foam dressing (Allevyn Life Border) square size 10 cm, change dressing every 48 hours and as needed if soiled or soaked. This order was discontinued by WRN #1 on 7/5/24.</li> </ul> <p>Further review of this order on the TAR, dated July 2024, revealed a treatment had been completed on 7/1/24 but not on 7/3/24.</p> <ul style="list-style-type: none"> <li>- 7/5/24: A current order for the sacral wound was placed: Wound #1, stage 4 reopened, Location: Sacrum, cleanse with Vashe cleanser, apply skin prep to intact skin surrounding wound, Pack or cover loosely with Puracol Plus (collagen wound dressing) to wound bed; cover wound with foam dressing (Allevyn Life) Border. Square size 10 cm. Change dressing every 48 hours and as needed if soiled or soaked.</li> </ul> <p>During a wound care observation and interview on 7/12/24 at 11:10 AM, WRN #1 was observed to change the sacral wound dressing of Resident #82. WRN #1 was observed to remove the dressing from the sacral region. WRN #1 stated this was a facility acquired wound and was a Stage 4 pressure ulcer. Bone is present in the wound bed and has epithelized (covered with epithelial tissue, stages of healing).</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</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 maintain accurate contents of dialysis communication binders consistent with professional standards of practice, which was shared between the facility and off-site dialysis centers, for 3 unsampled residents (#'s 40, 54, and 61) and 3 sampled residents (#'s 65, 83, and 87), out of 6 residents who receive off-site dialysis services. This failed practice had the potential to place the residents at risk for inconsistent care, potential for medication errors/interactions, and miscommunication between facilities which could affect overall resident wellbeing and outcome.</p> <p>Findings:</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed there were a total of six residents in the facility that required off-site dialysis services. Each resident had scheduled dialysis treatments at a dialysis center off campus and had a dialysis communication binder that accompanied them to each treatment and was used as a communication tool between the facility and the dialysis centers.</p> <p>Resident #40</p> <p>Review of Resident #40's most recent MDS (Minimum Data Set - A federally mandated nursing assessment), a quarterly assessment dated [DATE], revealed active diagnoses that included end stage renal disease (a condition in which kidney function is less than 10% of normal; the kidneys can no longer remove wastes, concentrate urine, and regulate electrolytes), type 1 diabetes, chronic pain syndrome, and depression.</p> <p>Resident #40 had a physician's order for dialysis, dated 7/1/24. Resident #40 was to be transported to and from the dialysis center every Monday, Wednesday, and Friday.</p> <p>Review of Resident #40's dialysis communication binder revealed the binder contained:</p> <ul style="list-style-type: none"> <li>- Contact numbers for the facility;</li> <li>- A demographic sheet with resident information;</li> <li>- The resident's advance directive and Medical Orders for Scope of Treatment (MOST) form;</li> <li>- Communication sheets;</li> <li>- Lab work results dated 5/1/24;</li> <li>- The facility's Care of Dialysis Vascular Access protocol;</li> <li>- The resident's immunization record;</li> <li>- One Midodrine (medication to treat low blood pressure) 10mg tablet; and</li> </ul> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Three Simethicone (medication to relief gas pressure of stomach and intestines) 80mg tablets.</p> <p>Further review of Resident #40's dialysis communication binder revealed:</p> <p>1). There was a facility baseline care plan in the binder, however it was printed on 10/2023. There was no current facility baseline care plan in the binder.</p> <p>2). There was no hemodialysis provider care plan in the binder.</p> <p>3). There was a 19-page medication list in the binder, which was undated. The first 12 pages were discontinued medications with first ordered dates of 12/29/20 through 10/13/23.</p> <p>4). Review of the active medications on the 19-page undated medication list, and compared to the current July medication administration record (MAR), dated 7/1/24 through 7/17/24 revealed:</p> <p>a. The following list of medications, or treatments, on the 19-page medication list in the dialysis communication binder were not listed, and not being given, on the current July MAR:</p> <ul style="list-style-type: none"> <li>- Fluocinolone Acetonide Scalp 0.01% Oil, topical three times a week for seborrheic dermatitis</li> <li>- Ketoconazole 2% Shampoo topical, two times a week for seborrheic dermatitis</li> <li>- Hydrophor - Petrolatum and Lanolin Ointment topical, every morning for chronic kidney disease- associated pruritus (skin itching)</li> <li>- Diphenhydramine (Benadryl - an antihistamine) 12.5 milligrams (mg)/ (per) 5 milliliters (mL) Elixir by mouth, twice a day as needed for chronic kidney disease- associated pruritus</li> <li>- Hibiclens (chlorhexidine gluconate - skin cleanser) 4% liquid topical, one time a week on Sunday apply to trunk, front and back for skin abscesses</li> <li>- Lidocaine (pain reliever) 2% solution topical, every six hours as needed for itching areas of forearms</li> <li>- Roxicodone (an opioid pain medication) 5mg by mouth twice a day as needed for severe pain</li> <li>- Diphenhydramine 2% cream topical, twice a day as needed for pruritis</li> <li>- Ammonium lactate 12% lotion topical, twice per day - apply to arch of left foot, let soak in then apply hydrophor for xerosis</li> <li>- Hydrophor - Petrolatum and Lanolin Ointment topical, twice per day for diabetic foot ulcer.</li> <li>- Midodrine 10mg by mouth twice a day as needed for hypotension</li> </ul> <p>b. The following medications, or treatments, were active orders, and documented as being given, on the current July MAR, and were not listed on the 19-page medication list in the dialysis communication book:</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- Biotene dry mouth mouthwash 5mL by mouth every four hours for xerostomia (dry mouth)</li> <li>- Nystatin 10,000 units/gram topical, twice per day to anterior (front) groin folds for cutaneous candidiasis (skin infection)</li> <li>- Santyl (Collagenase - wound treatment) 250 units/gram ointment topical, every morning for dermal ulcer</li> <li>- Insulin Degludec (long-acting insulin) 100 units/mL solution Pen-injector - 16 units subcutaneous every evening for diabetes mellitus</li> <li>- Oxycodone (an opioid pain medication) 5mg by mouth daily as needed Monday, Wednesday, and Friday may give with 2.5mg dose to equal 7.5mg for chronic severe pain on dialysis days only</li> <li>- Midodrine 10mg tablet by mouth three times a week. Send with resident to dialysis for hypotension.</li> <li>- Saline Mist spray 0.65% solution two sprays every four hours as needed for dry nose</li> <li>- Guaifenesin (cough suppressant) 200mg/10mL by mouth every four hours as needed for cough</li> <li>- Ondansetron (Zofran - an anti-nausea medication) 4mg by mouth every six hours as needed for nausea and vomiting</li> </ul> <p>Resident #54</p> <p>Review of Resident #54's most recent MDS assessment, a quarterly assessment dated [DATE], revealed active diagnoses that included end stage renal disease, hypotension of hemodialysis (low blood pressure during dialysis), chronic pain syndrome, and dementia.</p> <p>Resident #54 had a physician's order for dialysis, dated 5/29/24. Resident #54 was to be transported to and from the dialysis center every Tuesday, Thursday, and Saturday.</p> <p>Review of Resident #54's dialysis communication binder revealed the binder contained:</p> <ul style="list-style-type: none"> <li>- Contact numbers for the facility;</li> <li>- A demographic sheet with resident information;</li> <li>- The resident's advance directive;</li> <li>- Communication sheets; and</li> <li>- Three Midodrine 10mg tablets.</li> </ul> <p>Further review of Resident #54's dialysis communication binder revealed:</p> <ol style="list-style-type: none"> <li>1). There was no facility baseline care plan in the binder.</li> </ol> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Providence Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE  920 Compassion Circle Anchorage, AK 99504	
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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2). There was no hemodialysis provider care plan in the binder.</p> <p>3). There was a 4-page medication list in the binder, with a handwritten date of June 2024 at the top of page one.</p> <p>4). Review of the active medications on the 4-page June 2024 medication list, and compared to the current July MAR, dated 7/1/24 through 7/16/24 revealed:</p> <p>a. The following list of medications, or treatments, on the 4-page medication list in the dialysis communication binder were not listed, and not being given, on the current July MAR:</p> <ul style="list-style-type: none"> <li>- Lidocaine 4% patch topical, daily in morning and evening - 1 patch on the skin of left hip daily, remove after 12 hours</li> <li>- Gabapentin (an anticonvulsant medication used for seizures, nerve pain, and restless legs) 100mg by mouth every morning for nerve pain. Please administer after dialysis on dialysis days</li> <li>- Diclofenac Sodium 1% Gel (topical pain reliever) topical, four times a day apply to left hip</li> <li>- Primidone (an anticonvulsant medication) 25mg by mouth daily in morning for tremors</li> <li>- Oxycodone 5mg by mouth every six hours as needed for severe pain</li> </ul> <p>b. The following medications were active orders, and being given, on the current July MAR, and were not listed on the 4-page medication list in the dialysis communication book:</p> <ul style="list-style-type: none"> <li>- Omeprazole (proton pump inhibitor - stomach acid controller) 20mg delayed release capsule by mouth every morning for gastrointestinal hemorrhage (stomach bleeding)</li> <li>- Sucralfate (stomach lining protector) 1 gram by mouth four times a day, give one hours before each meal and at bedtime for gastrointestinal hemorrhage</li> <li>- Senna-Lax (Sennosides - treats constipation) 8.6mg by mouth daily as needed for constipation</li> <li>- Milk of Magnesia 2400mg/10mL - 30mL by mouth daily as needed for constipation</li> <li>- Hydrocodone-Acetaminophen (an opioid and Tylenol pain medication) 5mg-325mg tablet by mouth every six hours as needed for pain</li> </ul> <p>Resident #61</p> <p>Review of Resident #61's most recent MDS assessment, a quarterly assessment dated [DATE], revealed active diagnoses that included end stage renal disease, type 2 diabetes, chronic obstructive pulmonary disease (COPD), and heart failure.</p> <p>Resident #61 had a physician's order for dialysis, dated 6/2/23. Resident #61 was to be transported to and from the dialysis center every Monday, Wednesday, and Friday.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #61's dialysis communication binder revealed the binder contained:</p> <ul style="list-style-type: none"> <li>- Contact numbers for the facility;</li> <li>- A demographic sheet with resident information;</li> <li>- The resident's power of attorney, Physician Orders for Life Sustaining Treatment (POLST) form and MOST form;</li> <li>- Resident's facility care plan;</li> <li>- Communication sheets;</li> <li>- Lab work results dated 7/17/24;</li> <li>- The facility's Care of Dialysis Vascular Access protocol;</li> <li>- The resident's immunization record; and</li> <li>- One Midodrine (medication to treat low blood pressure) 10mg tablet.</li> </ul> <p>Further review of Resident #61's dialysis communication binder revealed:</p> <ol style="list-style-type: none"> <li>1). There was no hemodialysis provider care plan in the binder.</li> <li>2). There was a 7-page medication list in the binder, that was undated.</li> <li>3). Review of the active medications on the 7-page undated medication list, and compared to the current July MAR, dated 7/1/24 through 7/17/24 revealed:             <ol style="list-style-type: none"> <li>a. The following treatment on the 7-page medication list in the dialysis communication binder was not listed, and not being given, on the current July MAR:                 <ul style="list-style-type: none"> <li>- Minerin Creme (skin protectant) topical, apply to left below the knee amputation incision every five days</li> </ul> </li> <li>b. The following medication dosage changes occurred, that were on the current July MAR, and not on the 7-page medication list:                 <ul style="list-style-type: none"> <li>- Sevelamer (a phosphate binder) 800mg tablets, order #1:</li> </ul> </li> </ol> </li> </ol> <p>The 7-page medication list documented 3 tablets were to be given by mouth three times per day, with meals, four times a week (Sunday, Tuesday, Thursday, and Saturday) for hyperphosphatemia (a condition where the blood has too much phosphate, which can harm bones, muscles, and the heart).