

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  025038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/21/2024
NAME OF PROVIDER OR SUPPLIER  Maple Springs of Wasilla		STREET ADDRESS, CITY, STATE, ZIP CODE  3265 E Meridian Loop Wasilla, AK 99654	
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>40259</p> <p>Based on record review and interview, the facility failed to ensure the residents right to be informed, in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care and treatment recommendations were upheld. Specifically, the facility failed to ensure the Psychotropic Medication Informed Consent [and] Risk/Benefit Statement forms, used for education and consent for psychotropic medications (any drug that affects brain activities associated with mental processes and behavior), were completed accurately, timely, and by health care providers with an original signature for 9 sampled residents (#'s 6; 8; 15; 16; 18; 28; 33; 35; and 204) and 8 unsampled residents (#'s 2; 7; 19; 25; 31; 37; 41; and 105), out of 25 residents on psychotropic medications. This failed practice violated the resident's right to be informed and afforded the opportunity to ask questions of their health care provider and placed them at risk for unnecessary medication and/or adverse reactions.</p> <p>Findings:</p> <p>Record review on 6/16-21/24 revealed the facility used a Psychotropic Medication Informed Consent [and] Risk/Benefit Statement form (identified as consent form moving forward), dated 3/2023, to educate and obtain consent from residents and/or their representatives on any psychotropic medication recommended for use. This form would be used upon resident admissions if the resident was currently taking a psychotropic medication, or would be used if a psychotropic medication was initiated during their stay.</p> <p>Further review revealed the form documented the following information:</p> <ul style="list-style-type: none"> <li>- I [resident or representative name] have received information regarding the risks and benefits associated with using the psychotropic drugs that have been ordered for [resident's name] for the specific diagnosis listed below, manifesting target symptoms/behaviors . A list of diagnoses was available to check the appropriate diagnosis for individual residents.</li> <li>- Name and Dosage of psychotropic medication(s) A space to write the medication and dose was provided.</li> <li>- . The benefits expected from this medication . A list of benefits was on the form.</li> </ul> <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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  025038	Facility ID:  025038  If continuation sheet Page 1 of 56

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- The risks or side effects associated with this medication include, but are not limited to . A list of risks or side effects for different classes of medications: hypnotics/sedatives; antidepressants; anxiolytics (antianxiety medications); and antipsychotics were listed on the form.</p> <p>A review of the consent section of the form revealed the following places to check if agreed:</p> <ul style="list-style-type: none"> <li>- The risks and benefits of the use of psychotropic medication(s) have been explained to me;</li> <li>- I have asked, and had answered, all of the questions, which pertain to the use of psychotropic medication(s);</li> <li>- I understand and consent to the use of the medication described above; and</li> <li>- I do not consent to the use of the above mentioned medication.</li> </ul> <p>The consent form had a place for In person consent to indicate the individuals signing were present at the time of the form's completion: Physician Signature; Resident Name (print); and Resident Signature or Resident's Representative Signature. This was the only signature line for health care providers to sign on.</p> <p>There was also a place for Telephone Consent/Refusal: (2 staff witnesses) and had places for name of person giving consent/refusal; and two spaces for nurse signature.</p> <p>An observation on 6/20/24 at 10:38 AM, during an explanation of all the admission paperwork documents in an admission packet by Licensed Nurse (LN) #33, revealed a blank consent form with the Medical Director's signature photocopied on it.</p> <p>When asked about the photocopied signature on the blank consent form, LN #33 confirmed this form was used during admissions of new residents.</p> <p>During an interview on 6/21/24 at 4:23 PM, the Medical Director stated she approved her signature to be photocopied on a blank consent form for repeated use. The Medical Director further stated the nurses completed the consent forms with residents. When asked if there was anywhere in the chart that reflected the health care providers reviewed the admission paperwork to include the consent forms for psychotropic medications, the Medical Director stated there wasn't anywhere in the chart that she signed to say she reviewed these forms.</p> <p>Review on 6/17-21/24 of all 25 resident records, who were currently on psychotropic medications, revealed the following residents had consent forms that contained health care provider's photocopied signatures.</p> <p>Further review revealed some of the following residents also either had missing consent forms for psychotropic medications doses being administered, consents were not obtained prior to psychotropic medication administration, and/or consents were not accurately obtained with appropriate consent, for the following residents:</p> <p>Resident #2</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Escitalopram (Lexapro - an antidepressant)</p> <p>Resident #2's consent form was for the use of escitalopram 20 milligrams (mg). This form was signed by the resident on 5/2/24. The Medical Director's photocopied signature was on this form with the handwritten date of 5/2/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Resident #6</p> <p>Resident #6 had multiple consent forms for multiple psychotropic medications:</p> <p>Buspirone (an anxiolytic)</p> <p>The first consent form was for the use of buspirone 20 mg. This form was dated 4/15/24 and two nurses signed on the Resident's Representative Signature line under the In Person Consent section. Further review revealed no resident representative listed on the consent form. The Medical Director's photocopied signature was on this form with a computer-generated date of 4/15/24.</p> <p>Duloxetine (an antidepressant)</p> <p>The second consent form was for the use of duloxetine 60mg. This form was dated 4/15/24 and two nurses signed on the Resident's Representative Signature line under the In Person Consent section. Further review revealed no resident representative listed on the consent form. The Medical Director's photocopied signature was on this form with a computer-generated date of 4/15/24.</p> <p>Trazadone (an antidepressant)</p> <p>The third consent form was for the use of Trazadone 100mg. This form was dated 4/20/24 and two nurses signed on the Resident's Signature line and documented 2 nurse signature [with] resident. The Medical Director's photocopied signature was on this form with a handwritten date of 4/20/24.</p> <p>Further record review revealed Resident #6 started Trazadone on 4/15/24, five days prior to the date of the consent form.</p> <p>Hydroxyzine (an antihistamine, but can be used to treat anxiety)</p> <p>1. The fourth consent form was for the use of Hydroxyzine with no dose indicated. There was no class of medication marked to review risks or potential side effects for this medication. The resident's daughter signed this form on 4/24/24. Further review revealed the daughter put her name on the Resident's Name (print) line and signed her name on the Resident Signature line. The Medical Director's photocopied signature was on this form with a handwritten date of 4/24/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>2. The fifth consent form was for the use of Hydroxyzine 50mg every 6 hours PRN (as needed) and used for anxiety. The class of medication marked was anxiolytics. This form was dated 5/23/24 and two unrecognizable signatures were on the Resident's Signature line and documented verbally acknowledged. The Medical Director's photocopied signature was on this form with a handwritten date of 5/23/24.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Lorazepam (an anxiolytic)</p> <p>The sixth consent form was for the use of Lorazepam 0.5mg. This form was dated 5/23/24 and two unrecognizable signatures were on the Resident's Signature line and documented verbally acknowledged. The Medical Director's photocopied signature was on this form with a handwritten date of 5/23/24.</p> <p>Resident #7</p> <p>Resident #7 had two psychotropic medication consent forms:</p> <p>Fluoxetine (an antidepressant)</p> <p>The first consent form was for the use of Fluoxetine 20mg. This form was signed by the resident on 4/18/24. Further review the resident did not mark the section I have asked, and had answered, all of the questions, which pertain to the use of psychotropic medication(s) of the form. The Medical Director's photocopied signature was on this form with a handwritten date of 4/18/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Mirtazapine (an antidepressant)</p> <p>The second consent form was for the use of Mirtazapine 7.5mg. This form was signed by the resident on 4/18/24. Further review the resident did not mark the section I have asked, and had answered, all of the questions, which pertain to the use of psychotropic medication(s) of the form. The Medical Director's photocopied signature was on this form, however, was not dated. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Resident #8</p> <p>Resident #8 had two psychotropic medication consent forms:</p> <p>Seroquel (an antipsychotic)</p> <p>The first consent form was for the use of Seroquel 25mg twice a day and 50mg at bedtime (HS). This form had an illegible marking on the Resident Signature line, dated 4/17/24. The Medical Director's photocopied signature was on this form with a handwritten date of 4/17/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Citalopram (Celexa - an antidepressant)</p> <p>The second consent form was for the use of citalopram 20mg. This form was dated 4/20/24 and it was documented in the telephone consent/refusal section that a resident representative was called for consent. It was documented left a VM [voicemail] under the representative's name and two nurses signed the form. No documentation was added later to prove education was provided, or verbal consent was ever obtained. The Medical Director's photocopied signature was on this form with a handwritten date of 4/20/24.</p> <p>Further record review revealed Resident #8 started Citalopram on 4/18/24, two days prior to the facility's attempt to obtain consent.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident #15</p> <p>Risperdal (an antipsychotic)</p> <p>Review of Resident #15's medication administration record revealed an order for Risperidone Oral Tablet (Risperdal) Give 0.5mg by mouth every morning and at bedtime for mood disorder. The start date for this order was 12/21/23.</p> <p>Review of Resident #15's consent forms for Risperdal revealed:</p> <ul style="list-style-type: none"> <li>- The first consent form was for the use of Risperdal with no specified dose. This form was signed by the resident representative on 3/18/20. Further review revealed the resident representative did not mark the consent sections of The risks and benefits of the use of psychotropic medication(s) have been explained to me and I have asked, and had answered, all of the questions, which pertain to the use of psychotropic medication(s). Physician #22's original signature was on this consent form and dated 4/4/20.</li> <li>- The second consent form was for the use of Risperdal 0.25mg. This form was dated 4/6/23 and two nurse signatures were on the Resident Signature line with 2 nurse signature documented. Further review revealed no information that the resident representative was contacted for consent. Physician #22's original signature was on this consent form and dated 4/6/23.</li> </ul> <p>Further review of Resident #15's medical record revealed no consent for the current dose of Risperdal 0.5mg currently being administered.</p> <p>Resident #16</p> <p>Lexapro</p> <p>Resident #16's consent form was for the use of Lexapro 15mg. This form was dated 5/11/24 and it was documented in the telephone consent/refusal section that the resident gave consent and was signed by two nurses. Physician #22's original signature was on this form and dated 5/11/24.</p> <p>Further record review revealed Resident #16 started Lexapro 10mg on 1/18/23, 479 days prior to the date of the consent form, and the dose changed to 15mg on 2/28/23, 438 days prior to the date of the consent form. No other consent forms for Lexapro were found in the resident's medical record.</p> <p>Resident #18</p> <p>Resident #18 had multiple consent forms for multiple medications:</p> <p>Lorazepam</p> <p>1. The first consent form was for the use of liquid Lorazepam 2 milligram (mg)/(per) milliliter (ml). This form was signed by the resident representative on 10/4/23. Physician #5's photocopied signature was on this form with a handwritten date of 10/4/23. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. The second consent form was for the use of Lorazepam 1mg. This form was signed on 11/14/23 and consent was obtained by telephone consent with the resident representative and two nurse signatures. Physician #22's photocopied signature was on this form with a handwritten date of 11/14/23.</p> <p>Further record review revealed Resident #18 started this Lorazepam medication as an every hour PRN (as needed) dose on 10/3/23, 42 days prior to this consent being obtained.</p> <p>3. The third consent form was for the use of Lorazepam 0.5mg three times a day and every hour PRN dose. This form was signed on 3/4/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 3/4/24.</p> <p>Further record review revealed Resident #18's Lorazepam order that was started on 3/4/24 was for 1mg three times a day and every hour PRN Lorazepam dose was 1mg, not 0.5mg as the consent indicated.</p> <p>4. The fourth consent form was for the use of Lorazepam 1mg three times a day. This form was signed on 3/6/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 3/6/24.</p> <p>Further record review revealed Resident #18's Lorazepam order that was started on 3/6/24 was for 0.5mg three times a day, not 1mg as the consent indicated. No new consent form for this dosage change was in Resident #18's medical record.</p> <p>Resident #18's every hour PRN Lorazepam order stopped on 3/6/24.</p> <p>5. The fifth consent form was for the use of Lorazepam 0.5mg twice a day. This form was signed on 3/13/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 3/13/24.</p> <p>Further record review revealed this scheduled dose of Lorazepam started on 3/13/24. Resident #18's every hour PRN Lorazepam order was restarted on 3/16/24, three days after the 3/13/24 consent was obtained. No new consent form for this dosage change was in Resident #18's medical record.</p> <p>Seroquel (an antipsychotic)</p> <p>1. The first consent form was for the use of Seroquel 50mg. This form was signed by the resident representative on 10/4/23. Physician #5's photocopied signature was on this form with a handwritten date of 10/4/23. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Further record review revealed Resident #18 started Seroquel on 10/2/23, two days prior to this consent being documented. Further review revealed the dose of Seroquel changed on 10/17/23 to Seroquel 50mg twice a day, for a total of 100mg daily.