</p> <p>Review of the July MAR revealed the dose was changed to 2 tablets on 3/28/24.</p> <ul style="list-style-type: none"> <li>- Sevelamer 800mg tablets, order #2:</li> </ul> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 7-page medication list documented 3 tablets were to be given by mouth with meals, three times a week (Monday, Wednesday, and Friday) for hyperphosphatemia.</p> <p>Review of the July MAR revealed the dose changed to 2 tablets on 3/28/24.</p> <p>Resident #65</p> <p>Review of Resident #65's most recent MDS assessment, a quarterly assessment dated [DATE], revealed active diagnoses that included end stage renal disease, diabetes, hypertension (high blood pressure), and chronic pain.</p> <p>Review of Resident #65's dialysis communication binder revealed the binder contained:</p> <ul style="list-style-type: none"> <li>- Contact numbers for the facility;</li> <li>- A demographic sheet with resident information;</li> <li>- The resident's power of attorney, advance directive, and POLST form;</li> <li>- Communication sheets; and</li> <li>- Lab work results dated 6/2024.</li> </ul> <p>Further review of Resident #65's dialysis communication binder revealed:</p> <ol style="list-style-type: none"> <li>1). There was no facility baseline care plan in the binder.</li> <li>2). There was no hemodialysis provider care plan in the binder.</li> <li>3). A copy of the February 2024 MAR medication sheets was in the binder.</li> <li>4). There was a 6-page medication list in the binder, with a handwritten date of June 2024 at the top of page one.</li> <li>5). Review of the active medications on the 6-page June 2024 medication list, and compared to the current July MAR, dated 7/1/24 through 7/16/24 revealed:             <ol style="list-style-type: none"> <li>a. The following list of medications, or treatments, on the 6-page medication list in the dialysis communication binder were not listed, and not being given, on the current July MAR:                 <ul style="list-style-type: none"> <li>- Minerin Creme topical, every am apply to feet and legs daily for skin dermatitis</li> <li>- Lidocaine-Prilocaine 2.5%-2.5% cream (topical anesthetic) topical, 3 times a week. Apply topically to AVF 30 minutes prior to dialysis departure. Dialysis center to provide EMLA cream.</li> </ul> </li> </ol> </li> </ol> <p>Resident #83</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #83's most recent MDS assessment, a quarterly assessment dated [DATE], revealed active diagnoses that included end stage renal disease, diabetes, heart failure, and pain.</p> <p>Resident #83 had a physician's order for dialysis and was to be transported to and from the dialysis center every Tuesday, Thursday, and Saturday.</p> <p>Review of Resident #83's dialysis communication binder revealed the binder contained:</p> <ul style="list-style-type: none"> <li>- Contact numbers for the facility;</li> <li>- A demographic sheet with resident information;</li> <li>- Communication sheets; and</li> <li>- A sheet of resident label stickers.</li> </ul> <p>Further review of Resident #65's dialysis communication binder revealed:</p> <ol style="list-style-type: none"> <li>1). There was no facility baseline care plan in the binder.</li> <li>2). There was not hemodialysis provider care plan in the binder.</li> <li>3). There was no medication list in the binder.</li> <li>4). There was no advanced directive, power of attorney, POLST form, or MOST form in the binder.</li> </ol> <p>Resident #87</p> <p>Record review on 7/8-12/24 and 7/15-19/24 revealed Resident #87 was admitted to the facility with diagnoses that included end stage renal disease, type 2 diabetes, and depression.</p> <p>Resident #87 had a physician's order for dialysis and was to be transported to and from the dialysis center every Monday, Wednesday, and Friday.</p> <p>Review of Resident #87's dialysis communication binder revealed the binder contained:</p> <ul style="list-style-type: none"> <li>- Contact numbers for the facility;</li> <li>- A demographic sheet with resident information; and</li> <li>- Communication sheets.</li> </ul> <p>Further review of Resident #87's dialysis communication binder revealed:</p> <ol style="list-style-type: none"> <li>1). There was no facility baseline care plan in the binder.</li> <li>2). There was no hemodialysis provider care plan in the binder.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3). There was no medication list in the binder.</p> <p>4). There was no advanced directive, power of attorney, POLST form, or MOST form in the binder.</p> <p>During an interview on 7/16/24 at 4:10 PM, License Nurse (LN) #8 stated that a current medication list should accompany residents to the dialysis centers. When asked what other information should be in the communication binder, LN #8 stated whether medications are sent with the resident, and then whatever the dialysis center sends back on the communication sheet, like post dialysis weight, labs, or any dialysis doctor orders. LN #8 was not aware of any care plan that should be in the binder.</p> <p>Review of the Quality Insights Renal Network [qirn] 4 quality improvement task, requested by CMS, at <a href="https://www.qirn4.org/Files/Ongoing-Projects/2021/Nursing-Home/CommunicationStratTips4LTCTF.aspx">https://www.qirn4.org/Files/Ongoing-Projects/2021/Nursing-Home/CommunicationStratTips4LTCTF.aspx</a>, accessed 7/30/24, revealed: . CMS recognized there is an opportunity for improvement in the care of dialysis patients transitioning between outpatient dialysis clinics and nursing home (NH) settings, there for they have tasked the Network to identify and spread highly effective practices clinics develop or have developed to provide and maintain high quality of care during these transitions. At a minimum, CMS expects increased/improved the communication between these two organizations. Communication Strategies for Dialysis Facilities: Use a standardized form of communication - a standardized process such as the use of a communication book which travels between the dialysis center and the nursing home .</p> <p>A reference in this qirn4 improvement task, from the National Transitions of Care Coalition, at <a href="https://static1.squarespace.com/static/5d48b6eb75823b00016db708/t/5e837a30f7518a6872e34876/1585674803444/SevenEssentialElements_NTOCC+logo.pdf">https://static1.squarespace.com/static/5d48b6eb75823b00016db708/t/5e837a30f7518a6872e34876/1585674803444/SevenEssentialElements_NTOCC+logo.pdf</a>, accessed on 7/30/24, revealed: . Information transfer: Sharing important care information . Implementation of clearly defined communication models . timely feedback and feed-forward of information by utilizing specific communication models that support consistent and clear communication among healthcare practitioners and caregivers . Use of formal communication tools: use of personal health record, implementation of specifically designed tools . clearly identified practitioner to facilitate timely transfer of important information, timely transfer of critical patient information, preferably within 24 hours. Care Coordinators actively facilitating communications among providers and between the patient and the providers. Conduct real time patient and family handoff communication with accepted handoff communication techniques .</p> <p>Review of the facility's policy Hemodialysis, last revised 1/2023, revealed: . Dialysis Communication Notebook comes from medical records and is set up by the HUC [Health Unit Coordinator] in the following format: Contact numbers for PEC (Attachment A) . Tab #1 RDCP [baseline care plan] from ECS [electronic medical records system] and if appropriate of code status or MOST form. Tab #2 Dialysis communication form . Tab #3 copy of the current medication list from ECS. Tab #4 Blank provider consultation forms. Tab #5 Hemodialysis provider Care Plan .</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>50031</p> <p>Based on record review and interview, the facility failed to ensure the attending provider monitored changing medical status for 1 resident (#48), out of 20 sampled residents. Specifically, Medical Provider #4 failed to monitor weekly laboratory tests that he/she ordered and failed to respond to critically abnormal laboratory results from those tests. This failed practice placed the resident at risk for decompensation and a delay in intervening treatment, which had the potential to create the need for hospitalization .</p> <p>Findings:</p> <p>Record review from 7/8-12/24 and 7/15-19/24 revealed Resident #48 was admitted to the facility with diagnoses that included diabetes mellitus, multiple cerebrovascular accidents (CVA's), severe expressive aphasia (defect or loss of the power of expression by speech, writing, or signs, or of comprehending spoken or written language, due to injury or disease of the brain centers), severe dysphagia (difficulty swallowing), right sided hemiparesis (partial paralysis of one side of the body), and failure to thrive (weight loss of more than 5%, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction, and low cholesterol).</p> <p>Resident #48 was also being treated for a pressure injury of the left heel, which was unstageable (when stage of wound is not clear), and multiple venous stasis ulcers of lower extremities.</p> <p>Record review on 7/17/24 at 9:29 AM, revealed the following laboratory test results for Resident #48:</p> <p>1) 7/5/24 Hematology Report:</p> <ul style="list-style-type: none"> <li>- Red Blood Cell (RBC - the number of red blood cells in your blood) 2.88 million/(per) microliter (mcL) (normal value: 4.7 to 6.1 million/mcL);</li> <li>-Total Hemoglobin (the amount of hemoglobin in your blood) 8.0 grams (g)/deciliter (dL), (normal value: 13 to 17 g/dL);</li> <li>- Hematocrit (the percentage of your blood made up of red blood cells) 26.0% (normal value: 40% to 55%); and</li> <li>- C-Reactive Protein (CRP- a protein made by the liver. The level increases when there's inflammation in the body) 24.3 milligrams (mg)/liter (L) (normal value: less than 0.9 mg/L),</li> </ul> <p>2) 7/8/24 Hematology Report:</p> <ul style="list-style-type: none"> <li>- RBC 2.55 million/mcL;</li> <li>- Total Hemoglobin 7.3 g/dL;</li> <li>- Hematocrit 22.9%; and</li> </ul> <p>(continued on next page)</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- CRP 71.3 mg/L (more than 50mg/dL is considered a severe elevation, usually associated with acute bacterial infections about 90% of the time)</p> <p>3) 7/15/24 Hematology Report:</p> <p>- RBC 2.41 million/mcL;</p> <p>- Total Hemoglobin 6.8 g/dL;</p> <p>- Hematocrit 21.0%; and</p> <p>- CRP 141.0 mg/L</p> <p>Review of Resident #48's physician's notes revealed the last note written by Medical Provider #4 was for the date of service 6/14/24.</p> <p>Review of Resident #48's orders revealed a lab order, dated 6/24/24 from Medical Provider #4, for Comprehensive Metabolic Panel (CMP), CBC and differential, CRP, Recurring lab, 1 time per week, Mondays, diagnosis; wounds.</p> <p>Review of Resident #48's wound assessment notes, a late entry documented on 6/30/24, for a 6/24/24 weekly wound assessment revealed: . top of right foot . 100% black necrotic tissue. Peri wound with blanchable redness and puffy appearance, infectious process. open area in peri wound dripping serous fluid. talked with nurse practitioner, and labs are ordered to monitor for infection .</p> <p>Review of Resident #48's wound assessment note, a late entry documented on 7/7/24, for a 7/1/24 weekly wound assessment revealed: . right outer ankle . Discussed with NP [nurse practitioner] the need for checking labs for sign of infection.</p> <p>During an interview on 7/17/24 at 11:15 AM, Wound Care RN (WRN) #1 stated she monitored the labs for Resident #48 because there was a concern for osteomyelitis (a bone infection caused by bacteria or fungi) of the right foot and ankle. WRN #1 further stated that she had requested that Medical Provider #4 monitor the CRP level, and changes in Resident #48's wound bed as she was concerned for deterioration. WRN #1 stated she had not discussed Resident #48's; 7/5/24, 7/8/24, 7/15/24 lab results with provider at this time.</p> <p>During an interview on 7/17/24 at 12:30 PM, Medical Provider #4 stated when lab results were available for review, EPIC (Electronic Health Record) will send a notification to the ordering provider, and the results were reviewed daily by going through each one of the lab results. When asked if she had reviewed Resident #48's lab results, Medical Provider #4 stated, I may have missed them.</p> <p>When asked about what a hemoglobin level less than 7 would generally mean, Medical Provider #4 stated the resident would be sent for a blood transfusion. Medical Provider #4 further stated an elevated CRP results were concerning for infection. Medical Provider #4 stated if the CRP was elevated wound cultures would be ordered. When asked if Resident #48 had pending wound cultures, Medical Provider #4 stated no, as she hadn't seen [Resident #48] yet.</p> <p>(continued on next page)</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When presented with Resident #48's lab results from 7/5/24, 7/8/24, and 7/15/24, Medical Provider #4 stated there was a concern with the CRP level going from 24.3 to 141.0 in 10 days. Medical Provider #4 agreed, Progress Note, 6/14/24 was last visit with resident. Provider #4 stated, I must have missed [Resident #48] . I will see [him/her] today.</p> <p>Review of the facility's policy Pressure Ulcer Prevention and Treatment, last revised 03/2022, revealed: . Wound Care Team provider will visit/assess chronic non-healing pressure injury wounds at least monthly or sooner if PCN notes interval worsening.</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40259</p> <p>Based on record review, interview, and observation, the facility failed to ensure sufficient Licensed Nurses (LNs) and Certified Nursing Assistants (CNAs) were available to provide care to all residents, based on a census of 93, as determined by resident acuity (acuity is a measurement of the level of care a resident needs, based on the severity of either an illness or mental condition). This failed practice, to ensure sufficient staff to provide basic nursing care such as turning and repositioning and getting residents out of bed, resulted in harm to residents who developed Stage III, IV, unstageable pressure ulcers and deep tissue injuries. These failed practices caused actual harm due to the of deterioration of pressure ulcers. In addition, failure to ensure adequate staffing to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident caused psychosocial harm.</p> <p>Findings:</p> <p>Review of the facility campus revealed eight separate cottage buildings, with 12 resident bedrooms in each cottage, for a total of 96 resident beds. The facility's total census at the time of this survey was 93 residents.</p> <p>Resident Acuity</p> <p>Review of the facility-provided ADL [Activities of Daily Living] assistance documentation from resident's medical records, received 7/16-17/24, revealed the following need for assistance from staff:</p> <p>1) Bed Mobility (Turning or adjusting):</p> <ul style="list-style-type: none"> <li>- Independent: 4 residents</li> <li>- One-person assist: 62 residents</li> <li>- One to two person assist: 9 residents</li> <li>- Two-person assist: 15 residents</li> <li>- Information not provided: 3 residents (#s 8, 28, and 60)</li> </ul> <p>2) Transfer (from bed to wheelchair):</p> <ul style="list-style-type: none"> <li>- Independent: 2 residents</li> <li>- One-person assist: 62 residents</li> <li>- One to two person assist: 11 residents</li> <li>- Two-person assist: 15 residents</li> </ul> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 7/10/24 at 3:26 PM, the Administrator stated the Director of Nursing's (DON's) last full-time day was 6/21/24 and went to a schedule of coming to the facility Monday through Friday, 4:00 AM to 6:00 AM and then coming back in the afternoon if needed. Also, the DON would work Saturday and Sunday 6:00 AM to 12:00 PM as needed. The Administrator stated a new DON was hired and his/her start date was 7/29/24. When asked to describe the nursing supervisor staffing, the Administrator stated there were two manager positions, one of those positions was filled 6/17/24 and the other was still open, and four nursing supervisor positions that were filled.</p> <p>When asked if the nursing supervisors documented their activities during their shifts, to include providing support in the cottages, the Administrator stated there was no documentation to account for what the nursing supervisors did during their shifts.</p> <p>When asked to describe the current staffing situation in the cottages, the Administrator stated the facility traditionally would have had one nurse in every cottage (12 residents per cottage), and 16 CNAs (2 CNAs per cottage) scheduled on the dayshift, however since COVID they had not been able to meet that staffing level. The Administrator stated that the facility was currently running at crisis staffing level where there was one nurse for every 18 resident (one nurse per 1 and a half cottages) and one CNA for every 12 residents (one CNA per cottage), and there was a goal of having 4 support CNAs (1 support CNA per two cottages) to provide support and complete showers. However, when staff call out of work, the facility had only been able to provide about 3 support CNAs a day.</p> <p>When asked what other measures the facility had attempted to help support the cottages to meet the needs of the residents, the Administrator stated they increased training with home keepers (cooks), housekeepers, and activity staff to help with assisting CNAs when needed in bed mobility and transfers, as well, as assist with dining for residents who required minimal support. These staff were trained in safe patient handling and dining assistance but are not considered nursing staff.</p> <p>When asked if the facility had received any calls or grievances about the staffing shortages, the Administrator stated there had been grievances from families, and that the facility had explained the goals of the change in staffing.</p> <p>During an interview on 7/11/24 at 1:25 PM, when asked if staff had voiced any concerns about the staffing levels, the DON stated nurses had expressed concerns on having to pick up extra residents in a second cottage. The CNAs had expressed concerns that the home keepers, housekeepers, and activity staff weren't supporting them during the day because they were unsure on what they could or couldn't do.</p> <p>When asked specifically what the home keepers, housekeepers, and activity staff could do to support the CNAs, the DON stated they could assist only with bed mobility or transfers of resident when the CNAs were present, however they could not assist by themselves, and they could not assist with toileting. Also, for dining assistance, they could help with cuing and support resident's hands or arms to allow the residents to feed themselves, however they could not feed residents.</p> <p>Random observations on 7/8-10/24 and 7/15-18/24 revealed no home keepers, housekeepers, or activity staff assisted CNAs in any fashion with bed mobility, transfers, or dining assistance.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 7/11/24 at 2:26 PM, when asked who was designated the DON of the facility when she was not physically present during business hours, the DON stated she was the only DON and could be contacted through teams messaging and phone calls anytime.</p> <p>During an interview on 7/12/24 at 10:29 AM, the Lead CNA (LCNA) stated the support CNA was provided an assignment sheet every morning with a list of showers, vital signs, and weights that needed to be obtained for the shift. The support CNA's first priority was ensuring showers were completed for their assigned cottages, then they would complete vitals and weights if they had time. After the assignments were completed, the support CNA would then be available to assist in other regular CNA duties.</p> <p>When asked how the staffing shortage and crisis level staffing had affected resident care, the LCNA stated it was a challenge to meet the needs of residents as swiftly as they could have with a full complement of staff, and that staff were not able to give the residents the level of attention they used to. The LCNA stated it was hard to meet the needs of the residents, and residents had voiced that their care had been delayed, to include not getting showers, and they didn't like the new staffing schedule. The LCNA further stated that if there weren't enough support CNAs, residents would get bed baths instead of showers because there were not enough staff to provide showers.</p> <p>The LCNA further stated that having only one CNA per cottage now meant that residents had to wait longer for their needs to be met and it may have impacted pressure ulcers because the CNAs were having trouble meeting the turning schedule of every 2 hours.</p> <p>During an interview on 7/18/24 at 9:46 AM, Nurse Educator #3, who had been a nursing supervisor for years and covered the position from time to time, stated the nursing supervisor ensured that staffing was handled, managed requests for provider orders or guidance, communicated with providers on those requests every morning and input orders if needed. Nurse Educator #3 stated nursing supervisors also managed and adjusted resident appointments and addressed any concerns from residents and staff.</p> <p>When asked if there was any documentation a nursing supervisor completed that showed what they did during their shift, Nurse Educator #3 stated no, there was not.</p> <p>Pressure Wounds Assessment</p> <p>Review of the facility's Matrix for Providers, CMS-802 (a document used to identify pertinent care categories) documentation, completed on 7/8-9/24, revealed an overall pressure ulcer rate of 19% [18 residents total].</p> <ul style="list-style-type: none"> <li>- 3 residents had stage III pressure ulcers (involves the full thickness of the skin and may extend into the subcutaneous tissue layer)</li> <li>- 7 residents had stage IV pressure ulcers (the deepest, extending into the muscle, tendon, ligament, cartilage or even bone)</li> <li>- 6 residents had unstageable pressure ulcers (full thickness skin and tissue loss, but unable to stage the wound due to obscured visualization due to extent of tissue damage)</li> </ul> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>- 3 residents had deep tissue injuries (an injury to a resident's underlying tissue below the skin's surface that results from prolonged pressure).</p> <p>Review of the facility provided CASPER report (a document that calculates quality measures that are included in the Centers for Medicare &amp; Medicaid Services (CMS) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)), dated June 2024, revealed the facility's Pressure Ulcers facility adjusted percentage was 16.1% (compared to the comparison group national average of 7.4%). The July report was unavailable as it was too early in the month for that final report.</p> <p>During an interview on 7/12/24 at 2:30 PM, Wound Care Nurse (WRN) #1 stated there were currently 18 residents with pressure ulcers. When asked if limited staffing concerns contributed to the pressure ulcer numbers, the WRN #1 stated residents needed to be turned every 2 hours to relieve pressure. When asked if she felt residents were being turned every 2 hours, the WRN #1 stated, no. When asked if she felt this contributed the deterioration of the resident's pressure ulcers, WRN #1 stated, yes.</p> <p>During an interview on 7/18/24 at 11:27 AM, when asked if the Quality Assurance and Performance Improvement (QAPI) committee had implemented any performance action plans due to the high rate of pressure ulcers at the facility, the Quality Director stated she felt that the lack of staffing, and their inability to provide more one on one attention to residents, had attributed to this increase, and QAPI's focus had been to help boost staff numbers. The Quality Director further stated a performance improvement plan was in effect for pressure ulcers.</p> <p>When asked if the pressure ulcer rates had been discussed with the Governing Body (GB), the Quality Director stated the increase in pressure ulcer rates and the residents had been discussed. GB had been informed of low staffing levels. GB had discussed funding solutions, such as bringing in travelers, and leadership meetings had been held to possibly plan for this.</p> <p>Resident/Family Interviews and Observations</p> <p>Resident #26</p> <p>During an interview on 7/8/24 at 4:01 PM, Resident #26 stated he/she had requested . no male caregivers for changing and showering. Resident #26 stated males providing hygiene to him/her bothered his/her spouse as well. Resident #26 further stated CNA #3 told him/her, . If your husband doesn't know it will be ok. Resident #26 stated . But it bothers me.</p> <p>During an interview on 7/15/24 at 11:10 AM, CNA #6 stated Resident #26 refused CNA #6 to provide personal cares because Resident # 26's spouse does not like it. CNA #6 stated a male CNA on nights showered resident.