</p> <p>No new consent for this dosage change was in Resident #18's medical record.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. The second consent form was for the use of Seroquel 75mg at bedtime and 50mg PRN. This form was signed on 11/14/23 and consent was obtained by telephone consent with the resident representative and two nurse signatures. Physician #22's photocopied signature was on this form with a handwritten date of 11/14/23.</p> <p>Further record review revealed Resident #18 started Seroquel 75mg at bedtime on 11/1/23, 13 days prior to this consent being obtained. On 11/2/23, Resident #18 was started on Seroquel 50mg daily at 9:00 AM, not PRN like the consent form indicated. No new consent form for this dosage change was in Resident #18's medical record.</p> <p>3. The third consent form was for the use of Seroquel 75mg twice a day. This form was signed on 3/4/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 3/4/24.</p> <p>Trazadone</p> <p>Resident #18's consent form was for the use of Trazadone 25mg. This form was signed on 11/14/23 and consent was obtained by telephone consent with the resident representative and two nurse signatures. Physician #22's photocopied signature was on this form.</p> <p>Further record review revealed Resident #18 started Trazadone on 10/5/23, 40 days prior to the consent being obtained. No other consent forms for Trazadone were found in the resident's medical record.</p> <p>Resident #19</p> <p>Resident #19 had two psychotropic medications on one consent form:</p> <p>Paroxetine (an antidepressant) and Xanax (a sedative)</p> <p>Resident #19's consent form was for the use of paroxetine 40mg and Xanax 0.5mg. This form was dated 5/15/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. Physician #22's original signature was on this form and dated 5/29/24, 14 days after the resident signed the consent form.</p> <p>Further record review revealed Resident #19 started paroxetine 20mg on 2/4/22, 831 days prior to the consent being obtained. Resident #19's paroxetine dose was changed to 40mg on 12/21/23. No other consent forms for paroxetine were in the resident's record.</p> <p>Further record review revealed Resident #19 started Xanax 0.5mg on 9/30/22, 593 days prior to the consent being obtained. No other consent forms for Xanax were in the resident's record.</p> <p>Resident #25</p> <p>Resident #25 had two psychotropic medication consent forms:</p> <p>Duloxetine</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. The first consent form was for the use of Duloxetine 60mg. This form was signed by the resident on 4/12/24. The Medical Director's photocopied signature was on this form with a handwritten date of 4/12/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Hydroxyzine</p> <p>2. The second consent form was for the use of hydroxyzine 25mg. This form was signed by the resident on 4/16/24. The Medical Director's photocopied signature was on this form with a handwritten date of 4/16/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Further review revealed a nurse's initials were on bottom left second page of the form which indicated Document in Point Click Care that a telephone consent/refusal was obtained and scan this document under the Misc [Miscellaneous] tab, with heading of Consent: Medications. This consent was not obtained through telephone consent.</p> <p>Resident #28</p> <p>Resident #28 had multiple consent forms for multiple medications:</p> <p>Clonazepam (a sedative)</p> <p>1. The first consent form was for the use of clonazepam with no specified dose. This form was signed on 5/19/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form. This signature was not dated.</p> <p>Further record review revealed Resident #28 started Clonazepam on 5/18/24, 1 day prior to the consent being obtained.</p> <p>2. The second consent form was a photocopy of the original with the words updated with dose on the upper right corner of the consent form's first page. The dose 0.5mg Q AM [every morning] was added after the word Clonazepam. This form had no indication the resident representative authorized the addition of a dose to the consent form, or that the resident representative was called to be informed it was added. The Medical Director's photocopied signature was on this form. This signature was not dated.</p> <p>Further record review revealed Resident #18 started an additional order of Clonazepam 0.5mg every 24 hours PRN agitation on 5/24/24, which changed to 0.5mg every 12 hours PRN agitation on 6/17/24. No new consent for this dosage change was in Resident #28's medical record.</p> <p>Hydroxyzine</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. The third consent form was for the use of hydroxyzine 25mg. The indication for use was for generalized itching. The class of medication was marked as anxiolytics. This form was signed on 4/29/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 4/29/24.</p> <p>2. The fourth consent form was for the use of hydroxyzine 25mg. The class of medication was marked as Other and documented at antianxiety. No risks or side effects associated with this medication was not documented on the consent form. This form was dated 6/4/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form. This signature was not dated.</p> <p>Seroquel</p> <p>1. The fifth consent form was for the use of Seroquel 25mg. This form was signed on 5/13/24 and had an illegible marking on the Resident Signature line. Physician #5's original signature was on this form dated 5/13/24.</p> <p>2. The sixth consent form was for the use of Seroquel 25mg at HS. This form was half filled out by a nurse in blue ink, the other half was filled out by the resident in black. This form was dated 5/13/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. None of the sections for consent were marked: The risks and benefits of the use of psychotropic medication(s) have been explained to me; I have asked, and had answered, all of the questions, which pertain to the use of psychotropic medication(s); I understand and consent to the use of the medication described above; or I do not consent to the use of the above mentioned medication. The Medical Director's photocopied signature was on this form. This signature was not dated.</p> <p>3. The seventh consent form was for the use of Seroquel 50mg. This form was dated 5/24/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 5/24/24.</p> <p>4. The eighth consent form was for the use of Seroquel 100mg at HS and continue 50mg in AM. This form was dated 6/10/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 6/10/24.</p> <p>Resident #31</p> <p>Resident #31 had two psychotropic medication consent forms:</p> <p>Seroquel</p> <p>1. The first consent form was for the use of Seroquel 50mg. This form was signed on 11/14/23 and the resident signed this form with an illegible marking to the left of the resident's printed name added by staff. Physician #22's photocopied signature was on this form with a handwritten date of 11/14/23. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Further record review revealed Resident #31 started Seroquel on 10/13/23, 32 days prior to the 11/14/23 consent form. No other consent forms for Seroquel were in the resident's medical record.</p> <p>Lorazepam</p> <p>2. The second consent form was for the use of Lorazepam 1mg. This form was signed on 11/14/23 as well and had another illegible marking but this time was over Physician #22's photocopied signature that had a handwritten date of 11/14/23. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Resident #33</p> <p>Resident #33 had two psychotropic medication consent forms:</p> <p>Wellbutrin (an antidepressant)</p> <p>1. The first consent form was for the use of Wellbutrin 150mg. This form was signed by the resident on 5/10/24. The Medical Director's photocopied signature was on this form and had a handwritten date of 3/13/24, 58 days prior to the resident's consent was obtained. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Further record review revealed Resident #33 started Wellbutrin on 3/13/24, the day the Medical Director's photocopied signature was dated. No other consent forms for Wellbutrin were in the resident's medical record.</p> <p>Duloxetine</p> <p>2. The second consent form was for the use of duloxetine 30mg. This form was signed by the resident on 5/10/24. The Medical Director's photocopied signature was on this form and had a handwritten date of 3/16/24, 55 days prior to the resident signing. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Further record review revealed Resident #33 started Duloxetine on 3/16/24, the day the Medical Director's photocopied signature was dated. No other consent forms for Duloxetine were in the resident's medical record.</p> <p>Resident #35</p> <p>Resident #35 had two psychotropic medications with multiple consent forms:</p> <p>Sertraline</p> <p>The first consent form was for the use of Sertraline 50mg. This form was signed by the resident on 2/28/24. The Medical Director's photocopied signature was on this form had a handwritten date of 2/28/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Trazadone</p> <p>(continued on next page)</p>

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. The second consent form was for the use of Trazadone 150mg. This form was signed by the resident on 3/4/24. The Medical Director's photocopied signature was on this form with a handwritten date of 2/28/24, which was the date of admission for Resident #35 and 6 days prior to the resident signing. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Further record review revealed Resident #35 started Trazadone 150mg at bedtime on 2/28/24, the day of admission. No new consent form for this dosage change was in Resident #35's medical record.</p> <p>2. The third consent form was for the use of Trazadone 50mg. This form was signed by the resident on 3/13/24. The Medical Director's photocopied signature was on this form with a handwritten date of 3/13/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Resident #37</p> <p>Duloxetine</p> <p>Resident #37's consent form was for the use of duloxetine 30mg. This form was dated 2/29/24 and was obtained through telephone consent with a resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 2/29/24.</p> <p>Further record review revealed a second consent form for the same medication and same dose was completed and dated 4/27/24. This form was completely filled out and signed by the resident. Further review revealed this consent form was initialed by the resident on the sections of The risks and benefits of the use of psychotropic medication(s) have been explained to me and I have asked, and had answered, all of the questions, which pertain to the use of psychotropic medication(s), however there was a computer-generated pre-typed X on the line to indicate I understand and consent to the use of the medication described above. The Medical Director's photocopied signature was on this form and Resident #37 wrote the date 4/27/24 for this signature. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Resident #41</p> <p>Resident #41 has two psychotropic medications and multiple consent forms:</p> <p>Venlafaxine (an antidepressant)</p> <p>The first consent form was for the use of Venlafaxine 150mg. This form was signed by the resident on 5/10/24. The Medical Director's photocopied signature was on this form and had a handwritten date of 5/5/24, five days prior to the resident signing. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Further record review revealed Resident #41 started Venlafaxine 150mg on 5/5/24, the day the Medical Director's photocopied signature was dated. No other consent forms for Venlafaxine were in the resident's medical record.</p> <p>Hydroxyzine</p> <p>(continued on next page)</p>

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. The second consent form was for the use of hydroxyzine 25mg. This form was dated 4/10/24 and consent was documented in the telephone consent/refusal section. The word telephone was lined out and the words In Person were added. The form indicated the resident was on the name of person giving consent/refusal line and signed by two nurses. Medical Director's photocopied signature was on this form with a handwritten date of 4/10/24.</p> <p>2. The third consent form was for the use of hydroxyzine 25mg as well. This form was signed by the resident on 5/29/24. The Medical Director's photocopied signature was on this form with a handwritten date of 5/29/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Resident #105</p> <p>Resident #105 had three psychotropic medication consent forms:</p> <p>Amitriptyline (an antidepressant)</p> <p>The first consent form was for the use of amitriptyline 100mg. This form was signed by the resident representative on 6/5/24. The Medical Director's photocopied signature was on this form with a handwritten date of 6/5/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Fluoxetine</p> <p>The second consent form was for the use of fluoxetine 20mg. This form was signed by the resident representative on 6/5/24. Further review revealed the resident's printed name was not on the In person consent line and the resident's representative signed on the Resident's Signature line. The Medical Director's photocopied signature was on this form with a handwritten date of 6/5/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Memantine (cognitive enhancing medication to treat dementia associated with Alzheimer's)</p> <p>The third consent form was for the use of Memantine 10mg. This form was signed by the resident representative on 6/5/24. The Medical Director's photocopied signature was on this form with a handwritten date of 6/5/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Further review of this consent form revealed the class of this medication was marked as other. No risks or side effects were documented on the consent form to indicate the resident and/or resident representative were educated on these possibilities.</p> <p>Resident #204</p> <p>Escitalopram</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- Resident #204's consent form was for the use of escitalopram 10mg. This form was signed by the resident on 6/6/24. The Medical Director's photocopied signature was on this form and had a handwritten date of 6/6/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Review of the facility's policy Psychotropic Medication Use, dated 12/2023, revealed: . Drugs in the following categories are considered psycho[TRUNCATED]</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42377</b></p> <p>Based on record review and interview, the facility failed to ensure three residents' (#6; and #28) transfer notices were sent to the Alaska Office of the State Long Term Care Ombudsman (LTCO). This failed practice had the potential to affect all residents, based on a census of 53, by: 1) denying residents the added protection from being inappropriately discharged ; 2) providing the residents with access to an advocate who can inform them of their options and rights; and 3) ensuring the Office of the State (LTCO) was aware of facility practices and activities related to transfers and discharges.</p> <p>Findings:</p> <p>Record review from 6/17-21/24 revealed Resident #6 was admitted to the facility with diagnoses that included sepsis (an infection of the bloodstream), and quadriplegia (complete paralysis of the body from the neck down). Further review revealed the resident suffered from uncontrolled pain in the right hip. The staff observed Resident #6's right leg was abnormally shorter than the left leg. The provider ordered the resident to the emergency department for evaluation and the resident was hospitalized on [DATE]. No LTCO notification of the facility-initiated transfer was found on the record.</p> <p>Further record review revealed Resident #28 was admitted to the facility with diagnoses that included cardiac arrest, and hypertensive heart disease (prolonged unmanaged high blood pressure) with heart failure. Further review revealed the resident was hospitalized on [DATE] for pulmonary edema (a buildup of fluid in the air spaces or tissues of the lungs). No LTCO notification of the facility-initiated transfer was found on the record.</p> <p>During an interview on 6/21/24 at 2:54 PM, the Director of Nursing (DON) stated that the staff who sent facility-initiated transfers/discharge notifications to the LTCO had resigned in May 2024. She did not know if the Ombudsman was notified for Residents #6 and #28.</p> <p>During an interview on 6/21/24 at 5:29 PM, the Administrator stated that facility-initiated transfers/discharge notification was sent once a month via email to the Ombudsman's office. Unfortunately, the staff that handled the monthly notifications resigned in May 2024 and he was unable to access the staff's email account. He had called the Ombudsman's office earlier that day and confirmed they had received notifications for January, March, and April 2024. No notification for the month of May 2024 was sent.</p> <p>During an email correspondence with the office of the LTCO, on 6/21/24 at 1:35 PM, the LTCO wrote the facility had been inconsistent with sending the monthly facility-initiated discharges, and confirmed that only January, March, and April 2024 were received from the facility.</p> <p>Review of the facility's policy Transfer or Discharge, Facility-Initiated, dated 10/22, revealed: When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, NOT discharges, because the resident's return is generally expected . A copy of the [transfer or discharge] notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>47929</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>47929</p> <p>Based on record review and interview the facility failed to complete a comprehensive admission assessment using the Resident Assessment Instrument 3.0 Minimum Data Set (MDS, a federally required nursing assessment for long term care residents) for one resident (#204), out of 14 sampled residents. This failed practice had the potential to cause inaccurate health and functional status for the resident, of which placed the resident at risk for inconsistent care.</p> <p>Findings:</p> <p>Record review on 6/17-21/24, revealed Resident #204 was admitted to the facility with diagnoses that included Parkinsons disease (a progressive disorder that affects the nervous system and causes movement problems, such as shaking, stiffness, and difficulty with balance and coordination), and neurocognitive disorder with Lewy bodies (a form of dementia where abnormal amounts of protein deposits are located in the nerve cells of the brain affecting cognitive functioning).</p> <p>Review of Resident #204's MDS Summary, dated 6/11/24, revealed sections A (Identification), B (Hearing, Speech, and Vision), C (Cognitive Patterns), D (Mood), and V (Care Areas Assessment Summary) were all In Progress.</p> <p>Review of Resident #204's Care Plan, dated 6/6/24, revealed the following focus areas: . [Resident #204] has a hearing impairment. [Resident #204] uses anti-anxiety medications escitalopram r/t [related to] Anxiety disorder. [Resident #204] uses anti-depressant medication Escitalopram. [Resident #204] has impaired cognitive function/dementia or impaired thought processes r/t Dementia.</p> <p>During an interview on 6/21/24 at 11:11 AM, the MDS Nurse stated the facility had fourteen days after admission to complete a comprehensive admission assessment. After reviewing Resident #204's chart, she stated the admission assessment should have been completed by 6/19/24.</p> <p>Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, dated 10/2023, revealed: Admission (Comprehensive) . MDS Completion Date. 14th calendar day of the resident's admission.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>47929</p> <p>Based on record review, observation, and interview, the facility failed to complete a comprehensive reassessment within 14 days after the Resident was diagnosed with dementia for one resident (#28) out of 14 sampled residents. This failed practice had the potential to decrease the resident's quality of life and jeopardized potential for maintaining functional independence at the highest possible level.</p> <p>Findings:</p> <p>Resident #28</p> <p>Record review from 6/17-21/24 revealed Resident #28 was admitted to the facility in April 2024 with diagnoses that included cardiac arrest, and hypertensive heart disease (prolonged unmanaged high blood pressure) with heart failure.</p> <p>Further review revealed on 5/13/24, an additional diagnosis was added by the facility's provider of severe vascular dementia with psychotic disturbance (a condition caused by restricted blood flow to parts of the brain characterized by impaired reasoning, planning, judgement, and memory).</p> <p>Behaviors:</p> <p>Record review of the MDS (Minimum Data Set, a federally required nursing assessment) OBRA (Omnibus Budget Reconciliation Act) Admission assessment, dated 4/24/24 revealed: Section E - Behavior . Psychosis . None of the above [hallucinations or delusions] . Overall Presence of Behavioral Symptoms .No .</p> <p>Record review of the care plan focus dated 4/29/24 revealed, Resident #28 was: .independent for meeting emotional, intellectual, physical, and social needs .</p> <p>Record review of SNF [Skilled Nursing Facility] Visit Note dated 5/13/24, revealed: Nursing has noted some pretty intense agitation, anxiety, and hallucinations especially in the evenings this is pretty consistent . Examples of hallucinations include believing [he/she] had fish all over [him/her], also stating that someone in the therapy gym has been kidnapping [him/her] for days at a time and holds [him/her] hostage .</p> <p>Mood:</p> <p>Record review of the MDS OBRA Admission assessment, dated 4/24/24 revealed: Section F - Mood . Feeling down, depressed, or hopeless . No .</p> <p>Record review of SNF [Skilled Nursing Facility] Visit Note dated 4/24/24, the provider stated: Mood and Affect: Pleasant and cooperative.</p> <p>Review of IDT [Interdisciplinary Team] Care Conference 1.0 dated 5/1/24 stated, [Resident #28] reports that [he/she] is very scared but is unsure why [he/she] is scared.</p> <p>(continued on next page)</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the progress notes dated 5/14/24 at 11:08 AM revealed: .CNA [Certified Nursing Assistant] was outside of room and resident was heard stating I can't wait to kill myself.</p> <p>During an observation on 6/17/24 at 2:59 PM, revealed Resident #28 in bed yelling out Please God. repeatedly.</p> <p>Review of the facility's Resident Matrix printed on 6/17/24 revealed the column for Alzheimer's/Dementia was checked for Resident #28.</p> <p>Review of the MDS on 6/20/24 for Resident #28 revealed a Significant Change in Status Assessment (SCSA) was not completed.</p> <p>During an interview on 6/21/24 at 10:36 AM, the MDS Nurse stated that a diagnosis of dementia might qualify as a significant change if there was a change in the resident's functional status. If it looked like the resident was not going to get better, the diagnosis would be confirmed in an IDT meeting where they would review and make changes to different aspects of care if needed. She confirmed the last IDT meeting was on 5/1/24, which was before the diagnosis of dementia was made.</p> <p>During an interview on 6/21/24 at 2:49 PM, the Director of Nursing (DON) reviewed Resident #28's chart and agreed that the diagnosis of dementia was a new diagnosis on 5/13/24 and that a SCSA should have been completed in addition to an IDT meeting.</p> <p>Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 dated 10/2023, revealed A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan.</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>47929</p> <p>Based on record review, observation, and interview, the facility failed to ensure comprehensive care plans were developed and implemented with smoking care needs for two residents (#s 11, and 33), out of 14 sampled residents. Specifically, the facility failed to address risk factors and include specific information concerning the residents' smoking in their care plans. This failed practice had the potential to place the residents at risk for harm.</p> <p>Findings:</p> <p>Resident #11</p> <p>Record review on 6/17-21/24, revealed Resident #11 was admitted with diagnoses that included a right ankle fracture which was surgically fused making the joint immobile, diabetes, high blood pressure, and acute respiratory failure with hypoxia (below normal oxygen levels in the blood).</p> <p>An observation on 6/19/24 at 4:28 PM, revealed Resident #11 was outside by the dumpster listening to music and smoking.</p> <p>Review of the handwritten facility provided list of smokers, revealed Resident #11 was included on this list.</p> <p>Review of Resident #11's MDS (Minimum Data Set - A Federally required nursing assessment) admission assessment, dated 4/5/24, revealed: Section J1300. Current Tobacco Use . No . Yes did not contain an answer.</p> <p>Review of the facility's electronic health record Assessment tab on 6/19/24 at 2:16 PM, revealed no smoking assessment was conducted for Resident #11.</p> <p>Review of Resident #11's Care Plan, dated 4/5/24, revealed no focused care planning for Resident #11's smoking.</p> <p>During an interview on 6/19/24 at 2:20 PM, the Director of Nursing (DON) confirmed Resident #11 was a smoker but was not able to provide a smoking assessment for Resident #11.</p> <p>Resident #33</p> <p>Record review on 6/17-21/24, revealed Resident #33 was admitted with diagnoses that included a left below the knee amputation, peripheral vascular disease (where the blood vessels located anywhere outside the heart have narrowing, blockage, or spasms), and nicotine dependence.</p> <p>During an interview on 6/17/24 at 11:33 AM, Resident #33 stated that he/she rolled his/her own cigarettes and kept the cigarette rolling supplies (loose tobacco and papers) and lighter in his/her room. When he/she smoked, he/she did not wear a protective apron and did not feel that it was necessary because he/she had been smoking for a very long time and could control where the ashes fell .</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Maple Springs of Wasilla		STREET ADDRESS, CITY, STATE, ZIP CODE  3265 E Meridian Loop Wasilla, AK 99654	
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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 Resident #33's most recent MDS quarterly review assessment, dated 3/13/24, revealed: Section J1300. Current Tobacco Use . No . Yes . had a check mark beside Yes, indicating Resident #33 smoked.</p> <p>Review of Resident #33's Care Plan, dated 4/8/24, revealed no care planning for Resident #33's smoking.</p> <p>Review of the facility's electronic health record Assessment tab on 6/19/24 at 2:10 PM, revealed no smoking assessment was conducted for Resident #33.</p> <p>During an interview on 6/19/24 at 2:20 PM, the Director of Nursing (DON) confirmed Resident #33 was a smoker but was not able to provide a smoking assessment for Resident #33.</p> <p>During an additional interview on 6/21/24 at 4:00 PM, the DON confirmed that smoking should be included in the care plans for all residents who smoke. She further stated that somethings (such as smoking) were not coming over from the admission assessment.</p> <p>Review of the facility's policy Care Plans, Comprehensive Person-Centered, dated 12/2019, revealed: . The comprehensive, person-centered care plan will: . Incorporate identified problem areas . Incorporate risk factors associated with identified problems . Reflect the resident's expressed wishes regarding care and treatment goals .</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>40259</p> <p>Based on record review and interview, the facility failed to ensure comprehensive care plans were revised to meet the changing needs of 2 residents (#s 10 and 18), out of 14 sampled residents. Specifically, the facility failed to revise care plans to reflect: 1) the level of support needed during appointments for 1 resident (#10); 2) the interventions added for fall prevention for 1 resident (#18); and 3) the interventions trained to address behavioral/emotional needs for 1 resident (#18). These failed practices placed the residents at risk for less than the highest practicable mental, physical, and psychosocial well-being.</p> <p>Findings:</p> <p>Resident #10 - Level of Support Needed</p> <p>Record review on 6/17-21/24 revealed Resident #10 was admitted to the facility with diagnoses that included locked-in state (virtual total paralysis with retained consciousness), and dysphagia (difficulty swallowing). Resident #10 was also not able to communicate verbally.</p> <p>Further review revealed Resident #10 was totally dependent on staff for all Activities of Daily Living (ADLs) to include bed mobility, transfers, wheelchair placement and positioning, bathing, toileting, dressing, eating, and oral hygiene. Nutrition for Resident #10 was through tube feeding (a tube inserted directly into a person's stomach through the abdominal wall) but was able to enjoy pleasure feeding by mouth of soft pureed foods and pudding-like thickened liquids.</p> <p>Further review revealed Resident #10's parents have been his/her legal guardians and conservators since 2017 and have been given the court authority to meet the essential requirements for physical health or safety, to protect [Resident #10's] rights . to provide for [Resident #10's] medical care.</p> <p>During an interview on 6/17/24 at 3:09 PM, Resident #10's mother stated that Resident #10 communicated by using a letter board and eye movements, or with an iPad communication program that spoke as he/she typed. Resident #10's mother stated that some staff were familiar with these methods of communication with Resident #10, however it required training to learn.</p> <p>When asked if Resident #10 had received regular dental care while in the facility, Resident #10's mother stated he/she had, however the last dental appointment did not go well. Resident #10's mother stated that it was arranged that she would attend the last dental appointment with Resident #10, to be a support person and to verbalize Resident #10's needs to the dentist due to Resident #10's locked in state and difficulty swallowing. Resident #10's mother stated that the original dental appointment had been changed without her being informed and Resident #10 was driven to the appointment by the facility, however ended up attending the appointment alone. Resident #10's mother stated Resident #10 had no one to communicate for him/her and Resident #10 relayed to his/her mother afterwards that the experience was awful and he/she experienced choking from water used during the dental treatment and was distressed throughout the appointment.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/21/24 at 3:27 PM, when asked about the situation with Resident #10's last dental appointment, the Director of Nursing (DON) stated Resident #10 had attended a dental appointment on 12/8/23, and for reasons she could not explain, ended up attending the appointment alone. The DON stated usually, Resident #10 always attended appointments with family or a Certified Nursing Assistant (CNA) that knew him/her very well and was able to help communicate for him/her.</p> <p>When asked if it was written in Resident #10's care plan that Resident #10 needed to be accompanied on appointments, the DON stated there was nothing written to say that Resident #10 cannot go to appointments alone, but that it was a well-known fact that everyone knew.