</p> <p>During an interview on 7/15/24 at 3:20 PM, LN #7 stated Resident #26 did not want male caregivers providing personal/pericare [cleaning of the genitalia and buttock area]. LN #7 stated, .It is more his/her [spouse] and his/her culture. I have talked to his/her [spouse] many times and explained we do not always have a [female] CNA .</p> <p>Review of the facility-provided ADL assistance documentation from resident's medical records, received 7/16-17/24, revealed Resident #26: I BATHE with 1 helper providing all of the effort. I use the shower chair. I prefer showers .</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>Resident #34</p> <p>During an observation and interview on 7/8/24 at 12:04 PM, Resident #34 was sitting in his/her room, at his/her bedside table with a disposable Styrofoam clamshell food container containing the resident's lunch. Resident #34 stated that the food was cold, but it was no use to call someone to warm it up as it might be forgotten in the microwave, or the staff would take a long time to come get it to heat it up. The resident stated that he/she might as well eat it cold than bother the staff. Resident #34 stated he/she had been eating out of Styrofoam containers all weekend as well as that day. His/her meals were served this way when a cook would not come into work. When this happened, their meals would be prepared in another cottage and brought over. He/she stated the meals felt like he/she was eating take out and would rather eat off real dishes.</p> <p>During an interview on 7/8/24 at 1:50 PM, Resident #34 stated that he/she was at the mercy of the staff. He/she stated that he/she would like to shower every night before bed, but he/she was told the facility policy was to shower twice a week. The resident stated that his/her shower days were Wednesdays and Saturdays. The resident expressed concerns that he/she would not be able to get a shower if he/she had a bad episode of bowel incontinence.</p> <p>Review of Resident #34's MDS (Minimum Data Set - A federally required nursing assessment) annual assessment dated [DATE], revealed: . Section F0400. Interview for Daily Preferences: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Very important .</p> <p>During an interview on 7/15/24 at 11:43 AM, Resident #34 stated twice last week, he/she was not able to get out of bed until dinner time. He/she further stated he/she usually liked to be up and dressed by 8:00 AM daily. The resident expressed that it was very lonely waiting for the staff to come assist with getting him/her out of bed. The resident was unsure what activities he/she missed on those days and expressed that he/she felt that dining at the dining table with other residents at least once a week was important.</p> <p>Review of Resident #34's MDS annual assessment dated [DATE], revealed: . Section F0500. Interview for Daily Preferences: How important is it to you to do things with groups of people? Very important. How important is it to you to do your favorite activities? Very important .</p> <p>Resident #39</p> <p>During an interview on 7/8/24 at 10:58 AM, Resident #39 stated that his/her biggest complaint with the facility was the lack of staffing due to a new system which was one CNA per cottage. There were times when there was no cook, no nurse, or CNA. Resident #39 stated that the lack of staffing consequence was that he/she did not always get his/her shower. Resident #39 stated, when questioned about the lack of showers, stated, This is unacceptable. Resident #39 had concerns that his/her exercises were not always completed. Resident #39 stated, If we lack staff, the replacement has to come from a different cottage. The lack of CNAs has always a problem. The doctors are gone too. The [administrative leadership] are aware of this. We can't take care of ourselves. One CNA with 12 people is a lot.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>Review of Resident #39's Baseline Care Plan, printed on 7/17/24, revealed: Special Precautions . Assist me with ROM exercises to all extremities, 3-5 rep, BID [twice a day] with care as tolerated . I bathe with the help of 1-2 people doing 100% of the care, using the Carendo shower chair. Transfer me with the ceiling lift and blue sling. No Male CNAs during shower. Nails to be trimmed by PCN. Bath/shower: Tuesday (day); Friday (day).</p> <p>During an interview on 7/9/24 at 9:01 AM, Resident #39 stated he/she was not being able to choose more showers when she/he wished. Showers were scheduled two days a week. Resident #39 stated, I often miss showers due to there not being enough staff here.</p> <p>Review of Resident #39's MDS annual assessment, dated 3/14/24, revealed: . Section F0400. Interview for Daily Preferences: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Very important .</p> <p>Resident #47</p> <p>During an observation on 7/15/24 at 12:45 PM, Resident #47 was sitting at dining table and asked staff for help to the bathroom. Occupational Therapist (OT) #1 told Resident #47 that he/she would have to wait for staff. The Dietary Manager was serving food to residents at the dining table. It was observed that Licensed Nurse (LN) #4 was going room to room passing medications. Resident #47 started independently propelling his/her wheelchair (wc) with his/her feet to the nurse. LN #4 told Resident #47 he/she was trying to locate the CNA. It was observed CNA #7 came out of room [ROOM NUMBER] and went immediately towards room [ROOM NUMBER] as Resident #47 was looking towards CNA #7 saying he/she needed to go to the bathroom. CNA #7 ignored Resident #47 and entered room [ROOM NUMBER].</p> <p>At 1:05 PM, Resident #47 continued to request help to the bathroom propelling himself/herself in his/her wc throughout the common space in cottage. OT #1 told Resident #47 he/she would try and find staff to assist him/her. At 1:15 PM, CNA #7 told Resident #47 I have one more person to change first. CNA #7 then entered room [ROOM NUMBER]. At 1:27 PM, it was observed that CNA #7 walk up to the kitchen as OT #1 ask CNA #7 about another resident's meal. Resident #47 noted CNA #7 and started propelling him/herself toward the kitchen from the hallway and tried to get CNA #7's attention. Resident #47 stopped propelling and stopped trying to call out to CNA #7. Resident #47 started to frown and put his/her head down.</p> <p>During an interview on 7/15/24 at 1:28 PM, when asked if he/she still required assistance to the bathroom, Resident #47 frowned putting his/her head down stating they required assistance of toileting hygiene (because the resident had an accident). At 1:29 PM, CNA #7 took Resident #47 to his/her room.</p> <p>Resident #56</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation and interview on 7/15/24 at 1:48 PM, no CNA, LN, or cook were visibly present in the Yukon cottage. Further observation in Resident #56's room revealed his/her had a breakfast tray to be picked up. Resident #59 used the call light and stated, They won't come, I always wait. Resident #59 stated the breakfast had been delivered around 11:00 AM. The breakfast tray was on his/her lap and the resident was in bed with the head of the bed raised 45 degrees. Observation of the open common areas of the cottage revealed no staff visible. CNA #8 arrived at 2:09 PM and asked Resident #56 what he/she wanted. When asked, why the call light had been delayed and no staff were present in the dayroom, CNA #8 stated he/she did not hear the call light because he/she was in the office charting since the other computer out on the floor did not work.</p> <p>Resident #61</p> <p>During an interview on 7/16/24 at 3:30 PM, Resident #61 stated he/she had to stay in bed for days because there is only one CNA, and they don't have time to get me up. Resident #61 stated he/she missed activities because [of] not enough staff. missed BINGO today .</p> <p>Review of the facility-provided ADL assistance documentation from resident's medical records, received 7/16-17/24, revealed Resident #61: I TRANSFER with the dependent assistance of 1 person, using the ceiling lift with green-trimmed bariatric sling .</p> <p>Resident #77</p> <p>During an interview on 7/10/24 at 9:30 AM, Resident #77's family stated the facility had reduced their CNAs dramatically. This family member stated he/she had witnessed residents in Deskha cottage crying out saying they needed help, however there was no one in the Deshka cottage to help because the CNA was busy with someone else. The family member further stated he/she had called and filed a grievance, however never received a response about it. The family member stated he/she turned the grievance into LN #14 on 6/13/24 and he/she had a copy of the grievance.</p> <p>Resident #78</p> <p>During an interview on 7/15/24 at 11:53 AM, Resident #78 stated that the nursing staff do not ask her when she wants to get up, they just let her sleep. The resident stated that he/she is on a diuretic (a drug that helps remove excess water, salts, and other accumulated metabolic products from the body through urine), which increases his/her need to urinate. The resident stated he/she cannot wait long periods of time for staff to answer the call light, which resulted in the resident urinating in bed. This had happened regularly and as recent as two days ago.</p> <p>Review of Resident #78's Baseline Care Plan, printed on 7/12/24, revealed: I USE THE BATHROOM: with the help of 1 person doing less than half the effort. I am continent of bladder and bowel, but wear incontinence briefs in case I have an accident.</p> <p>Resident #86</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 7/12/24 at 1:09 PM, Resident #86 stated since the staffing change there has been a big problem getting showers because he/she required assistance. Resident #86 stated he/she rarely received a shower, unless he/she felt brave enough to try and take a shower by himself/herself. Resident #86 also stated there had been delays in obtaining a bedpan when needed because there were no staff to answer the request, and he/she had to wait 3 hours once just to relieve himself/herself.</p> <p>Review of the facility-provided ADL assistance documentation from resident's medical records, received 7/16-17/24, revealed Resident #86: I BATHE with 1 helper providing more than half the effort. I sit on the shower chair. I prefer showers .</p> <p>Review of Resident #86's MDS annual assessment, dated 1/23/24, revealed: . Section F0400. Interview for Daily Preferences: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Very important .</p> <p>Resident #86 further stated because nurses must go to other cottages now to help other residents, he/she has had to wait hours for as needed medications for shortness of breath. This had happened so often that he/she had resorted to calling the nurse supervisors for help when nurses weren't in the cottage.</p> <p>Resident #92</p> <p>During an observation and interview on 7/15/24 at 11:49 AM, Resident #92 was in bed and had just finished his/her breakfast of pancakes and peanut butter. The resident said that he/she had waited to be served breakfast since 7:00 AM and had received it about an hour ago. He/she was going to skip lunch because it was so late in the day. The resident pressed his/her call light because he/she wanted nicotine gum. The surveyor left the resident's room.</p> <p>Continued observation on 7/15/24 at 12:38 PM, 46 min later, this surveyor walked over to the call light monitoring system in the common area and saw that Resident #92's call light had been on for 46 minutes. Further observation revealed Resident #92 called out from his/her room to [NAME] #2 in the kitchen. The cook was busy and stated that someone would be in shortly. This surveyor asked Resident #92 if anyone had been in to help, the resident stated no one had come.</p> <p>During an interview while continuing the observation on 7/15/24 at 12:39 PM, CNA #11 stated he/she was the only CNA in the cottage. CNA #11 then went into Resident #92's room and the call light was turned off. Resident #92 waited approximately 51 minutes for staff. At 1:17 PM Resident #92 was observed coming out of his/her room in his/her wheelchair. When asked if he/she received his/her nicotine gum, the resident stated, No and that he/she was headed out to go smoke.</p> <p>Resident Council Meeting Minute Review</p> <p>Review of Resident Council meeting minutes, dated 1/17/24, revealed: . Resident shared concerns of the night CNA's leaving the cottage for an extended amount of time and not available to help with their own resident[s]. Resident believes it is a safety concern. Resident shared concerns that his call light is not being answered at nights due to caregivers not being available in the cottages. He feels this is escalating and not being addressed.