</p> <p>Review of Resident #10's Nurse's Note, dated 12/8/23 at 12:28 PM, revealed: Resident up in [wheelchair], alert. Resident leaving with driver for [appointment] .</p> <p>Review of Resident #10's Nurse's Note, dated 12/8/23 at 4:55 PM, revealed: Resident returned to facility from [appointment] . with driver at [3:15 PM] this afternoon.</p> <p>Review of Resident #10's care plan, first initiated 1/14/20, revealed the following identified focus concerns:</p> <p>- Focus: [Resident #10] has oral/dental health problems. (Date initiated: 1/14/20. Revision on: 2/4/20) . Interventions: Coordinate arrangements for dental care, transportation as needed/as ordered. (Date initiated on 2/4/20).</p> <p>Further review revealed no intervention to ensure Resident #10 was accompanied by a guardian or staff member to these dental appointments.</p> <p>Resident #18 - Fall Prevention</p> <p>Review on 6/17-21/24 revealed Resident #18 was admitted to the facility under hospice care for diagnoses that included dementia, unspecified severity, with agitation. Resident #18 had a history of stroke which had contributed to the decline of his/her dementia.</p> <p>Further review revealed Resident #18 has had 28 falls since his/her admission 8 months ago.</p> <p>A review of Resident #18's Initial Post Fall Clinical Review documentation, dated 10/4/23 through 6/17/24 which was completed after each fall, revealed how the fall occurred and any additional interventions that were added to Resident #18's care to prevent further falls:</p> <p>1) 10/4/23: unwitnessed, found on floor on left side in front of his/her wheelchair (wc).</p> <p>- Review of documentation revealed: . Interventions added for safety . an alarm for chair would be good .</p> <p>2) 10/7/23: unwitnessed, found on floor, wc in front of him/her.</p> <p>- Review of documentation revealed: . Intervention added for safety . Mats on Floor .</p> <p>3) 10/12/23: unwitnessed, found on floor in doorway of room, wc behind him/her.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>24) 3/24/24: witnessed fall, resident slid out of wc onto floor.</p> <p>- No Initial Post Fall Clinical Review was provided for this fall.</p> <p>25) 4/2/24: unwitnessed, found on floor in bathroom.</p> <p>- Review of documentation revealed: . Intervention added for safety . Call light adjusted .</p> <p>26) 4/26/24: witnessed, resident slid out of wc onto floor.</p> <p>- Review of documentation revealed: . Intervention added for safety . clothing/shoe adjustment . [wc] alarm in place and alerted CNA of incident .</p> <p>27) 4/27/24: witnessed, resident slid out of wc onto floor.</p> <p>- Review of documentation revealed: . Intervention added for safety . clothing/shoe adjustment . [wc] alarm in place and alerted CNA of incident .</p> <p>28) 6/17/24: witnessed, resident slid out of wc onto floor.</p> <p>- Review of documentation revealed: . Intervention added for safety . current orders for bed and [wc] alarm, low bed, mats on floor. Frequent monitoring while up in [wc] .</p> <p>During an interview on 6/20/24 at 3:04 PM, when asked how the facility monitors resident falls and ways to minimize the risks of falls, Physician #5 stated there was a fall huddle, or meeting for falls, that occurred every Monday. During the meeting each resident fall would be discussed, and interventions would be discussed to add to the resident's care to help prevent further falls.</p> <p>During an interview on 6/21/24 at 9:14 AM, when asked about Resident #18's plan of care and any interventions added to help prevent falls, Physician #11, who was Resident #18's primary provider, stated when staff reported Resident #18's fall there was always discussion about interventions that could be added. Increased toileting, fall mat, bed in lowest position at all times, and increased rounding were all added.</p> <p>During an interview on 6/21/24 at 2:57 PM, when asked what interventions had been placed during Resident #18's stay at the facility for fall prevention, the Director of Nursing (DON) stated interventions for a fall mat by the bed, increased monitoring was moved to every two hours, increased toileting, and increased 1:1 activity, as well as having Resident #18 attend activities in the activity room, was all initiated. The DON further stated that the chair and bed alarm were also initiated.</p> <p>Fall Huddle Review</p> <p>Review of the facility provided Weekly Fall Meeting minutes revealed Resident #18 was first documented at the 12/11/23 meeting, which documented his/her 11th fall on 12/5/23. No interventions were added at this time. Further review revealed:</p> <p>- 12/18/23 meeting: Documented Resident #18's 12/13/23 fall, which was his/her 13th fall. The intervention documented was all staff to get resident more activities throughout day.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 12/26/23 meeting: Documented Resident #18's 12/24/23 fall, which was his/her 14th fall. No new interventions were documented at this time.</p> <p>- 2/5/24 meeting: Documented Resident #18's 2/3/24 fall, which was his/her 18th fall. The intervention that was documented was Room change - 109.</p> <p>- 2/19/24 meeting: Documented Resident #18's 2/18/24 fall, which was his/her 21st fall. No new interventions were documented at this time.</p> <p>- 3/4/24 meeting: Documented Resident #18's 2/29/24 fall, which was his/her 22nd fall. No new interventions were documented at this time.</p> <p>- 3/25/24 meeting: Documented Resident #18's 3/24/24 fall, which was his/her 24th fall. The intervention that was documented was PT to [evaluate] [wc].</p> <p>- 4/8/24 meeting: Documented Resident #18's 4/2/24 fall, which was his/her 25th fall. No new interventions were documented at this time.</p> <p>- 4/29/24 meeting: Documented Resident's 4/26/24 fall, which was his/her 26th fall. The intervention that was documented was [rehabilitation] adjust chair.</p> <p>Further review of the fall huddles meeting minutes provided by the facility revealed no other falls or interventions were documented for Resident #18.</p> <p>Fall Mats</p> <p>Review of Resident #18's record revealed it could not be determined when exactly the fall mats were initiated. Where the use of fall mats was first documented on 10/7/23 Initial Post Fall Clinical Review form, there was no order for fall mats in Resident #18's medical record. The risk and benefits form for a fall mat was not completed until 12/1/23, which was after the eighth fall.</p> <p>Chair and Bed Alarm</p> <p>Review of Resident #18's record revealed an order for a motion detector and chair alarm, dated 4/3/24, on the day of the 25th fall. The risk and benefits forms for the chair and bed alarms were not completed until 4/23/24.</p> <p>Care Plan Review</p> <p>Review of Resident #18's care plan revealed the following identified focus problem: [Resident #18] is at risk for falls [related to] weakness and decreased safety awareness. Date initiated: 10/3/2023, Revision on: 10/17/2023.</p> <p>Further review of the care plan revealed:</p> <p>1) the fall mat was not added to the care plan until 1/15/24, which was more than three months after its first documented use;</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) increased toileting was not on the care plan;</p> <p>3) the chair alarm and the bed alarm were not on the care plan;</p> <p>4) Increasing 1:1 activity was not added to the care plan until 1/30/24, after the 16th fall;</p> <p>5) Encouraging Resident #18 to attend activities was added to the care plan on 3/26/24, after the 24th fall.</p> <p>Resident #18 - Behavior Interventions</p> <p>Review on 6/17-21/24 revealed Resident #18 had documented history of multiple times of striking out, hitting, grabbing onto staff, and injuring staff during day-to-day cares. This was attributed to Resident #18's dementia. Further review revealed Resident #18 was also on the antipsychotic medication Seroquel and the antianxiety medication Lorazepam (Ativan).</p> <p>Review of Resident #18's care plan revealed the identified focus problems:</p> <p>1) [Resident is at risk for anxiety, loneliness, grief, coping with death/dying. Date initiated: 1/22/2024. Revision on: 1/30/2024. The only intervention added to this focus problem was provide empathic listening. Date initiated: 1/22/2024.</p> <p>2) [Resident #18] is experiencing delirium and agitation. Date initiated: 1/22/2024. Revision on: 1/30/2024. Interventions for this focus problem were: 1) Encourage patient and/or caregiver(s) to express needs, fears, concerns, and frustrations. Date initiated: 1/22/2024; and 2) Hospice to assess coping mechanisms of family. Provide support, as needed. Date initiated: 1/22/2024.</p> <p>3) [Resident #18] has a risk for behavior problems [related to] Dementia. Date initiated: 10/16/2023. Revision on: 10/17/2023. Interventions for this focus problem were: 1) Administer medications as ordered. Monitor/document for side effects and effectiveness. Date initiated: 10/16/2023; 2) Anticipate and meet the resident's needs. Date initiated: 10/16/2023; and 3) Explain all procedures to the resident before starting and allow the resident to adjust to changes. Date initiated: 10/16/2023. Revision on: 10/17/23.</p> <p>Further review of the care plan revealed no interventions on how best to interact or work with the resident to minimize agitation and risk of aggressive behavior.</p> <p>During an interview on 6/21/24 at 9:14 AM, when asked if there were interventions that could be used for working with Resident #18 that would minimize agitation or aggression, Physician #11 stated the key to working with Resident #18 was that staff needed to approach him/her in a friendly manner and he/she had to be able to see you approaching. Physician #11 stated he/she had never had any aggression from him/her when working with Resident #18. If spoken to loudly or if staff approached him/her from behind, this could trigger aggression. Physician #11 further stated that there were concerns that night shift staff had not been as patient with Resident #18, which caused aggression. Physician #11 stated he/she approached the DON and requested staff be educated on how best to work with Resident #18, to be more patient, friendly, and speak and move calmly around him/her.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/21/24 at 2:55 PM, when asked about the request for staff training from Physician #11 concerning how to work best with Resident #18, the DON stated she remembered this request and stated she tailored some training with CNAs who worked with Resident #18, such as not getting in his/her face, getting on his/her level, speak in a normal tone, and identifying Resident #18's tell-alls or cues he/she had, like a special look, that told staff they needed to disengage and try later.</p> <p>When asked if these techniques were added to Resident #18's care plan for all staff to use, the DON stated they were not added to the care plan.</p> <p>Review of the facility's policy Care Plans, Comprehensive Person-Centered, dated 2001, revealed: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical psychosocial and functional needs is developed and implemented for each resident . The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42377</p> <p>Based on record review and interview, the facility failed to ensure two nursing staff (Certified Nursing Assistant [CNA] #3 and Licensed Nurse [LN] #7), out of 15 personnel records reviewed, had valid Cardiopulmonary Resuscitation (CPR) certificates. This failed practice placed all residents at risk for not receiving timely CPR or emergency care when needed.</p> <p>Findings:</p> <p>CNA#3</p> <p>Review of the personnel records on [DATE] at 3:16 PM, revealed CNA #3 was hired on [DATE] with an expired CPR certificate, dated ,d+[DATE].</p> <p>Review of CNA #3's work schedule, revealed the CNA worked on the following dates: ,d+[DATE]-,d+[DATE], [DATE], ,d+[DATE]-,d+[DATE], [DATE], [DATE], [DATE], [DATE], ,d+[DATE]-,d+[DATE], and ,d+[DATE]-, d+[DATE], with a total of 17 days worked without a valid CPR certificate.</p> <p>During an interview with the Human Resources Director (HRD) on [DATE] at 9:53 AM, the HRD stated CNA #3 was a new employee, but the HRD was not aware that CNA #3's CPR certificate was expired. The HRD stated she received CNA #3's CPR card that morning with a valid date of ,d+[DATE].</p> <p>LN#7</p> <p>Review of the personnel records on [DATE] at 3:16 PM, revealed LN #7's CPR certificate expired on [DATE] and had a new CPR certificate dated [DATE].</p> <p>Review of LN #7's work schedule revealed LN worked on the following dates: [DATE], ,d+[DATE]-,d+[DATE], [DATE], ,d+[DATE]-,d+[DATE], with a total of 7 days worked without a valid CPR certificate.</p> <p>During an interview with the HRD [DATE] at 9:58 AM, the HRD stated LN #7 thought his/her CPR was good for the month of June and did not realize it was expired. HRD stated the LN was working on the floor for two weeks without valid CPR.</p> <p>During an interview with the HRD [DATE] at 9:58 AM, the HRD stated the facility had CPR training every month. She further explained for those CNAs who were previously certified, they would take it on the next training date. The HRD further stated CNAs were hired and allowed to work without active CPR certificates but not allowed to provide CPR to residents during an emergency. Other staff on duty with active CPR would intervene in case of emergency.</p> <p>During an interview and document review on [DATE] at 2:21 PM, the HRD stated the facility had no CPR policy. She provided a page of the Employee Handbook, dated ,d+[DATE], which revealed: . CPR All employees that provide care for residents are required to provide evidence of passing a First Aid/CPR class within the first 30 days of hire.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>42377</p> <p>Based on record review and interview, the facility failed to ensure range of motion (ROM) exercises were provided to 1 resident (#6), out of 14 sampled residents. This failed practice had the potential to place the resident at risk of not receiving the necessary care and therapy to maintain his/her level of mobility.</p> <p>Findings:</p> <p>Review on 6/17-21/24, revealed Resident #6 was admitted to the facility with diagnoses that included sepsis (an infection of the bloodstream) and quadriplegia (complete paralysis of the body from the neck down).</p> <p>During an interview on 6/17/24 at 2:19 PM, Resident #6 stated he/she had difficulty moving his/her arms. When asked if he/she had therapy, Resident #6 stated No.</p> <p>Review of Minimum Data Set (MDS- a federally required nursing assessment) Admission Assessment, dated 4/22/24, revealed: Section GG. Functional Limitation in Range of Motion A. Upper extremity 2=impairment on both sides, B. Lower extremity 2=impairment on both sides.</p> <p>Review of Resident #6's Care Plan, dated 4/15/24, revealed: Focus: . [Resident #6] has limited physical mobility related to quadriplegia, Desired outcome: [Resident #6] will maintain current level of mobility, [Resident #6] will remain free of complications related to immobility . Intervention: . resident is totally dependent . PT/OT, referral as ordered, PRN [as needed] .</p> <p>During an interview on 6/19/24 at 9:13 AM, Restorative Nurse Aide (RNA) #1 stated he/she provided ROM exercises to Resident #6 three times a week. RNA #1 also stated that ROM exercises were coordinated with a physical therapist. When asked of the ROM goals for Resident #6, RNA #1 stated Resident #6 had very limited movement. Resident #6 could touch his/her phone, grab his/her wheelchair and wheel himself/herself around. The goal was to sustain the resident's ability.</p> <p>Review of the Maple Springs RNA Program, dated 4/23/24, revealed Resident #6 had 2-3 x/week ROM. Further review revealed: Goals: Maintain ROM in UB [upper body] and Avoid Contractures .ROM: UE [upper extremity] ROM at all joints of the upper body shoulders, elbow, wrist, digits.</p> <p>During an interview on 6/21/24 at 1:00 PM, Physical Therapist (PT) #1 stated Resident #6 had restorative care. Surveyor requested for a copy of the restorative plan and RNA documentation of the restorative care provided to Resident #6.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/21/24 at 3:46 PM, when asked of the status of RNA documentation, the Director of Nursing (DON) stated the RNA had a hard time accessing the point click care (PCC-the facility's electronic health record) and the PCC was not saving RNA notes. When asked if PCC was not saving notes since 4/23/24 as indicated date in the RNA Program, the DON stated it was not saving. The DON further stated she did not know that RNA notes were not saved and there was no other place the documentation could be saved. The DON stated the RNA started charting on 6/20/24 because the DON asked for it.</p> <p>Review of the facility's policy Restorative Nursing Services, dated 12/2023, revealed: . Restorative goals may include, but not limited to supporting and assisting the resident in: a. adjusting or adapting to changing abilities; b. developing, maintaining or strengthening his/her physiological and psychological resources.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>40259</p> <p>42377</p> <p>47929</p> <p>Based on record review, observation, and interview, the facility failed to ensure residents were free from accident hazards and/or received adequate supervision. Specifically, the facility failed to:</p> <p>1) Ensure the care plan was followed regarding the total number of staff needed for safe bed mobility for 1 Resident (#6), out of 14 sampled residents;</p> <p>2) Ensure neurological assessments, after unwitnessed falls, were conducted accurately for 1 Resident (#18), out of 14 sampled residents; and</p> <p>3) Ensure 3 residents (#s 11; 16; and 33), out of 3 residents reviewed for smoking, were assessed for safe storage of smoking paraphernalia (cigarettes and lighter or matches).</p> <p>These failed practices created a potential for accidents and injury to the residents.</p> <p>Findings:</p> <p>1) Care Plan - Bed Mobility</p> <p>Resident #6</p> <p>Record review on 6/17-21/24 revealed Resident #6 was admitted to the facility with diagnoses that included Type 2 Diabetes (chronic condition involving insulin resistance), osteomyelitis (bone infection), stage 4 pressure ulcer (deep skin sore), quadriplegia (complete paralysis of the body from the neck down), neuromuscular dysfunction of the bladder (impaired bladder control), chronic obstructive pulmonary disease (lung disease), anemia (low red blood cell count), and anxiety (mental health condition).</p> <p>Review of the physician's orders for Resident #6 revealed a plan of care (POC) ordered on 4/15/24, approving the plan of care for this resident to continue current physicians orders as written including medications and treatments, and appropriate activities, unless otherwise specified.</p> <p>Review of Resident #6's care plan, dated 5/6/24 with a target completion date on 7/14/24, revealed: Bed mobility: the resident is totally dependent on (2) staff for repositioning and turning in bed; Toilet use: the resident is totally dependent on (2) staff for toilet use; and Transfer: the resident is totally dependent on (2) staff for transferring.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 6/19/24 at 12:00 PM, made after the wound care team changed a pressure sore dressing and while staff prepared to transfer Resident #6 to the shower, revealed CNA #1 repositioned Resident #6 in bed, placing a Hoyer sling under both sides of Resident #6 with a 1-person assist, rotating him/her from side to side. Resident #6 was observed to grimace and become tearful during this repositioning. At the time of this observation, a second CNA (CNA #2) was out of the room retrieving extra clean supplies. CNA #2 later returned and together with CNA #1 performed the transfer of Resident #6 with the Hoyer lift (Hoyer lift - mechanical device designed to lift and transfer patients) to the bathroom in preparation for hygiene care.</p> <p>Review of a document regarding Resident #6's bed mobility POC Response History indicated that on 6/19/24 Resident #6 was total dependence - full staff performance.</p> <p>Review of the facility's policy Activities of Daily Living (ADL's) Supporting, revised March 2018, revealed: . Total dependence - full staff performance of an activity with no participation by resident for any aspect of the ADL activity. Resident was unwilling or unable to perform any part of the activity over entire 7-day look back period .</p> <p>During an interview on 6/19/24 at 1:00 PM, CNA #1 stated: to know what type of transfer is required, we have multiple ways: the report sheets which are 'print outs' we receive at the beginning of the shift, there we can see their level of care, but we can also look inside their Armoire closets [Armoire - large freestanding wardrobe] and our tablets and then we do what we need to do.</p> <p>An observation on 6/21/24 at 1:19 PM, of the Armoire sheet posted on the inside of Resident #6 Armoire revealed: . transfer: Hoyer . Fall risk: No . Further review revealed no documentation of the number of staff required for bed mobility or transfers.</p> <p>A review of the unit's report sheet, dated 6/21/24 and used for Resident #6 at the time of this interview, revealed: . Transfers: Hoyer . Notes: 1/1 assist with meals, encourage to turn position, educate about wound, Quadriplegic. Further review revealed no documentation of the number of staff required for bed mobility or transfers.</p> <p>During an interview on 6/19/24 at 1:15 PM, Licensed Nurse (LN) #6 confirmed what CNA #1 had said regarding the process of discerning what type of assist to perform and while reviewing the current Report Sheet described above. After consulting the online care plan, LN #6 then manually altered the Report Sheet mentioned above, and added the following: Notes: Requires 2 person assist in bed mobility and repositioning.</p> <p>When asked if the CNA's had access to the plan of care, LN #6 stated: they don't have access to it online, they can only see their interventions on the tablet and what is written in the report sheet, which is updated by the nurses on every shift.</p> <p>During an interview on 6/19/24 at 1:00 PM, CNA #1 stated: regarding morning care of Resident #6, I was putting the sling first since Resident #6 helps in bed and by grabbing the sheet and keeping it close to my body, in case he/she rolls then he/she still has room to roll and not fall off the bed. CNA #1 also stated he/she was under the impression Resident #6 was a 1 Person assist while in bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/20/23 at 11:00 AM, the CNA coordinator stated: regarding the typical workflow of a CNA first thing CNA's do is a shift meeting with charge nurse of their hallways, then they walk around and check AM vitals, AM cares, showers, help with breakfast, get people ready in their rooms; they are given 1 report sheet for each hallway and the dietary outline; also, there are 2 CNA's and 1 nurse per hallway, except for the hospice hall .regarding the process of discerning what type of assist to perform, they can consult the report sheet and inside the wardrobe - Armoire there is a fillable form that PT [Physical Therapy] updates . they can also access the Kardex online, which has a simplified version of the Care Plan for bed mobility and transfers.</p> <p>When the bed mobility observation earlier with Resident #6 and the 1 Person Assist was discussed, the CNA coordinator stated that the CNAs should always follow the order for transfer in the plan of care.</p> <p>Review of the facility Policy on Activities of Daily Living (ADL's) Supporting, revised March 2018, revealed: . Policy interpretation and Implementation . Appropriate care and services will be provided for residents who are unable to carry out ADL's independently . in accordance with the plan of care, including appropriate support and assistance with: Hygiene (bathing, dressing, grooming, and oral care) . Mobility (transfer and ambulation, including walking) . Elimination (toileting).</p> <p>2) Neurological Checks - Unwitnessed Falls</p> <p>Resident #18</p> <p>Review on 6/17-21/24 revealed Resident #18 was admitted to the facility under hospice care for diagnoses that included dementia, unspecified severity, with agitation. Resident #18 had a history of stroke which had contributed to the decline of his/her dementia. Further review revealed Resident #18 has had 28 falls since his/her admission 8 months ago.</p> <p>Review of the facility's protocol Falls - Definition [and] Protocol, undated, revealed: . If the resident has [h]it their head or if the fall was unwitnessed, neuro checks should be started.</p> <p>Review of Resident #18's unwitnessed falls revealed the following Neurological Assessment Flow Sheets with discrepancies:</p> <p>1) 10/4/23 - unwitnessed fall, resident was found on floor on left side in front of his/her wheelchair (wc).</p> <p>Review of Resident #18's Neurological Assessment Flow Sheet, dated 10/4/23, revealed the assessment were to be completed 10/4-8/23. Further review revealed:</p> <ul style="list-style-type: none"> <li>- The assessments for Level of Consciousness, Pupil Response, Motor Functions, and Pain Response were not completed on 10/4/24 at 5:20 PM (the first set to be completed);</li> <li>- The second and third sets had no dates or times and was not completed at all, documented In dining room for dinner;</li> <li>- The assessment Motor Functions was not completed on 10/4/23 at 6:30 PM (the fourth set to be completed), documented unable;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- The fifth set assessment included a time of 7:30 PM and only included the blood pressure, pulse, respirations, and oxygen saturation level. No other assessment was completed; and</p> <p>- The rest of the neurological assessment flow sheet was left blank.</p> <p>2) 10/7/23 - unwitnessed fall, resident was found on floor, wc in front of him/her.</p> <p>Review of Resident #18's Neurological Assessment Flow Sheet, dated 10/7/23, revealed the assessment were to be completed 10/7-11/23. Further review revealed the assessments were not completed on 10/8/23 at 4:00 AM and 10/8/23 at 8:00 AM, and documented the resident was sleeping.</p> <p>3) 10/12/23 - unwitnessed fall, resident was found on floor in doorway of room, wc behind him/her.</p> <p>Review of Resident #18's Neurological Assessment Flow Sheet, dated 10/12/23, revealed the assessments were to be completed 10/12-15/23. Further review revealed the assessments were not completed on 10/12/23 at 6:30 PM; 10/12/23 at 7:30 PM; 10/12/23 at 8:30 PM; 10/13/24 at 12:20 AM; 10/13/23 at 4:30 AM, and documented the resident was sleeping. Vital signs were not completed for night shift 10/13/23 and night shift 10/14/23.</p> <p>4) 10/26/23 - unwitnessed fall, resident was found on floor in front of wc.</p> <p>Review of Resident #18's Neurological Assessment Flow Sheet, dated 10/26/23, revealed the assessments were to be completed 10/26-29/23. Further review revealed the assessments were not completed on 10/26/23 at 3:00 PM; 10/26/23 at 3:30 PM; 10/26/24 at 4:30 PM; 10/26/24 at 5:30 PM; and 10/27/23 at 1:30 AM, and documented the resident was sleeping.</p> <p>5) 11/21/23 at 5:25 PM - resident was found on [his/her] knees on floor by [his/her] bed.</p> <p>Review of Resident #18's Neurological Assessment Flow Sheet, dated 11/21/23 at 5:25 PM, revealed the assessments were to be completed 11/21-24/23. Further review revealed vital signs were not obtained for the night shift 11/24/24 assessment.</p> <p>6) 1/24/24 - unwitnessed fall, resident was found on floor between bed and window.</p> <p>Review of Resident #18's Neurological Assessment Flow Sheet, dated 1/24/24, revealed the assessments were to be completed 1/24-28/24. Further review revealed:</p> <p>- The Level of Consciousness; Pupil Response; Motor Functions; and Pain Response assessments were not completed for 1/24/24 at 11:20 PM; 1/24/24 at 11:50 PM; 11/25/24 at 12:50 AM; and 11/25/24 at 1:50 AM;</p> <p>- The assessment was not completed at all on 1/25/24 at 5:50 AM; and</p> <p>- Vital signs were not completed on day shift of 1/27/24 or night shift on 1/27/24.</p> <p>7) 2/1/24 - unwitnessed fall, resident was found on floor by bed, blood on head and hands.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #18's Neurological Assessment Flow Sheet, dated 2/1/24, revealed the assessments were to be completed 2/1-5/24. Further review revealed the assessments were not completed on 2/1/24 at 11:40 PM and 2/2/24 at 4:40 AM and documented the resident was sleeping.</p> <p>8) 3/9/24 - unwitnessed fall, resident was found on floor in hall outside of room. fell from wc.</p> <p>Review of Resident #18's Neurological Assessment Flow Sheet, dated 3/9/24, revealed the assessments were to be completed 3/9-13/24. Further review revealed the Pupil Response assessment was not completed on 3/9/24 at 10:55 PM and documented sleeping - unable to determine.</p> <p>9) 4/2/24 - unwitnessed fall, resident was found on floor in bathroom.</p> <p>Review of Resident #18's Neurological Assessment Flow Sheet, dated 4/2/24, revealed the assessments were to be completed 4/1-5/24, however ended on dayshift 4/4/24. A second flow sheet was created on 4/4/24 at 9:45 PM, and the assessments were continued on this sheet. Further review revealed the assessments were not completed on dayshift on 4/6/24.</p> <p>During an interview on 6/21/24 at 4:14 PM, the Director of Nursing (DON) stated it was the expectation of the facility when a neurological assessment was initiated, it was to be completely and accurately filled out. The DON further stated the neurological assessments should not be skipped if a resident was sleeping because sleeping is not necessarily a good thing. The DON stated the facility had recognized this type of deficiency before and educated staff on the importance of completing neurological assessments, even if the resident was sleeping.</p> <p>Review of the facility's policy Neurological Assessment (Routine), dated 12/2023, revealed: The following information should be recorded in the resident's medical record. The date and time the procedure was performed. The name and title of the individual(s) who performed the procedure. All assessment data obtained during the procedure. How the resident tolerated the procedure. If the resident refused the procedure, the reason(s) why and the intervention taken. The signature and title of the person recording the data. Reporting . Notify the supervisor if the resident refuses the procedure .</p> <p>3) Safe Smoking Assessments</p> <p>Resident #11</p> <p>Record review on 6/17-21/24, revealed Resident #11 was admitted with diagnoses that included a right ankle fracture which was surgically fused making the joint immobile, diabetes, high blood pressure, and acute respiratory failure with hypoxia (below normal oxygen levels in the blood).</p> <p>An observation on 6/19/24 at 4:28 PM, revealed Resident #11 was outside by the dumpsters listening to music and smoking.</p> <p>Review of the handwritten facility provided list of smokers revealed Resident #11 was included on this list.</p> <p>Review of the facility's electronic health record Assessment tab on 6/19/24 at 2:16 PM, revealed no smoking assessment was conducted for Resident #11.