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>Review of Resident Council meeting minutes, dated 4/17/24, revealed: . [DON] shared with group that staffing situation for C.N.A's and the ability to fill the 17 open positions which led to the leadership team to be creative and revamp the staffing structure . Staffing will be as follows: 1 C.N.A. per cottage during the day with a 4-person support team responsible for showers and weights, meal assist, transferring/transporting to activities etc. and on call as needed when C.N.A's need assistance in the cottages . Resident asked for clarification on toileting assistance with 1 C.N.A. in each cottage. Residents concern is waiting for assistance at night to get help to the toilet and will that also be a problem during the day? [DON] acknowledged and assured resident the scheduled C.N.A. in the cottage will be available to assist and if need of further support, they are to contact the support team. If the new staffing structure does not work [DON] will revisit the process .</p> <p>Review of Resident Council meeting minutes, dated 6/20/24, revealed: [DON] shared with the group the new C.N.A. process that started this week. Process is structured with 1 C.N.A. in the cottage and a 4 person C.N. A. support team each supporting 2 cottages . [Home keepers] and Housekeepers are currently in orientation for more extensive training to assist in the cottages . As this is the first week of the new process we are hoping to see a positive outcome . We will be evaluating the process by asking for feedback from our residents . Residents' concerns as follows: Will we have someone on the weekends helping us get out of bed and help with getting ready for the day including church services on Sundays? Per [Administrator] this concern was part of the reason we created the new process . Yes there will be more caregivers available to assist with getting out of bed. What happened if our C.N.A. calls out? Per [DON] if your C.N.A. calls our one of the support team caregivers will jump in while we start calling for someone to come in. Resident shared she has not been getting up daily as she should and having to wait to be put back to bed causing her pain on the weekend. [DON] acknowledged residents' complaint and explained that the weekend was very challenged with caregivers calling out and staffing being extremely short, but nursing leadership did step in and assisted as needed . [Administrator] shared with group the new process which went live on Tuesday. To reiterate the support team of 4 C.N.A.s will be doing the showers and vitals and as needed assists. Any concerns please reach out to [DON] and/or [RN Manager] .</p> <p>Direct Care Staff Interviews</p> <p>During an interview on 7/8/24 at 9:27 AM, CNA #10 stated the Aniak cottage did not have a home keeper (cook) that day for the cottage. When the cooks were short staffed, the meals for the cottage were prepared in another cottage, placed in separate disposable Styrofoam clamshell food containers labeled with the resident's room number, and brought over. The CNA and LN would serve the meals.</p> <p>During an interview on 7/8/24 at 1:20 PM, LN #3 stated the lack of staff was a problem. Whenever a CNA was missing, that was a problem. If the cottage's cook was not working that day, the food came from a different cottage. LN #3 stated the housekeepers are often short staffed too.</p> <p>During an interview on 7/9/24 at 9:07 AM, [NAME] #2 stated that the Aniak cottage did not have a cook for the last three days (7/6-8/24), and other cooks in the other cottages would rotate preparing meals for the day. [NAME] #2 stated that meals were served in the disposable Styrofoam clamshell food containers because when a cook was covering another cottage, there was no time to wash dishes for both cottages and complete other duties. If another cottage did not have a cook available for the day, [NAME] #2 would prepare meals for the other cottage first before working on the meals for his/her assigned cottage.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 7/10/24 at 4:39 PM, the Dietary Manager stated serving meals from disposable Styrofoam clamshell food containers was not ideal and needed to ask dietary why they were delivering food like that. She stated that it did not happen very often and did not know why the food could not be plated.</p> <p>During an interview on 7/15/24 at 12:39 PM, CNA #11 stated there were no limits on the frequency a resident can get up out of bed or have a shower but depended on the availability of staff. Most of the time the staff were busy, and it was much harder to give showers outside of the resident's schedule.</p> <p>During an interview on 7/16/24 at 4:35 PM, LN #8 stated staff shortages had affected the ability to spend time with the residents. LN #8 stated it was a struggle to complete turns every 2 hours and showers. When properly staffed it used to be enjoyable and staff could spend time with residents to put on lotion, however staff are now rushed due to the increased workload that resulted in the staff being less available. LN #8 further stated quality time with residents wasn't possible anymore.</p> <p>During an interview on 7/17/24 at 3:28 PM, CNA #11 stated the 4 person CNA support teams doesn't work and cottage CNAs end up doing everything on their own. CNA #11 further stated nurses would help, when they are available, but it wasn't easy for the nurses because they now had to cover other cottages.</p> <p>Administration</p> <p>During an interview on 7/17/24 at 8:17 AM, when asked if the concerns with low staffing had impacted the resident's care, the Medical Director stated residents did talk to her about how staff needed help. The Medical Director further stated low staffing was affecting the residents with higher acuity, who required heavier assistance in cares, more than the residents who were more independent.</p> <p>When asked if she was involved with any leadership meetings that would discuss staffing levels and resident care, the Medical Director stated she was only at the facility every other week and when she was here was only at the facility for three days that week. The Medical Director further stated staffing was not something she would be involved with and didn't think it was her lane to get involved in, If turning residents isn't getting completed, I would say we need to find avenues to get it done.</p> <p>During an interview on 7/17/24, the Administrator stated she had the overall responsibility of the campus, and that she set the expectation and goals. When asked what kind of involvement in leadership oversight the Medical Director should have, the Administrator stated the Medical Director was supposed to be involved in quality and infection control, but that she had just started the position in May 2024 and was still learning the role.</p> <p>When asked how many open nursing positions the facility had, the Administrator stated there were currently 10 CNA positions and 5 nursing positions posted, however there were more that needed to be filled.</p> <p>When asked if the number of staff currently working, based on the bed capacity of 96, was able to meet the needs of the resident acuity levels, the Administrator stated she felt they were able to meet the needs, but not at the standard we would want to meet them.</p> <p>(continued on next page)</p>		

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F 0725  Level of Harm - Actual harm  Residents Affected - Many	When asked if they facility had considered lowering the census numbers, to help ease the staffing strain and better meet the resident's needs, the Administrator stated they would consider lowering the census if the facility could not meet the staffing crisis level for 4 consecutive da [TRUNCATED]		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>40259</p> <p>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.</p> <p>Based on interview and record review, the facility failed to designate a registered nurse to serve as the Director of Nursing (DON) on a full-time basis. Specifically, from 6/21/24 to 7/15/24 there was no full-time DON for the facility. This failed practice, of not having a full-time DON to provide oversight of nursing staff, including scheduling, responsibilities, and support, placed all residents (based on a census of 93) at substantial risk for subquality of care.</p> <p>Findings:</p> <p>During an interview on 7/10/24 at 3:26 PM, the Administrator stated the DON's last full-time day was 6/21/24 and went to a schedule of coming to the facility Monday through Friday, 4:00 AM to 6:00 AM and then coming back in the afternoon if needed. Also, the DON would work Saturday and Sunday 6:00 AM to 12:00 PM or 2:00 PM depending on need. The Administrator stated a new DON was hired and his/her start date was 7/29/24.</p> <p>When asked for a timesheet accounting of the exact hours the DON worked weekly, from 6/21/24 to present, through the kronos system (time keeping system that tracked working hours of an employee) of the facility, the Administrator stated this could not be given as the DON's position was salary-based pay and the DON did not clock in and out as an hourly-based pay employee would.</p> <p>During an interview on 7/11/24 at 2:26 PM, when asked who was designated the DON of the facility when she was not physically present during business hours, the DON stated she was the only DON and could be contacted through teams messaging and phone calls anytime.</p> <p>During an interview on 7/16/24 at 10:00 AM, the Administrator stated the DON's last day of employment was 7/15/24 and the Quality Director was designated the interim DON until the newly hired DON could take over the position.</p> <p>The Quality Director worked full-time at the facility, Monday through Friday.</p> <p>Review of the facility's job description Director Long Term Care RN [Registered Nurse], revised 9/30/19, revealed: . The Director of Nursing is responsible for the administrative direction and clinical leadership of resident care areas and clinical support. Is responsible for the implementation of clinical services and programs that contribute to safe, effective, and efficient resident-centered care and meet all state and federal Long Term Care Regulations.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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 accurately maintain, dispense, and have accountability of controlled drugs for 1 unsampled resident (#54) who received dialysis, out of 6 dialysis residents reviewed. Specifically, the facility sent the controlled drug oxycodone (an opioid pain medication) with the resident when he/she went to dialysis, which inhibited the facility's control and accountability for this medication. This failed practice placed the resident at risk for not receiving this medication and increased the risk of possible loss or diversion of the medication.</p> <p>Findings:</p> <p>Review of Resident #54's most recent MDS assessment, a quarterly assessment dated [DATE], revealed active diagnoses that included end stage renal disease, hypotension of hemodialysis (low blood pressure during dialysis), chronic pain syndrome, and dementia.</p> <p>Resident #54 had a physician's order for dialysis, dated 5/29/24. Resident #54 was to be transported to the dialysis center every Tuesday, Thursday, and Saturday and returned to the facility after.</p> <p>Resident #54 had a dialysis communication binder that accompanied the resident at every visit for communication between the facility and the dialysis center.</p> <p>Review of Resident #54's dialysis communication binder revealed a handwritten note from the dialysis center, dated 4/13/24, which read, Please do not send controlled substances to dialysis. We do not administer them. We cannot be responsible for administration of pain medication that is a controlled substance. We can administer Tylenol that we have here in the clinic .</p> <p>Further review of Resident #54's dialysis communication binder revealed:</p> <ul style="list-style-type: none"> <li>- A provider's order, dated 3/18/24, that read, . oxycodone 2.5mg [milligrams] PO [by mouth] PRN [as needed] pain. Please send 1 dose to dialysis [with] resident included chain of custody letter .; and</li> <li>- Two narcotic count sheets, dated 3/30/24 through 4/13/24, which revealed:</li> </ul> <p>1) One oxycodone 2.5mg tablet was documented as being sent to dialysis on 3/30/24. It was documented as not given on the count sheet, however, was not documented as accounted for and returned, when the resident returned to the facility (this section of the form was left blank). No nursing signatures or initials were on the narcotic count sheet for this date.</p> <p>Further review of Resident #54's binder Dialysis Communication sheet, dated 3/30/24, revealed that one oxycodone 2.5mg tablet was sent with the resident to dialysis. Further review revealed a handwritten message from the dialysis center: [no] oxy [oxycodone] IR [immediate release] given [at] the dialysis center .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2) One oxycodone 2.5mg tablet was documented as being sent to dialysis on 4/4/24. It was not documented as given (this section of the form was left blank), and not documented as accounted for and returned, when resident returned to the facility (this section of the form was left blank). No nursing signatures or initials were on the narcotic count sheet for this date.</p> <p>Further review of Resident #54's binder Dialysis Communication sheet, dated 4/4/24, revealed that one oxycodone 2.5mg tablet was sent with the resident to dialysis. Further review revealed no documentation that the oxycodone was, or was not, administered at the dialysis center.</p> <p>3) It was documented on the narcotic count sheet that one oxycodone 2.5mg was documented as sent to dialysis on 4/1/24 at 7:00 PM, not given, and returned to the facility. There was no documentation in Resident #54's binder that he/she attended dialysis on 4/1/24. Licensed Nurse (LN) #11 was the only initials on the control count sheet for this date; and</p> <p>4) It was documented that oxycodone 2.5mg tablets were also transported to the dialysis center on 4/6/24 (documented as given), 4/9/24 (documented as given), 4/11/24 (documented as not given, and returned), and 4/13/24 (documented as not given and returned).</p> <p>During an interview on 7/18/24 at 11:30 AM, the Quality Director stated no controlled substances should be allowed to go with residents to dialysis.</p> <p>Review of the facility's policy Medication for Use Outside of the Facility, last revised 7/2024, revealed it only provided guidance for a limited supply of medication with them [the resident] while on a prescriber approved absence from the facility . The dispensing pharmacy prepares an adequate supply of prescription medication for residents who leave the facility during short periods of time, or are en route to another destination . There was no guidance on medications taken with residents to appointments, to include dialysis.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>50031</p> <p>Based on observation and interview, the facility failed to: 1) discard expired medical supplies in the Nenana cottage; and 2) remove and replace expired medication for 1 resident (#93), out of 12 residents reviewed for medication. These failed practices: 1) placed the residents of the Nenana cottage (based on a census of 11) at risk of receiving expired medical supplies and experiencing potential adverse reactions; and 2) placed resident #93 at risk for not having therapeutic emergent medication during a medical emergency.</p> <p>Findings:</p> <p>Nenana Cottage</p> <p>An observation, during the Nenana cottage tour, on 7/12/24 at 8:20 AM, revealed:</p> <p>1) Medication supply storage room:</p> <ul style="list-style-type: none"> <li>- 1- BD Secondary Set (vented/nonvented), MS3500-15, intravenous (IV) tubing secondary set; manufacture expiration date was 4/21/24.</li> <li>- 3- BD MaxGuard Extension Set (microbore), ME2020, IV tubing; manufacture expiration date was 12/21/23.</li> <li>- 2- BD MaxGuard Extension Set (microbore), ME2020, IV tubing; manufacture expiration date was 12/20/23.</li> <li>- 1- BD MaxGuard Extension Set (microbore), ME2020, IV tubing; manufacture expiration date was 7/12/23.</li> <li>- 1- Medline Suction Swab tray, package opened.</li> <li>- 104- Medline Eanser Denture Tablet EFFER, 250709, not in manufacture box, individually package, no expiration date identified on packaging.</li> </ul> <p>2) Nurse office:</p> <ul style="list-style-type: none"> <li>- 1- 3M Tegaderm dressing, Antimicrobial Dressing with 2% CHG, packaging found opened.</li> <li>- 2- Medline PSJH IV Start Kit, DYNDV2337A, packaging found opened, manufacture expiration date was 9/30/24.</li> <li>- 2- BD SafetyGlide Needle, 23G x 1 1/2, 304387, packaging found opened, manufacture expiration date was 12/31/27.</li> </ul> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- 1- 10-millimeter (ml) syringe, found without packaging.</li> <li>- 4- BD Vacutainer, Buffered Sodium Citrate 3.2 %, Blood Collection Tubes, 3257667, manufacture expiration date was 6/30/24.</li> <li>- 1- Preoperative skin preparation, 12101451, manufacture expiration date was 12/23.</li> <li>- 1- BD MaxGuard Extension Set (microbore), ME2020, IV tubing; manufacture expiration date was 7/1/24.</li> <li>- 2- BD Insyte Autoguard, IV Catheter, 381412, 24 ga x 0.75-inch, manufacture expiration date was 6/30/24.</li> <li>- 1- BD Insyte Autoguard, IV Catheter, 381423, 22 ga x 1.00-inch, manufacture expiration date was 6/30/24.</li> <li>- 2- BD Instyte Autoguard, IV Catheter, 381444, 18 ga x 1.16-inch, manufacture expiration date was 5/31/24.</li> </ul> <p>During an interview on 7/12/24 at 9:10 AM, Licensed Nurse (LN) #2 informed of medical supplies found during observation of medical supply storage room and nursing office. LN #2 stated the facility usually finds expired products when stocking, not sure how this happens when they are supposed to be stocked newest in back. LN #2 took expired medical supplies.</p> <p>Resident #93</p> <p>An observation on 7/16/24 at 2:18 PM, revealed Resident #93's medical closet in his/her room contained a bottle of Nitroglycerin 0.4mg tablets. Further observation revealed this bottle of medication expired on 5/2024. There were no other bottles of Nitroglycerin tablets in the resident's medical closet.</p> <p>During an interview on 7/16/24 at 2:18 PM, Licensed Nurse (LN) #8 confirmed the Nitroglycerin was expired and removed it from the resident's room.</p> <p>Review of facilities policy Medication Storage, last revised 5/2024, revealed: . Improperly labeled, deteriorated, and expired items are quarantined from general inventory.</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>47929</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient dietary support staff were available to safely and effectively carry out the functions of the food and nutrition services in 1 cottage (Aniak), out of 8 cottages sampled. This failed practice placed all residents in the Aniak cottage (based on a census of 12), who received meals from the kitchen, at risk to be served meals that did not meet their needs and cause a less than optimal dining experience.</p> <p>Findings:</p> <p>Random observations on 7/8/24 in the Aniak cottage, revealed there was no Home Keeper (cook) working in the kitchen.</p> <p>During an interview on 7/8/24 at 9:27 AM, Certified Nurse Assistant (CNA) #10 stated there was no cook assigned to the Aniak Cottage that day.</p> <p>During an observation and interview on 7/8/24 at 12:04 PM, Resident #34 was sitting in his/her room, at his/her bedside table with a disposable Styrofoam clamshell food container containing the resident's lunch. Resident #34 stated that the food was cold, but it was no use to call someone to warm it up as it might be forgotten in the microwave, or the staff would take a long time to come get it to heat it up. The resident stated that he/she might as well eat it cold than bother the staff.</p> <p>During an interview on 7/8/24 at 3:44 PM, Resident #78 showed this surveyor a picture of a meal that was served to him/her on 7/6/24. The picture contained potatoes and carrots that had small traces of pot roast on the food (Resident #78 was a vegetarian) and was served in a disposable Styrofoam clamshell food container. The resident stated this was very upsetting.</p> <p>During an interview on 7/9/24 at 9:07 AM, [NAME] #2 stated the cottage did not have a cook working in the cottage for the past 3 days. The cottage had not been stocked during the absence. During the initial inspection of the kitchen and food storage areas, multiple food items in the main kitchen and pantry refrigerators were found to be missing open dates, produce was found to have indented brown spots with mold, and frozen chicken was thawing in the pantry's refrigerator with no thaw-by dates indicated. [NAME] #2 stated the cooks from the other cottages were supposed to cover the duties in the cottage in addition to theirs when a cook is absent.</p> <p>During an interview with the Resident Council on 7/12/24 at 11:01 AM, Resident #44 stated that he/she was not always happy with the food situation in the cottage. The resident stated there always seemed to be cooks missing. Several of the other residents who attended the meeting agreed with Resident #44.</p> <p>Review of the Aniak cottage's FREEZER TEMPERATURE LOG on 7/9/24 at 9:04 AM, for the month of July, revealed no temperature checks were performed on 7/7/24. The bottom of the log stated, CHECK TEMPERATURE AT LEAST DAILY, CLEAN ONCE A WEEK AND AS NEEDED.</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Aniak cottage's REFRIDGERATOR/WALK-IN TEMPERATURE LOG on 7/9/24 at 9:04 AM, for the month of July, revealed no temperature checks were performed on 7/7/24.</p> <p>The bottom of the log stated, CHECK TEMPERATURE AT LEAST DAILY, CLEAN ONCE A WEEK AND AS NEEDED. There were no initials for the first week of July indicating that the weekly refrigerator cleaning had not occurred.</p> <p>During an interview on 7/12/24 at 9:33 AM, the Manager of Food Services (MFS) stated the cooks assigned to a cottage are responsible for stocking, labeling, cleaning, and cooking the meals. When one cook calls out the entire day's routine implodes. Other cooks from other cottages were supposed to cover the duties in the cottage that did not have a cook. It was also expected of the cooks to help with resident cares in addition to their normal kitchen duties.</p> <p>Review of Providence Extended Care: The Cottages A handbook for residents and their families. Revised 7/24 revealed: Our vision is to provide excellent care in a place that truly is a home to those who live here . Just like mealtime at home, mealtime in the Cottage is a cherished time .</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47929</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on interview, observation, and record review, the facility failed to ensure food and drinks were prepared at a safe and appetizing temperature for 1 resident (#34) in the Aniak cottage (out of 12 residents in the cottage), and all residents who received meals prepared in the Deska cottage (based on a census of 11), out of 8 sampled cottages. Failure of the food to be at a palatable temperature had the potential to lower consumption and place the residents at risk for decreased nutritional intake and/or weight loss.</p> <p>Findings:</p> <p>Aniak Cottage:</p> <p>During an interview on 7/8/24 at 9:27 AM, Certified Nurse Assistant (CNA) #10 stated that the cottage did not have a home keeper (cook) that day for the cottage. When the cooks are short staffed, the meals for the cottage were prepared in another cottage, placed in separate disposable Styrofoam clamshell food containers labeled with the resident's room number, and brought over. The CNA and licensed nurse (LN) would serve the meals.</p> <p>During an observation on 7/8/24 at 11:59 AM, an open cart, containing disposable Styrofoam clamshell food containers, was brought into the cottage by [NAME] #1. [NAME] #1 placed all containers on the kitchen counter. At 12:02 PM [NAME] #1 left the cottage. The CNA and LN began serving the meals in the disposable Styrofoam clamshell food containers.</p> <p>During an observation and interview on 7/8/24 at 12:04 PM, Resident #34 was sitting in his/her room, at his/her bedside table with a disposable Styrofoam clamshell food container containing the resident's lunch. Resident #34 stated that the food was cold, but it was no use to call someone to warm it up as it might be forgotten in the microwave, or the staff would take a long time to come get it to heat it up. The resident stated that he/she might as well eat it cold than bother the staff.</p> <p>During an interview on 7/9/24 at 9:07 AM, [NAME] #2 stated that the cottage did not have a cook for the last three days, and other cooks in the other cottages would rotate preparing meals for the day. [NAME] #2 stated when a cook is covering another cottage, there was no time to wash dishes for both cottages and complete other duties. If another cottage did not have a cook available for the day, [NAME] #2 would prepare meals for the other cottage first before working on the meals for his/her assigned cottage, and food temperatures are taken prior to serving.