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #11's Care Plan, dated 4/5/24, revealed no care planning for Resident #11.</p> <p>During an interview on 6/19/24 at 2:20 PM, the Director of Nursing (DON) confirmed Resident #11 was a smoker but was not able to provide a smoking assessment for Resident #11.</p> <p>Resident #16</p> <p>Record review on 6/17-21/24, revealed Resident #16 was admitted to the facility with diagnoses that included hemiplegia (weakness or paralysis of one side of the body), hemiparesis (partial paralysis of one side of the body), epilepsy (a neurological disorder that causes seizures, or unusual sensations or behavior) and major depressive disorder (mood disorder).</p> <p>Review of Resident #16's Care Plan, dated 2/8/23, revealed: Focus . [Resident #16] is a smoker. desired outcome . [Resident #16] will not suffer injury from unsafe smoking practices. intervention .notify charge nurse immediately if it is suspected resident violated facility's smoking policy, observe clothing and skin for signs of cigarette burns .</p> <p>During an interview and concurrent observation on 6/17/24 at 2:36 PM, Resident #16 stated he/she smoked cigarettes. The Resident showed his/her opened pack of Marlboro. When asked where he/she kept his/her cigarettes and lighter or match, Resident #16 stated in his/her room. When asked if the facility knew that he/she was smoking, Resident #16 stated, yes. When asked if the facility conducted a smoking assessment, he/she stated, no.</p> <p>Review of the facility's electronic health record Assessment tab on 6/19/24 at 10:56 AM, revealed no smoking assessment was conducted for Resident #16.</p> <p>Resident #33</p> <p>Record review on 6/17-21/24, revealed Resident #33 was admitted with diagnoses that included a left below the knee amputation, peripheral vascular disease (where the blood vessels located anywhere outside the heart have narrowing, blockage, or spasms), and nicotine dependence.</p> <p>During an interview on 6/17/24 at 11:33 AM, Resident #33 stated that he/she rolled his own cigarettes and kept the cigarette rolling supplies (loose tobacco and papers) and lighter in his/her room. When he/she smoked, he/she did not wear a protective apron and did not feel that it was necessary because he/she had been smoking for a very long time and could control where the ashes fell .</p> <p>Review of the facility's electronic health record Assessment tab on 6/19/24 at 2:10PM, revealed no smoking assessment was conducted for Resident #33.</p> <p>During an interview on 6/19/24 at 2:20 PM, the Director of Nursing (DON) confirmed Resident #33 was a smoker but was not able to provide a smoking assessment for Resident #33.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a joint interview on 6/19/24 at 2:43 PM, with the DON and Assistant Director of Nursing (ADON), the DON stated there were no smoking assessments in the electronic health record (EHR). The DON stated smoking assessment should have been done. The ADON stated upon admission, residents who smoked would sign the smoking policy stating the facility was a non-smoking campus. The DON stated after admission, the resident would not smoke for a while but when the resident would see other residents smoking, then the resident would start smoking. The DON explained Resident #16 quit smoking for a while and recently started again, she found out the other day [6/18/24] that Resident #16 was smoking again.</p> <p>During the same interview, the DON stated the residents who smoke kept their matches or lighters in their rooms. When asked how the facility managed residents' matches or lighters and cigarettes, the DON stated, we have not had anyone (residents) unsafe. The DON stated the facility would not necessarily know when the resident would bring in cigarettes and matches or lighters.</p> <p>When asked, how the facility ensured there were no risk of fire, the DON stated, that's a hard one.</p> <p>She stated the residents who smoked were cognitive. The residents had the right to say no. The DON further stated the facility had not tried the process of keeping cigarettes and lighters.</p> <p>During a follow-up interview on 6/19/24 at 3:19 PM, the DON stated a smoking assessment was not done for Resident #16 because the resident signed the no smoking policy upon admission.</p> <p>Review of the facility's Smoking/Vaping Policy, signed on 1/20/23, by Resident #16, revealed: . Maple Springs is a smoke -free . campus. Smoking . not permitted on Maple Springs property. residents who wish to smoke . must do so off the property. there are no designated smoking times or locations.</p> <p>Review of the facility's Smoking Policy - Residents, dated 12/2023, revealed: . Policy Statement[;] this facility shall establish and maintain safe resident smoking practices. Maple springs is a smoke free campus. Policy interpretation and implementation 1. Prior to and upon admission, resident shall be informed of the facility no smoking or vaping policy. 2. The resident will be evaluated prior to admission to determine if he or she is a smoker or non-smoker. If smoking, the evaluation will include a. current level of tobacco consumption; method of tobacco consumption; desire to quit smoking, if a current smoker; facility provider will offer to order smoking cessation medication upon admission as needed. 3. The facility has the right to confiscate smoking articles found in violation of our smoking policies. 4. Confiscated property will be itemized and ultimately returned to the resident .</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</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: 1) physicians completed the Physician Orders for Life-Sustaining Treatment (POLST - Physician orders that clarify life sustaining measures if needed, to include cardiopulmonary resuscitation [CPR], initial treatment orders, and medically assisted nutrition) physician order forms with residents; and 2) were signed and dated with an original signature for 9 sampled residents (#s 3; 6; 8; 17; 28; 33; 35; 38; and 204), out of 14 sampled residents reviewed; and 35 unsampled residents (#s 2; 4; 5; 7; 11; 14; 21; 22; 24; 25; 26; 30; 31; 32; 34; 36; 37; 39; 40; 41; 42; 45; 46; 48; 49; 103; 104; 105; 203; 205; 206; 253; 254; 303; and 304), out of 39 unsampled residents reviewed. This failed practice had the potential to deny these residents to be offered life sustaining options by an authorized health care provider, placing them at risk for not understanding the risk and benefits of those options which could affect their overall well-being and end of life choices.</p> <p>Findings:</p> <p>Record review on ,d+[DATE]-,d+[DATE] revealed all resident charts contained a completed POLST order form.</p> <p>During an interview on [DATE] at 2:05 PM, Licensed Nurse (LN) #1 stated POLST forms were completed by nurses on every admission.</p> <p>During an interview on [DATE] at 9:42 AM, LN #24 stated POLST forms were completed by charge nurses.</p> <p>An observation on [DATE] at 10:38 AM, during an explanation of all the admission paperwork documents in an admission packet by LN #33, revealed a blank POLST form with a photocopy of the Medical Director's signature on it.</p> <p>When asked about the photocopied signature on the blank POLST form, LN #33 confirmed these forms were used during admissions of new residents.</p> <p>Review of all 53 resident records revealed the following POLST physician order forms were used with provider signatures photocopied onto a blank form and later filled out during the resident's admission:</p> <p>1) The Medical Director's photocopied signature was on 40 resident's POLST forms, Resident #'s 2; 3; 4; 5; 6; 7; 8; 11; 17; 21; 22; 24; 25; 26; 28; 32; 34; 35; 36; 37; 38; 39; 40; 41; 42; 45; 46; 48; 49; 103 104; 105; 203; 204; 205; 206; 253; 254; 303; and 304.</p> <p>2) Physician #22's photocopied signature was on four resident POLST forms, Resident #'s 14; 30; 31; and 33.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 4:23 PM, the Medical Director stated she approved her signature to be photocopied on a blank POLST for repeated use. The Medical Director further stated it was the nurses who completed the POLST forms upon admission and confirm the resident's wishes. When asked if there was anywhere in the chart that reflected the health care providers reviewed the admission paperwork to include the POLST form, the Medical Director stated there wasn't anywhere in the chart that she signed to say she reviewed these forms.</p> <p>Review of the facility's blank POLST form, dated [DATE], revealed: Health care providers should complete this form only after a conversation with their patient or the patient's representative . This is a medical order .</p> <p>Further review revealed a section on the POLST form for the health care provider to sign: . Signature: Health Care Provider (required, eSigned [electronically signed] documents are valid) Verbal orders are acceptable with follow up signature: I have confirmed that this order was discussed with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. (Note: Only licensed health care providers authorized by law to sign POLST form in Alaska may sign this order.) .</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>40259</p> <p>Based on record review and interview, the facility failed to review the drug regimen for 1 resident (#18), out of 14 sampled residents, for adequate parameters of a medication dose range order (orders in which there are dosing amount options over a prescribed range). This failed practice had the potential to expose the resident to unnecessary medications.</p> <p>Findings:</p> <p>Review on 6/17-21/24 revealed Resident #18 was admitted to the facility under hospice care for diagnoses that included dementia, unspecified severity, with agitation. Resident #18 had a history of stroke which had contributed to the decline of his/her dementia.</p> <p>Review of Resident #18's electronic medication administration record (eMAR), dated 6/2024, revealed the following pain medication: Morphine Sulfate (Concentrate) Solution [liquid form of morphine, a narcotic used to treat moderate to severe pain] 20 milligrams [mg] / [per] milliliter [ml] - Give 0.25ml [or 5mg] by mouth every 2 hours as needed for moderate to severe pain/shortness of breath.</p> <p>Further review of this order revealed the following instructions that included a range order: May have 0.25mL to 1.0mL by mouth or under tongue.</p> <p>Further review of these instructions revealed no parameters for the dosage ranges provided to determine which dose should be administered when.</p> <p>The start date for this medication order was on 10/4/23 for 14 days, ending on 10/17/23. This medication was then renewed on 10/18/23 and ordered to continue until 6/18/24.</p> <p>Review of Resident #18's Morphine administration history, from 10/2023 to 6/2024, revealed that Resident #18 mostly received the maximum dose of 1.0ml (or 20mg) of Morphine when given:</p> <p>10/7/23 - 1ml 10/8/23 - 1ml 10/16/23 - 1ml 11/5/23 - 1ml 11/6/23 - 1ml 11/13/23 - 1ml 11/19/23 - 1ml 2/3/24 - 0.25ml</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3/15/24 - 0.25ml</p> <p>6/16/24 - 1ml</p> <p>6/17/24 - 1ml</p> <p>6/18/24 - 0.5ml</p> <p>During an interview on 6/20/24 at 12:02 PM, when asked about Resident #18's Morphine PRN medication and the associated range order without parameters, Pharmacist #20 (who oversaw the facility resident's medication management) stated range orders usually come from hospitals and the facility usually discontinued those for more accurate dosage orders. Pharmacist #20 further stated that range orders also came from hospice agencies and can be difficult to consistently administer at the minimum therapeutic dose, as residents tend to ask for the maximum dose.</p> <p>During an interview on 6/20/24 at 3:01 PM, when asked about Resident #18's Morphine PRN medication and the associated range order without parameters, Physician #5 (who managed residents in the facility) stated he/she hadn't overseen Resident #18's medication management as the resident was on hospice status. Physician #5 further stated that hospice residents were seen by hospice agencies who had full control of the resident's care, to include medication management.</p> <p>During an interview on 6/20/24 at 4:03 PM, when asked about Resident #18's Morphine PRN medication and the associated range order without parameters, the Ancora Hospice Medical Director (who oversaw Resident #18's care) stated he was aware of hospital guidelines to give parameters of a range of pain levels and associated doses of medication per level of pain, however hospice agencies didn't provide parameters with range orders. The Ancora Hospice Medical Director stated the idea behind range orders in hospice was to give the lowest dose first and move up in dose if needed. When informed of the maximum dose administration history with Resident #18's Morphine PRN order, the Ancora Hospice Medical Director stated the maximum dose was not intended to be administered first, but an option if needed when smaller doses were ineffective.</p> <p>Review of the facility's policy Medication Orders, dated 12/2023, revealed: . The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. Recording Orders. Medication Orders - When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered . PRN Medication Orders - When recording PRN medication orders, specify the type, route, dosage, frequency, strength and the reason for administration .</p> <p>Review of the facility's policy Administering Medications, dated 12/2022, revealed: . If a dosage is believed to be inappropriate or excessive for a resident . the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns .</p> <p>When asked for a policy regarding the policy and procedures for hospice resident care at the facility, the Director of Nursing stated there was no policy regarding hospice resident care in the facility.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>40259</p> <p>Based on record review and interview, the facility failed to ensure medical records were accurately completed in accordance with accepted professional standards of practice. Specifically, the facility failed to ensure:</p> <p>1) The Psychotropic Medication Informed Consent [and] Risk/Benefit Statement forms, used for education and consent for psychotropic medications (any drug that affects brain activities associated with mental processes and behavior), were completed accurately, timely, and by authorized health care providers with an original signature for 9 sampled residents (#'s 6; 8; 15; 16; 18; 28; 33; 35; and 204) and 8 unsampled residents (#'s 2; 7; 19; 25; 31; 37; 41; and 105), out of 25 residents on psychotropic medications in the facility.</p> <p>2) The nursing staff accurately documented the removal of a medication patch for one resident (#41) out of 25 medication administrations reviewed.</p> <p>These failed practices created incomplete medical records and/or inaccurate documentation, which placed these residents at risk for inconsistencies in care and treatment provided.</p> <p>Findings:</p> <p>1) Psychotropic Medication Informed Consent</p> <p>Record review on 7/16-21/24 revealed the facility used a Psychotropic Medication Informed Consent [and] Risk/Benefit Statement form (identified as consent form moving forward), dated 3/2023, to educate and obtain consent from residents and/or their representatives on any psychotropic medication recommended for use. This form would be used upon resident admissions, if the resident was currently taking a psychotropic medication, or would be used if a psychotropic medication was initiated during their stay.</p> <p>Further review revealed the form documented the following information:</p> <ul style="list-style-type: none"> <li>- I [resident or representative name] have received information regarding the risks and benefits associated with using the psychotropic drugs that have been ordered for [resident's name] for the specific diagnosis listed below, manifesting target symptoms/behaviors . A list of diagnoses was available to check the appropriate diagnosis for individual residents.</li> <li>- Name and Dosage of psychotropic medication(s) A space to write the medication and dose was provided.</li> <li>- . The benefits expected from this medication . A list of benefits was on the form.</li> <li>- The risks or side effects associated with this medication include, but are not limited to . A list of risks or side effects for different classes of medications: hypnotics/sedatives; antidepressants; anxiolytics (antianxiety medications); and antipsychotics were listed on the form.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A review of the consent section of the form revealed the following places to check if agreed:</p> <ul style="list-style-type: none"> <li>- The risks and benefits of the use of psychotropic medication(s) have been explained to me;</li> <li>- I have asked, and had answered, all of the questions, which pertain to the use of psychotropic medication(s);</li> <li>- I understand and consent to the use of the medication described above; and</li> <li>- I do not consent to the use of the above mentioned medication.</li> </ul> <p>The consent form had a place for In person consent to indicate the individuals signing were present at the time of the form's completion: Physician Signature; Resident Name (print); and Resident Signature or Resident's Representative Signature. This was the only signature line for health care providers to sign on.</p> <p>There was also a place for Telephone Consent/Refusal: (2 staff witnesses) and had places for name of person giving consent/refusal; and two spaces for nurse signature.</p> <p>An observation on 6/20/24 at 10:38 AM, during an explanation of all the admission paperwork documents in an admission packet by Licensed Nurse (LN) #33, revealed a blank consent form with the Medical Director's signature photocopied on it.</p> <p>When asked about the photocopied signature on the blank consent form, LN #33 confirmed this form was used during admissions of new residents.</p> <p>During an interview on 6/21/24 at 4:23 PM, the Medical Director stated she approved her signature to be photocopied on a blank consent form for repeated use. The Medical Director further stated the nurses completed the consent forms with residents. When asked if there was anywhere in the chart that reflected the health care providers reviewed the admission paperwork to include the consent forms for psychotropic medications, the Medical Director stated there wasn't anywhere in the chart that she signed to say she reviewed these forms.</p> <p>Review on 6/17-21/24 of all 25 resident records, who were currently on psychotropic medications, revealed the following residents had consent forms that contained health care provider's photocopied signatures.</p> <p>Further review revealed some of the following residents also either had missing consent forms for psychotropic medications doses being administered, consents were not obtained prior to psychotropic medication administration, and/or consents were not accurately obtained with appropriate consent, for the following residents:</p> <p>Resident #2</p> <p>Escitalopram (Lexapro - an antidepressant)</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident #2's consent form was for the use of escitalopram 20 milligrams (mg). This form was signed by the resident on 5/2/24. The Medical Director's photocopied signature was on this form with the handwritten date of 5/2/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Resident #6</p> <p>Resident #6 had multiple consent forms for multiple psychotropic medications:</p> <p>Buspirone (an anxiolytic)</p> <p>The first consent form was for the use of buspirone 20 mg. This form was dated 4/15/24 and two nurses signed on the Resident's Representative Signature line under the In Person Consent section. Further review revealed no resident representative listed on the consent form. The Medical Director's photocopied signature was on this form with a computer-generated date of 4/15/24.</p> <p>Duloxetine (an antidepressant)</p> <p>The second consent form was for the use of duloxetine 60mg. This form was dated 4/15/24 and two nurses signed on the Resident's Representative Signature line under the In Person Consent section. Further review revealed no resident representative was listed on the consent form. The Medical Director's photocopied signature was on this form with a computer-generated date of 4/15/24.</p> <p>Trazadone (an antidepressant)</p> <p>The third consent form was for the use of Trazadone 100mg. This form was dated 4/20/24 and two nurses signed on the Resident's Signature line and documented 2 nurse signature [with] resident. The Medical Director's photocopied signature was on this form with a handwritten date of 4/20/24.</p> <p>Further record review revealed Resident #6 started Trazadone on 4/15/24, five days prior to the date of the consent form.</p> <p>Hydroxyzine (an antihistamine, but can be used to treat anxiety)</p> <p>1. The fourth consent form was for the use of Hydroxyzine with no dose indicated. There was no class of medication marked to review risks or potential side effects for this medication. The resident's daughter signed this form on 4/24/24. Further review revealed the daughter put her name on the Resident's Name (print) line and signed her name on the Resident Signature line. The Medical Director's photocopied signature was on this form with a handwritten date of 4/24/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>2. The fifth consent form was for the use of Hydroxyzine 50mg every 6 hours PRN (as needed) and used for anxiety. The class of medication marked was anxiolytics. This form was dated 5/23/24 and two unrecognizable signatures were on the Resident's Signature line and documented verbally acknowledged. The Medical Director's photocopied signature was on this form with a handwritten date of 5/23/24.</p> <p>Lorazepam (an anxiolytic)</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The sixth consent form was for the use of Lorazepam 0.5mg. This form was dated 5/23/24 and two unrecognizable signatures were on the Resident's Signature line and documented verbally acknowledged. The Medical Director's photocopied signature was on this form with a handwritten date of 5/23/24.</p> <p>Resident #7</p> <p>Resident #7 had two psychotropic medication consent forms:</p> <p>Fluoxetine (an antidepressant)</p> <p>The first consent form was for the use of Fluoxetine 20mg. This form was signed by the resident on 4/18/24. Further review revealed the resident did not mark the section I have asked, and had answered, all of the questions, which pertain to the use of psychotropic medication(s) of the form. The Medical Director's photocopied signature was on this form with a handwritten date of 4/18/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Mirtazapine (an antidepressant)</p> <p>The second consent form was for the use of Mirtazapine 7.5mg. This form was signed by the resident on 4/18/24. Further review revealed the resident did not mark the section I have asked, and had answered, all of the questions, which pertain to the use of psychotropic medication(s) of the form. The Medical Director's photocopied signature was on this form, however, was not dated. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Resident #8</p> <p>Resident #8 had two psychotropic medication consent forms:</p> <p>Seroquel (an antipsychotic)</p> <p>The first consent form was for the use of Seroquel 25mg twice a day and 50mg at bedtime (HS). This form had an illegible marking on the Resident Signature line, dated 4/17/24. The Medical Director's photocopied signature was on this form with a handwritten date of 4/17/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Citalopram (Celexa - an antidepressant)</p> <p>The second consent form was for the use of citalopram 20mg. This form was dated 4/20/24 and it was documented in the telephone consent/refusal section that a resident representative was called for a consent. It was documented left a VM [voicemail] under the representative's name and two nurses signed the form. No documentation was added later to prove education was provided, or verbal consent was ever obtained. The Medical Director's photocopied signature was on this form with a handwritten date of 4/20/24.</p> <p>Further record review revealed Resident #8 started Citalopram on 4/18/24, two days prior to the facility's attempt to obtain consent.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident #15</p> <p>Risperdal (an antipsychotic)</p> <p>Review of Resident #15's medication administration record revealed an order for Risperidone Oral Tablet (Risperdal) Give 0.5mg by mouth every morning and at bedtime for mood disorder. The start date for this order was 12/21/23.</p> <p>Review of Resident #15's consent forms for Risperdal revealed:</p> <ul style="list-style-type: none"> <li>- The first consent form was for the use of Risperdal with no specified dose. This form was signed by the resident representative on 3/18/20. Further review revealed the resident representative did not mark the consent sections of The risks and benefits of the use of psychotropic medication(s) have been explained to me and I have asked, and had answered, all of the questions, which pertain to the use of psychotropic medication(s). Physician #22's original signature was on this consent form and dated 4/4/20.</li> <li>- The second consent form was for the use of Risperdal 0.25mg. This form was dated 4/6/23 and two nurse signatures were on the Resident Signature line with 2 nurse signature documented. Further review revealed no information that the resident representative was contacted for consent. Physician #22's original signature was on this consent form and dated 4/6/23.</li> </ul> <p>Further review of Resident #15's medical record revealed no consent for the current dose of Risperdal 0.5mg currently being administered.</p> <p>Resident #16</p> <p>Lexapro</p> <p>Resident #16's consent form was for the use of Lexapro 15mg. This form was dated 5/11/24 and it was documented in the telephone consent/refusal section that the resident gave consent and was signed by two nurses. Physician #22's original signature was on this form and dated 5/11/24.</p> <p>Further record review revealed Resident #16 started Lexapro 10mg on 1/18/23, 479 days prior to the date of the consent form, and the dose changed to 15mg on 2/28/23, 438 days prior to the date of the consent form. No other consent forms for Lexapro were found in the resident's medical record.</p> <p>Resident #18</p> <p>Resident #18 had multiple consent forms for multiple medications:</p> <p>Lorazepam</p> <p>1. The first consent form was for the use of liquid Lorazepam 2 milligram (mg)/(per) milliliter (ml). This form was signed by the resident representative on 10/4/23. Physician #5's photocopied signature was on this form with a handwritten date of 10/4/23. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. The second consent form was for the use of Lorazepam 1mg. This form was signed on 11/14/23 and consent was obtained by telephone consent with the resident representative and two nurse signatures. Physician #22's photocopied signature was on this form with a handwritten date of 11/14/23.</p> <p>Further record review revealed Resident #18 started this Lorazepam medication as an every hour PRN (as needed) dose on 10/3/23, 42 days prior to this consent being obtained.</p> <p>3. The third consent form was for the use of Lorazepam 0.5mg three times a day and every hour PRN dose. This form was signed on 3/4/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 3/4/24.</p> <p>Further record review revealed Resident #18's Lorazepam order that was started on 3/4/24 was for 1mg, three times a day, and every hour PRN. Lorazepam dose was 1mg, not 0.5mg as the consent indicated.</p> <p>4. The fourth consent form was for the use of Lorazepam 1mg three times a day. This form was signed on 3/6/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 3/6/24.</p> <p>Further record review revealed Resident #18's Lorazepam order that was started on 3/6/24 was for 0.5mg three times a day, not 1mg as the consent indicated. No new consent form for this dosage change was in Resident #18's medical record.</p> <p>Resident #18's every hour PRN Lorazepam order stopped on 3/6/24.</p> <p>5. The fifth consent form was for the use of Lorazepam 0.5mg twice a day. This form was signed on 3/13/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 3/13/24.</p> <p>Further record review revealed this scheduled dose of Lorazepam started on 3/13/24. Resident #18's every hour PRN Lorazepam order was restarted on 3/16/24, three days after the 3/13/24 consent was obtained. No new consent form for this dosage change was in Resident #18's medical record.</p> <p>Seroquel (an antipsychotic)</p> <p>1. The first consent form was for the use of Seroquel 50mg. This form was signed by the resident representative on 10/4/23. Physician #5's photocopied signature was on this form with a handwritten date of 10/4/23. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Further record review revealed Resident #18 started Seroquel on 10/2/23, two days prior to this consent being documented. Further review revealed the dose of Seroquel changed on 10/17/23 to Seroquel 50mg twice a day, for a total of 100mg daily.</p> <p>No new consent for this dosage change was in Resident #18's medical record.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. The second consent form was for the use of Seroquel 75mg at bedtime and 50mg PRN. This form was signed on 11/14/23 and consent was obtained by telephone consent with the resident representative and two nurse signatures. Physician #22's photocopied signature was on this form with a handwritten date of 11/14/23.</p> <p>Further record review revealed Resident #18 started Seroquel 75mg at bedtime on 11/1/23, 13 days prior to this consent being obtained. On 11/2/23, Resident #18 was started on Seroquel 50mg daily at 9:00 AM, not PRN like the consent form indicated. No new consent form for this dosage change was in Resident #18's medical record.</p> <p>3. The third consent form was for the use of Seroquel 75mg twice a day. This form was signed on 3/4/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 3/4/24.</p> <p>Trazadone</p> <p>Resident #18's consent form was for the use of Trazadone 25mg. This form was signed on 11/14/23 and consent was obtained by telephone consent with the resident representative and two nurse signatures. Physician #22's photocopied signature was on this form.</p> <p>Further record review revealed Resident #18 started Trazadone on 10/5/23, 40 days prior to the consent being obtained. No other consent forms for Trazadone were found in the resident's medical record.</p> <p>Resident #19</p> <p>Resident #19 had two psychotropic medications on one consent form:</p> <p>Paroxetine (an antidepressant) and Xanax (a sedative)</p> <p>Resident #19's consent form was for the use of paroxetine 40mg and Xanax 0.5mg. This form was dated 5/15/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. Physician #22's original signature was on this form and dated 5/29/24, 14 days after the resident signed the consent form.</p> <p>Further record review revealed Resident #19 started paroxetine 20mg on 2/4/22, 831 days prior to the consent being obtained. Resident #19's paroxetine dose was changed to 40mg on 12/21/23. No other consent forms for paroxetine were in the resident's record.