</p> <p>Deska Cottage:</p> <p>Review of the recorded menus for 7/8/24 revealed the menu for breakfast included: oatmeal, cheese omelet, blueberries, milk, juice. The menu for lunch included: half meatloaf sandwich, tomato soup, milk.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 7/8/24 at 9:15 AM, revealed one disposable cup of milk and a disposable cup of coffee sitting on a tray, two pieces of toast sitting in the toaster, and several pieces of cheese in a measuring cup left unattended on the kitchen counter area of the cottage until 10:07 AM, 47 minutes later, when [NAME] #9 delivered these items to a resident, with no prior temperature checks.</p> <p>An observation on 7/8/24 at 11:00 AM, revealed [NAME] #9 prepared oatmeal for a resident requesting a late breakfast and served it without checking the temperature.</p> <p>An observation on 7/8/24 at 11:06 AM, revealed [NAME] #9 poured canned tomato soup into a pot and heated it up on an electric range stove, at a heat of level 2. At 11:32 AM, [NAME] #9 checked the temperature while the soup was still simmering, it was 159.8 degrees F (Fahrenheit). The soup continued to simmer on a level 2 for another 44 minutes, after which the cook then began placing the soup into bowls and assembling the residents' meal trays. Soup was served without further temperature checks. The last bowl of soup served was at 12:24 PM, 52 minutes after the previous temperature check mentioned above.</p> <p>Review of the HOMEKEEPERS ASSIGNMENT CHECKLIST, dated 7/8/24 revealed the soup temperature was logged at 166 degrees F.</p> <p>During an interview on 7/10/24 at 4:39 PM, the Dietary Manager stated food temperatures should be check prior to serving meals.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43792</p> <p>47929</p> <p>Based on observation, interview, and record review, the facility failed to ensure: 1) food was stored under proper sanitary conditions and stored at safe temperatures for the Aniak and Yukon cottages, out of 4 cottages observed, and 2) staff wore hairnets consistently when in the kitchen for the Matanuska and Kenai cottages, out of 4 cottages observed. This failed practice placed all residents who received food from the affected kitchens, based on a census of 46, at risk for foodborne illness and communicable disease.</p> <p>Findings:</p> <p>1) Food Storage</p> <p>Aniak Kitchen and Storage area:</p> <p>An observation on [DATE] at 9:17 AM, revealed the following food and beverages issues on the initial inspection of the kitchen and food storage areas:</p> <p>Main Kitchen and Refrigerator:</p> <ul style="list-style-type: none"> <li>- 1 pack - 14 oz Kirkland Black Forest Ham, open package, no open date;</li> <li>- 1 partial container - Glenview Farms Whipped Butter Blend Margarine, no open date.</li> <li>- 1 - uncovered oatmeal in a disposable Styrofoam bowl;</li> <li>- 1 bottle - Kirkland Organic Raw &amp; Unfiltered Honey, no open date;</li> <li>- 3 partial bags - Denali [NAME] Bread, no open date;</li> <li>- 1 partial bag - Cinnamin Raisin Bread, no open date;</li> <li>- 1 Regal Cinema soda cup with a resident number written on it, no use by date.</li> </ul> <p>Pantry Refrigerator:</p> <ul style="list-style-type: none"> <li>- yellow squash with small circular indented brown and mold spots</li> <li>- 2 bags of Frozen Tyson Boneless Skinless Chicken Thighs thawing in clear containers, no thaw by date.</li> </ul> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Aniak cottage pantry's FREEZER TEMPERATURE LOG on [DATE] at 9:04 AM, for the month of [DATE], revealed no temperature checks were performed on [DATE]. The bottom of the log stated, CHECK TEMPERATURE AT LEAST DAILY, CLEAN ONCE A WEEK AND AS NEEDED.</p> <p>Review of the Aniak cottage pantry's REFRIDGERATOR/WALK-IN TEMPERATURE LOG on [DATE] at 9:04 AM, for the month of [DATE], revealed no temperature checks were performed on [DATE].</p> <p>The bottom of the pantry's refrigerator log stated, . CLEAN ONCE A WEEK AND AS NEEDED. There were no initials from ,d+[DATE]-,d+[DATE] in the column titled, Cleaning Initials indicating the refrigerator cleaning had not occurred.</p> <p>During an interview on [DATE] at 9:27 AM, Certified Nurse Assistant (CNA) #10 stated there was no Homekeeper (Cook) assigned to the Aniak Cottage that day, and the cooks were responsible for labeling, stocking, and preparing food for the cottage.</p> <p>During an interview on [DATE] at 9:07 AM, [NAME] #2 stated the cottage did not have a cook working in the cottage for the past 3 days. The cottage had not been stocked and routine duties did not occur during the absence.</p> <p>Yukon Cottage Kitchen and Storage area</p> <p>An observation on [DATE] at 1:15 PM revealed the following food and beverages issues on the initial inspection of the kitchen and food storage areas:</p> <p>Kitchen Refrigerator:</p> <ul style="list-style-type: none"> <li>- 1 - Gallon container of Glenview Farms 2 % milk - unopened and full - expiration date was [DATE].</li> <li>- 1- Gallon container of Glenview Farms 2% milk- opened, no open date, ,d+[DATE] full-expiration date was [DATE]</li> </ul> <p>- Storage area Refrigerator:</p> <ul style="list-style-type: none"> <li>- 1-Gallon container of Glenview Farms 2 % milk - unopened and full - expiration date was [DATE].</li> </ul> <p>During an interview on [DATE] at 1:17 PM, Licensed Nurse (LN) #3 stated there were expired milks in the refrigerators. LN #3 also stated the cleaning schedule had not been completed, and the cook was not here today.</p> <p>During an additional interview on [DATE] at 1:30 PM, LN #3 stated he/she could not find the refrigerator and panty refrigerator temperature logs.</p> <p>2) Hairnets</p> <p>Matanuska Cottage</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on [DATE] at 10:13 AM, revealed Licensed Nurse (LN) #15 entered the kitchen without a hairnet and retrieved cold water from the refrigerator, then exited the kitchen.</p> <p>An observation on [DATE] at 9:12 AM, revealed [NAME] #3, who was working another cottage, entered the cottage from the back door and walked directly into the kitchen. [NAME] #3 was not wearing a mask or a hairnet, he/she did not wash his/her hands prior to entering the kitchen. [NAME] #3 was observed to open the refrigerator while rubbing the nares of his/her nose with the opposite hand. [NAME] #3 noticed this surveyor, exited the kitchen and donned a mask. [NAME] #3 re-entered the kitchen, without washing his/her hands and re-opened the refrigerator.</p> <p>An observation on [DATE] at 9:42 AM, revealed LN #16 entered the kitchen without a hairnet on after washing his/her hands. LN #16 took scrambled eggs from the food warmer and prepared some toast. LN #16 was observed to initially start to eat this meal while standing at the kitchen counter, then moved into the nurse's station to finish.</p> <p>Kenai Cottage</p> <p>An observation on [DATE] at 9:30 AM, revealed Certified Nursing Assistant (CNA) #10 in the kitchen without a hair net. When CNA #10 noticed this surveyor, he/she exited the kitchen and donned a hairnet, then returned into the kitchen.</p> <p>During an interview on [DATE] at 9:33 AM, the Manager of Food Services (MFS) stated every food item should have an open date and a use by date. Food items that are thawing in the refrigerators should have a blue tape labeled with the thaw by date. The thaw by date is three days from the date it was pulled from the freezer. Hairnets should be worn by anyone who goes into the kitchen. The temperature logs should be filled out every day. In the morning, the cooks are expected to check the fridge and freezer temperatures. When one cook calls out the entire day's routine implodes. It is expected of the cooks to help with resident cares in addition to their normal kitchen duties.</p> <p>Review of the facility's dietary protocol LABELING FOR RECEIVING AND STORAGE OF FOOD ITEMS dated ,d+[DATE], revealed: Items left in their original containers will have an opened date .The date will say 'Open Date . use by date' . Items repackaged or processed within the department will be labeled with a use by date for 3 days later . Personal items for residents must be labeled and dated with a use by date of three days .</p> <p>Review of the facility's dietary protocol REFRIDGERATOR/FREEZER CLEANING IN COTTAGES dated , d+[DATE] revealed: Dietary responsible for weekly cleaning and sanitizing of Refrigerators.</p> <p>Review of the facility's dietary protocol FOOD HANDLING REQUIREMENTS revised ,d+[DATE] revealed: Hairnets and/or caps are required while in the kitchen area.</p> <p>Review of The Food Code, U.S. Public Health Service 2022, accessed from <a href="https://www.fda.gov/media/164194/download?attachment">https://www.fda.gov/media/164194/download?attachment</a>, revealed: ,d+[DATE] Hair Restraints. (A) FOOD EMPLOYEES shall wear hair restraints .</p>		

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<p>F 0835</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>40259</p> <p>Based on interview, observation, and record review, the facility administration failed to ensure effective and efficient use of resources to provide for resident safety and to ensure the highest practicable physical, mental, and psychosocial well-being. This placed all residents (based on a census of 93) at risk for physical and/or psychosocial harm.</p> <p>The facility administration failed to maintain the facility in substantial compliance with regulatory requirements which resulted in substandard quality of care in which residents experienced actual physical harm including development of Stage III, IV, and unstageable pressure ulcers and deep tissue injuries. These failed practices caused actual harm due to the of deterioration of pressure ulcers. In addition, failure to ensure adequate staffing to provide for residents' physical, social, and emotional needs caused psychosocial harm.</p> <p>The facility administration was aware of the concerns but failed to identify or implement effective corrective measures.</p> <p>Findings:</p> <p>Review of the facility campus revealed eight separate cottage buildings, with 12 resident bedrooms in each cottage, for a total of 96 resident beds. Facility administrative and support staff (e.g. pharmacist, laundry, therapies) were located at the commons building. The facility's total census at the time of this survey was 93 residents.</p> <p>During an interview on 7/10/24 at 3:26 PM, the Administrator stated the Director of Nursing's (DON's) last full-time day was 6/21/24 and went to a schedule of coming to the facility Monday through Friday, 4:00 AM to 6:00 AM and then coming back in the afternoon if needed. Also, the DON would work Saturday and Sunday 6:00 AM to 12:00 PM if needed. The Administrator stated a new DON was hired and his/her start date was 7/29/24. See F727 for additional information regarding not having a full-time DON.</p> <p>During an interview on 7/17/24, the Administrator stated she had the overall responsibility of the campus, and that she set the expectations and goals.</p> <p>Staffing</p> <p>During an interview on 7/10/24 at 3:26 PM, when asked to describe the current staffing situation in the cottages, the Administrator stated the facility traditionally would have had one nurse in every cottage, and 16 CNAs (2 CNAs per cottage) scheduled on the dayshift, however since COVID they had not been able to meet that staffing level. The Administrator stated that the facility was currently running at crisis staffing level where there was one nurse for every 18 resident (one nurse per 1 and a half cottages) and one CNA for every 12 residents (one CNA per cottage), and there was a goal of having 4 support CNAs (1 support CNA per two cottages) to provide support and complete showers. This had been a challenge to attain, however, due call outs, and currently had been able to only provide about 3 support CNAs a day.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>When asked if the facility had received any calls or grievances about the staffing shortages, the Administrator stated there had been grievances from family.</p> <p>During an interview on 7/11/24 at 1:25 PM, when asked if staff had voiced any concerns about the staffing levels, the DON stated nurses had expressed concerns on having to pick up extra residents in a second cottage.</p> <p>During an interview on 7/12/24 at 10:29 AM, when asked how the staffing shortage and crisis level staffing had affected resident care, the Lead CNA (LCNA) stated it was a challenge to meet the needs of residents as swiftly as they could have with a full complement of staff, that staff able to give the residents the attention as they used to. The LCNA stated it was hard to meet the needs of the residents, and residents had voiced that their care had been delayed, to include not getting showers, and they didn't like the new staffing schedule. The LCNA further stated that if there weren't enough support CNAs, residents would get bed baths instead of showers because there weren't enough staff to provide showers.