</p> <p>Further record review revealed Resident #19 started Xanax 0.5mg on 9/30/22, 593 days prior to the consent being obtained. No other consent forms for Xanax were in the resident's record.</p> <p>Resident #25</p> <p>Resident #25 had two psychotropic medication consent forms:</p> <p>Duloxetine</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. The first consent form was for the use of Duloxetine 60mg. This form was signed by the resident on 4/12/24. The Medical Director's photocopied signature was on this form with a handwritten date of 4/12/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Hydroxyzine</p> <p>2. The second consent form was for the use of hydroxyzine 25mg. This form was signed by the resident on 4/16/24. The Medical Director's photocopied signature was on this form with a handwritten date of 4/16/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Further record review revealed a nurse's initials were on bottom left second page of the form which indicated Document in Point Click Care that a telephone consent/refusal was obtained and scan this document under the Misc [Miscellaneous] tab, with heading of Consent: Medications. This consent was not obtained through telephone consent.</p> <p>Resident #28</p> <p>Resident #28 had multiple consent forms for multiple medications:</p> <p>Clonazepam (a sedative)</p> <p>1. The first consent form was for the use of clonazepam with no specified dose. This form was signed on 5/19/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form. This signature was not dated.</p> <p>Further record review revealed Resident #28 started Clonazepam on 5/18/24, 1 day prior to the consent being obtained.</p> <p>2. The second consent form was a photocopy of the original with the words updated with dose on the upper right corner of the consent form's first page. The dose 0.5mg Q AM [every morning] was added after the word Clonazepam. This form had no indication the resident representative authorized the addition of a dose to the consent form, or that the resident representative was called to be informed it was added. The Medical Director's photocopied signature was on this form. This signature was not dated.</p> <p>Further record review revealed Resident #28 started an additional order of Clonazepam 0.5mg every 24 hours PRN agitation on 5/24/24, which changed to 0.5mg every 12 hours PRN agitation on 6/17/24. No new consent for this dosage change was in Resident #28's medical record.</p> <p>Hydroxyzine</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. The third consent form was for the use of hydroxyzine 25mg. The indication for use was for generalized itching. The class of medication was marked as anxiolytics. This form was signed on 4/29/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 4/29/24.</p> <p>2. The fourth consent form was for the use of hydroxyzine 25mg. The class of medication was marked as Other and documented as antianxiety. No risks or side effects associated with this medication was not documented on the consent form. This form was dated 6/4/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form. This signature was not dated.</p> <p>Seroquel</p> <p>1. The fifth consent form was for the use of Seroquel 25mg. This form was signed on 5/13/24 and had an illegible marking on the Resident Signature line. Physician #5's original signature was on this form dated 5/13/24.</p> <p>2. The sixth consent form was for the use of Seroquel 25mg at HS [bedtime]. This form was half filled out by a nurse in blue ink, the other half was filled out by the resident in black. This form was dated 5/13/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. None of the following sections for consent were marked: The risks and benefits of the use of psychotropic medication(s) have been explained to me; I have asked, and had answered, all of the questions, which pertain to the use of psychotropic medication(s); I understand and consent to the use of the medication described above; or I do not consent to the use of the above mentioned medication. The Medical Director's photocopied signature was on this form. This signature was not dated.</p> <p>3. The seventh consent form was for the use of Seroquel 50mg. This form was dated 5/24/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 5/24/24.</p> <p>4. The eighth consent form was for the use of Seroquel 100mg at HS and continue 50mg in the AM. This form was dated 6/10/24 and consent was obtained by telephone consent with the resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 6/10/24.</p> <p>Resident #31</p> <p>Resident #31 had two psychotropic medication consent forms:</p> <p>Seroquel</p> <p>1. The first consent form was for the use of Seroquel 50mg. This form was signed on 11/14/23 and the resident signed this form with an illegible marking to the left of the resident's printed name added by staff. Physician #22's photocopied signature was on this form with a handwritten date of 11/14/23. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Further record review revealed Resident #31 started Seroquel on 10/13/23, 32 days prior to the 11/14/23 consent form. No other consent forms for Seroquel were in the resident's medical record.</p> <p>Lorazepam</p> <p>2. The second consent form was for the use of Lorazepam 1mg. This form was signed on 11/14/23 as well and had another illegible marking but this time was over Physician #2's photocopied signature that had a handwritten date of 11/14/23. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Resident #33</p> <p>Resident #33 had two psychotropic medication consent forms:</p> <p>Wellbutrin (an antidepressant)</p> <p>1. The first consent form was for the use of Wellbutrin 150mg. This form was signed by the resident on 5/10/24. The Medical Director's photocopied signature was on this form and had a handwritten date of 3/13/24, 58 days prior to the resident's consent was obtained. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Further record review revealed Resident #33 started Wellbutrin on 3/13/24, the day the Medical Director's photocopied signature was dated. No other consent forms for Wellbutrin were in the resident's medical record.</p> <p>Duloxetine</p> <p>2. The second consent form was for the use of duloxetine 30mg. This form was signed by the resident on 5/10/24. The Medical Director's photocopied signature was on this form and had a handwritten date of 3/16/24, 55 days prior to the resident signing. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Further record review revealed Resident #33 started Duloxetine on 3/16/24, the day the Medical Director's photocopied signature was dated. No other consent forms for Duloxetine were in the resident's medical record.</p> <p>Resident #35</p> <p>Resident #35 had two psychotropic medications with multiple consent forms:</p> <p>Sertraline</p> <p>The first consent form was for the use of Sertraline 50mg. This form was signed by the resident on 2/28/24. The Medical Director's photocopied signature was on this form had a handwritten date of 2/28/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Trazadone</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. The second consent form was for the use of Trazadone 150mg. This form was signed by the resident on 3/4/24. The Medical Director's photocopied signature was on this form with a handwritten date of 2/28/24, which was the date of admission for Resident #35 and 6 days prior to the resident signing. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Further record review revealed Resident #35 started Trazadone 150mg at bedtime on 2/28/24, the day of admission. No new consent form for this dosage change was in Resident #35's medical record.</p> <p>2. The third consent form was for the use of Trazadone 50mg. This form was signed by the resident on 3/13/24. The Medical Director's photocopied signature was on this form with a handwritten date of 3/13/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Resident #37</p> <p>Duloxetine</p> <p>Resident #37's consent form was for the use of duloxetine 30mg. This form was dated 2/29/24 and was obtained through telephone consent with a resident representative and two nurse signatures. The Medical Director's photocopied signature was on this form with a handwritten date of 2/29/24.</p> <p>Further record review revealed a second consent form for the same medication and same dose was completed and dated 4/27/24. This form was completely filled out and signed by the resident. Further review revealed this consent form was initialed by the resident on the sections of The risks and benefits of the use of psychotropic medication(s) have been explained to me and I have asked, and had answered, all of the questions, which pertain to the use of psychotropic medication(s), however there was a computer-generated pre-typed X on the line to indicate I understand and consent to the use of the medication described above. The Medical Director's photocopied signature was on this form and Resident #37 wrote the date 4/27/24 for this signature. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Resident #41</p> <p>Resident #41 has two psychotropic medications and multiple consent forms:</p> <p>Venlafaxine (an antidepressant)</p> <p>The first consent form was for the use of Venlafaxine 150mg. This form was signed by the resident on 5/10/24. The Medical Director's photocopied signature was on this form and had a handwritten date of 5/5/24, five days prior to the resident signing. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Further record review revealed Resident #41 started Venlafaxine 150mg on 5/5/24, the day the Medical Director's photocopied signature was dated. No other consent forms for Venlafaxine were in the resident's medical record.</p> <p>Hydroxyzine</p> <p>(continued on next page)</p>		

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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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. The second consent form was for the use of hydroxyzine 25mg. This form was dated 4/10/24 and consent was documented in the telephone consent/refusal section. The word telephone was lined out and the words In Person were added. The form indicated the resident was on the name of person giving consent/refusal line and signed by two nurses. Medical Director's photocopied signature was on this form with a handwritten date of 4/10/24.</p> <p>2. The third consent form was for the use of hydroxyzine 25mg as well. This form was signed by the resident on 5/29/24. The Medical Director's photocopied signature was on this form with a handwritten date of 5/29/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent from the resident.</p> <p>Resident #105</p> <p>Resident #105 had three psychotropic medication consent forms:</p> <p>Amitriptyline (an antidepressant)</p> <p>The first consent form was for the use of amitriptyline 100mg. This form was signed by the resident representative on 6/5/24. The Medical Director's photocopied signature was on this form with a handwritten date of 6/5/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Fluoxetine</p> <p>The second consent form was for the use of fluoxetine 20mg. This form was signed by the resident representative on 6/5/24. Further review revealed the resident's printed name was not on the In person consent line and the resident's representative signed on the Resident's Signature line. The Medical Director's photocopied signature was on this form with a handwritten date of 6/5/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Memantine (cognitive enhancing medication to treat dementia associated with Alzheimer's)</p> <p>The third consent form was for the use of Memantine 10mg. This form was signed by the resident representative on 6/5/24. The Medical Director's photocopied signature was on this form with a handwritten date of 6/5/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent.</p> <p>Further review of this consent form revealed the class of this medication was marked as other. No risks or side effects were documented on the consent form to indicate the resident and/or resident representative were educated on these possibilities.</p> <p>Resident #204</p> <p>Escitalopram</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  025038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/21/2024
NAME OF PROVIDER OR SUPPLIER  Maple Springs of Wasilla		STREET ADDRESS, CITY, STATE, ZIP CODE  3265 E Meridian Loop Wasilla, AK 99654	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- Resident #204's consent form was for the use of escitalopram 10mg. This form was signed by the resident on 6/6/24. The Medical Director's photocopied signature was on this form and had a handwritten date of 6/6/24. No other staff's signatures or initials were on the form to indicate who provided education or obtained consent f[TRUNCATED]</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>50031</p> <p>Based on observation, interview, and record review, the facility failed to ensure kitchen equipment was in a safe operating condition. Specifically, the facility failed to ensure the walk-in freezer door's gasket (a flexible rubber strip that runs along the edge of the door to create an airtight seal) was without compromise. This failed practice placed all residents (based on a census of 53) at risk for food borne illnesses.</p> <p>Findings:</p> <p>Review on 6/17-21/24 revealed the facility's walk-in freezer was inside the facility's walk-in refrigerator.</p> <p>An observation, during initial kitchen tour, on 6/17/24 at 8:30 AM, revealed a puddle of free-standing water approximately 18 inches x 12 inches in the walk-in refrigerator, on the floor directly in front of the walk-in freezer door. Further observation revealed two dark gray strings of like-rubber pieces of material hanging off the bottom of the door, one approximately 1/4 inch by 6 inches long and the other approximately 1/4 inch by 3 inches long.</p> <p>During an observation on 6/18/24 at 8:45 AM, revealed the same puddle of free-standing water approximately 18 inches x 12 inches in the walk-in refrigerator, on the floor directly in front of the walk-in freezer door. The two dark gray strings of like-rubber pieces of material were still hanging off the bottom of the freezer door.</p> <p>During an observation on 6/19/24 at 12:50 PM, revealed the puddle of free-standing water approximately 18 inches x 12 inches in the walk-in refrigerator, remained on the floor directly in front of the walk-in freezer door. The two dark gray strings of like-rubber pieces of material were still present hanging off the bottom of the door.</p> <p>During an interview on 6/19/21 at 1:15 PM, when shown the two dark gray string of like rubber pieces of material hanging off the bottom of the freezer door and water on floor in the walk-in refrigerator in front of the walk-in freezer, Dietary Staff (DS) #4 stated that he/she was not aware of the water but would submit a maintenance request.</p> <p>Record review on 6/19/21 at 3:00 PM, of the Maintenance Request revealed the request was for maintenance to assess the freezer door seal.</p> <p>During an interview on 6/20/24 at 10:04 AM, DS #19 shared he/she was not aware of the water on the floor in walk-in refrigerator until brought to his/her attention. DS #19 informed a maintenance request was placed to look at bottom of seal of the door. DS #19 shared the condenser works more as the freezer door is opened. DS #19 shared kitchen equipment is scheduled for maintenance quarterly.</p> <p>During the survey it was requested to review the kitchen's walk-in freezer user guide or manual, DS #19 stated he/she was not aware of the location of a manufacture manual. The freezer manual/guide was not provided.</p>