</p> <p>The LCNA further stated that having only one CNA per cottage now meant that residents had to wait longer for their needs to be met and it may have been impacting pressure ulcers because the CNAs were having trouble meeting the turning schedule of every 2 hours. See F676 for additional information regarding Activities of Daily Living (ADLs).</p> <p>During an interview on 7/17/24, when asked if the number of staff currently working, and based on the bed capacity of 96, was affecting the facility's able to meet the needs of the resident acuity levels, the Administrator stated she felt they were able to meet the needs, but not at the standard we would want to meet them.</p> <p>When asked how many open nursing positions the facility had, the Administrator there were currently 10 CNA positions and 5 nursing positions posted, however there were more that needed to be filled.</p> <p>Home Keepers/Housekeepers/Activity Staff</p> <p>During an interview on 7/10/24 at 3:26 PM, when asked what other measures the facility had attempted to help support the cottages to meet the needs of the residents, the Administrator stated they increased training with home keepers (cooks), housekeepers, and activity staff to help with assisting CNAs when needed in bed mobility and transfers, as well, as assist with dining for residents who required minimal support. These staff were trained in safe patient handling and dining assistance.</p> <p>During an interview on 7/11/24 at 1:25 PM, when asked if staff had voiced any concerns about the staffing levels, the DON stated the CNAs had expressed concerns that the home keepers, housekeepers, and activity staff weren't supporting them during the day because they were unsure on what they could or couldn't do.</p> <p>Random observations on 7/8-10/24 and 7/15-18/24 revealed no home keeper, housekeeper, or activity staff assisted CNAs with bed mobility, transfers, or dining assistance.</p> <p>See F725 for additional information regarding Sufficient Staffing and F675 for additional information regarding Quality of Life.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>Pressure Ulcers</p> <p>Review of the facility provided CASPER report, dated June 2024, revealed the facility's Pressure Ulcers facility adjusted percentage was 16.1% (compared to the comparison group national average of 7.4%). The July report was unavailable as it was too early in the month for that final report.</p> <p>Review of the facility's Matrix for Providers, CMS-802 [a document used to identify pertinent care categories] documentation, completed on 7/8-9/24, revealed an overall pressure ulcer rate of 19% [18 residents total].</p> <p>During an interview on 7/12/24 at 2:30 PM, Wound Care Nurse (WRN) #1 stated there were currently 18 residents with pressure ulcers. When asked if limited staffing concerns contributed to the pressure ulcer numbers, the WRN #1 stated residents needed to be turned every 2 hours to relieve pressure. When asked if she felt residents were being turned every 2 hours, the WRN #1 stated, no. When asked if she felt this contributed the deterioration of the resident's pressure ulcers, WRN #1 stated, yes.</p> <p>During an interview on 7/17/24 at 8:17 AM, the Medical Director stated, If turning residents isn't getting completed, I would say we need to find avenues to get it done.</p> <p>During an interview on 7/18/24 at 11:27 AM, when asked if the Quality Assurance and Performance Improvement (QAPI) committee had implemented any performance action plans due to the high rate of pressure ulcers at the facility, the Quality Director stated she felt that the lack of staffing, and their inability to provide more one on one attention to residents, had attributed to this increase, and QAPI's focus had been to help boost staff numbers. The Quality Director further stated a performance improvement plan was in effect for pressure ulcers.</p> <p>When asked if the pressure ulcer rates had been discussed with the Governing Body (GB), the Quality Director stated the increase in pressure ulcer rates and the residents had been discussed. GB had been informed of low staffing levels. GB had discussed funding solutions, such as bringing in travelers, and leadership meetings had been held to possibly plan for this.</p> <p>See F725 for additional information regarding sufficient staffing.</p> <p>Quality of Life</p> <p>During an interview on 7/17/24 at 8:17 AM, when asked if the concerns with low staffing had impacted the resident's care, the Medical Director stated residents talked to her about how staff needed help. The Medical Director further stated low staffing was affecting the residents with higher acuity, who required heavier assistance in cares, more than the residents who were more independent.</p> <p>Review of the Resident Council Meeting Minutes, dated 1/17/24, 4/17/24, and 6/20/24, the DON noted a decrease in staffing had been occurring. During the 6/20/24 meeting the [Administrator] shared with group the new process [staffing restructure] which went live on Tuesday [6/23/24].</p> <p>(continued on next page)</p>		

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  07/19/2024
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.			
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<p>F 0835</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 7/11/24 at 1:25 PM, when asked if staff had voiced any concerns about the staffing levels, the DON stated nurses had expressed concerns on having to pick up residents in a second cottage. The CNAs had expressed concerns that the home keepers, housekeepers, and activity staff weren't supporting them during the day because they were unsure on what they could or couldn't do.</p> <p>During an interview on 7/16/24 at 4:35 PM, LN #8 stated staff shortages had affected the ability to spend time with the residents. LN #8 stated it was a struggle to complete turns every 2 hours and showers. When properly staff showers used to be enjoyable and staff could spend time with residents to put on lotion, however staff are now rushed due to the increased workload that resulted in the staff being less available. LN #8 further stated quality time with residents wasn't possible anymore.</p> <p>During random interviews and observations, 7/8-10/24 and 7/15-18/24, revealed multiple residents expressed feelings of hopelessness, had sad-tones verbal expressions, tearfulness, and shared they experienced apathy, humiliation, frustration, and/or feelings of helplessness about the current staffing situation and how it had affected their livelihood at the facility.</p> <p>See F725 for additional information regarding sufficient staffing and F675 for additional information regarding quality of life.</p> <p>Review of the facility's policy SNF [skilled nursing facility]/AL [assisted living] Abuse Prohibition and Prevention, revised 1/2024, revealed: . The purpose of this policy is to set forth the . policy regarding the prohibition and prevention of resident . neglect . Definitions . Neglect . means 'the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43792</p> <p>50031</p> <p>Based on record review, interview, and observation, the facility failed to: 1) ensure personal protective equipment (PPE) was worn during wound care for 1 resident (#48), out of 9 wound care records reviewed; and 2) ensure proper hand hygiene was performed and completed during wound care treatments for 1 resident (#82), out of 4 wound care treatments observed. This failed practice created potential risk for infection in the wounds, decreased wound healing, and resident well-being.</p> <p>Findings:</p> <p>Resident #48</p> <p>Review on 7/8-12/24 and 7/15-19/24 revealed Resident # 48 was admitted to the facility with diagnoses that included diabetes mellitus, multiple CVA's (cerebrovascular accident - strokes), resulting in severe expressive aphasia (defect or loss of the power of expression by speech, writing, or signs, or of comprehending spoken or written language, due to injury or disease of the brain centers), severe dysphagia (difficulty swallowing), right sided hemiparesis (partial paralysis of one side of the body), and failure to thrive (weight loss of more than 5%, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction, and low cholesterol)</p> <p>Review of Resident #48's Baseline Care Plan/RDCP, on 7/10/24, revealed: Resident/Patient is on Enhanced Barrier Precautions. Use gown &amp; gloves during high-contact activities.</p> <p>Record review, on 7/11/24 at 11:22 AM, of Resident #48's wound photographs of pressure ulcer on the left heel, dated 4/25/23, revealed Certified Nursing Assistant (CNA) #3's hand holding a wound measurement tape on resident's wound. Further review revealed CNA #3 was not wearing gloves, and CNA #3's artificial nails were touching the wound's edges.</p> <p>During an interview on 7/17/24 at 11:15 AM, the Wound Care Nurse (WRN) #1 stated any caregiver should use the resident's daily care plan located on back of resident's door for resident care. Resident #48's left heel picture, dated 4/25/23, was presented to WRN#1. WRN #1 stated CNA #3, who assisting in the wound care, should have been wearing gloves.</p> <p>During an interview on 7/17/24 at 1:45 PM, the Infection Preventionist (IP) was presented with Resident #48's left heel picture, dated 4/25/23. IP stated he/she was severely concerned the employee was not wearing PPE and fingernails were touching the wound.</p> <p>Review of the facility's Providence Extended Care Sufficient Staffing Education HR Worksheet, dated 7/10/24, revealed CNA #3 completed Infection Control (IC) initial education on 5/9/22 and annual IC education on 7/27/23.</p> <p>Resident #82</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review on 7/8-12/24 and 7/15-19/24 revealed Resident # 82 was admitted to the facility with diagnoses that included Chronic Respiratory failure with hypercapnia (condition of abnormally elevated carbon dioxide levels in the blood) and chronic obstructive pulmonary disease (chronic lung disorders resulting in blocked air flow in the lungs).</p> <p>Review of Resident #82's Baseline Care Plan/RDCP, on 7/16/24, revealed: Resident/Patient is on Enhanced Barrier Precautions. Use gown &amp; gloves during high-contact activities.</p> <p>An observation on 7/12/24 at 11:10 AM, of Resident #82's wound dressing change, revealed WRN #1, with gloved hands removed a dressing from Resident #82's coccyx area. WRN #1, without removing the soiled gloves, proceeded to cleanse the wounds with Vashe, a wound wash, and then assessed and measured the wound, and placed the sterile dressing onto the bedside table, before removing the soiled gloves and washing hands. WRN #1 then applied the skin prep to the surrounding skin, applied Puracol Plus, a wound care treatment, to the wound bed, and applied the foam dressing. WRN #1 did not remove gloves and perform hand hygiene after removing a soiled dressing.</p> <p>During an interview on 7/12/24 at 11:17 AM, WRN #1 agreed that removing gloves and washing hands after dressing removal was best practice. He/she used [NAME] for wound care practice.</p> <p>During an interview on 7/16/24 at 11:55 AM, the Infection Preventionist stated that during a wound care dressing change the nurse would remove the soiled dressing and discard appropriately and then remove soiled gloves and discard and then perform hand hygiene and then apply clean gloves before proceeding with dressing change.</p> <p>Review of Clinical Safety: Hand Hygiene for Healthcare Workers retrieved at <a href="https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html">https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html</a>, dated 2/27/24, revealed: Know when to clean your hands . After contact with blood, body fluids or contaminated surfaces.</p> <p>Review of the Providence Extended Care: The Cottages, A handbook for residents and their families, revised date July 2024, Infection Prevention is a program to prevent the spread of infection among our residents . This involves handwashing and wearing personal protective equipment (PPE) when coming in contact with body fluids or contaminated surfaces.</p> <p>Review of the Centers for Disease Control (CDC) web site accessed 7/22/24 at <a href="https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html">https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html</a> , revealed Clinical Safety: Hand Hygiene for Healthcare Workers, . natural nails should not extend past the fingertip.</p>		