STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025039	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Springs of Palmer	12130 East Maple Springs Way Palmer, AK 99645

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. . Based on record review, observation, and interview, the facility failed to ensure one resident (#48), out 15 sampled residents, was provided care in a manner that promoted dignity and respect. Specifically, staff failed to cover the resident's buttocks and genitals, for dignity, while staff walked away to empty a urinal. This failed practice had the potential to cause the resident humiliation and shame. Findings: Record review from 3/23-27/25 revealed Resident #48 was admitted to the facility with diagnoses that included Parkinsons disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), left femur fracture, osteoporosis (a disorder characterized by abnormal loss of bone density and deterioration of bone tissue), history of strokes, and heart failure. Review of Resident #48's care plan Interventions, revised on 10/7/24, revealed: The resident requires extensive assistance on (1) staff for toilet use . An observation on 3/23/25 at 9:26 AM, revealed Resident #48 in his/her room, standing up in front of his/her recliner on a Sara Steady (a manual sit-to-stand lift support aid, which encouraged the user to pull themselves up into a standing position). Certified Nursing Assistant (CNA) #2 pulled up the resident's shirt, then pulled down the resident's shorts to his/her shins. CNA #2, then, detached one side tab of the resident's brief and pulled it down as well. Next, the CNA placed the resident's penis into a urinal and held the urinal in place while the resident urinated. Once Resident #48 finished urinating, the CNA carried the full urinal into the bathroom to empty and rinse the urinal. While waiting for the CNA to return, Resident #48's buttocks and genitals were exposed. When the CNA returned, the CNA wiped the resident's genitals, pulled up and secured the brief, then pulled up his/her shorts, and, lastly, pulled down the resident's shirt. The CNA then helped Resident #48 sit back into his/her recliner. During an interview on 3/24/25 at 4:15 PM, Resident #48 stated there were some CNA's that needed more training with caring for private parts. The resident further stated that being exposed while the CNA walked away made him/her, a little uncomfortable. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/24 at 5:13 PM, the Director of Nursing emphasized that leaving a resident exposed during care was not ideal. Review of the facility's employee training agreement titled Safe Lifting and Movement of Residents, revised 7/2017, revealed: Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. Review of the facility's Resident Rights, undated, revealed: Each Resident has a right to be treated with dignity and respect . .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. . Based on record review, interview, and observation, the facility failed to ensure reasonable accommodation of needs, of always having a call light within reach, was maintained for 1 resident (#39), out of 15 sampled residents reviewed. This failed practice placed the resident at risk for not being able to call for help if needed. Findings: Resident #39 Record review on 3/23-27/25 revealed Resident #39 was admitted to the facility with diagnoses that included dysphagia following nontraumatic intracerebral hemorrhage (difficulty swallowing due to bleeding in the brain not caused by trauma, due to damage affecting the brain regions responsible for controlling swallowing), unspecified dementia, unspecified severity, with other behavioral disturbance (a decline in intellectual functioning, including problems with memory, reasoning and thinking without enough information to identify a specific type or cause), seizures and anemia. During an interview on 3/24/25 at 9:34 AM, Resident #39's Resident Representative (RR) stated he/she video-called with Resident #39 frequently. The RR further stated, I will be on FaceTime, and [he/she] is yelling because [he/she] needs help, when I tell [him/her] to use the call light, [he/she] can't find it or it is on [his/her] left side, so [he/she] whistles really loud. It happens often that the call light is not within reach. Observations on 3/25/25 at 8:28 AM, 3/25/25 at 11:28 AM, and 3/25/25 at 4:40 PM revealed Resident #39 lying in bed with the resident's call light out of reach between the headboard and mattress. During an observation and interview on 3/25/25 at 4:40 PM, Resident #39 stated, most of the time I can't reach the call light, so I start whistling. I would whistle right now but my mouth is dry. When asked to reach for the call light, which was clipped to the right side of his/her pillow but hanging in the gap between the mattress and the headboard, Resident #39 was not able to reach the call light. Resident #39 further stated he/she was unable to use the left side of his/her body because of a stroke. Record review of the Skilled Charting-V2 Nursing Assessment, dated 3/19/25 at 8:10 AM, revealed: ADL's [Activities of Daily Living]/FUNCTIONAL STATUS . Weakness . Paralysis .Decreased Sensation . Requires assistance with bed mobility . Review of Resident #39's care plan, last revised 1/6/23, revealed: The resident is totally dependent on (1) staff for repositioning and turning in bed .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance . Every 1 hour safety checks. During an interview on 3/26/25 at 11:13 AM, Certified Nursing Assistant (CNA) #2 stated Resident #39 could push his/her call light but usually he/she will yell out for help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/25 at 11:36 AM, the Director of Nursing (DON) stated Resident #39 should have safety checks every hour and ensure call light is within reach. Review of the facility's policy Routine Resident Checks, last revised 7/2013, revealed: Staff shall make routine resident checks to help maintain resident safety and well-being . 1. To ensure the safety and well-being of our residents, nursing staff shall make a routine resident check at least once per each 8-hour shift. 2. Routine resident checks involve entering the residents' room and/or identifying if the residents' needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc . Further review of the policy revealed no procedure to ensure the call light was always within reach of the residents. Review of the facility policy Call Light Policy, last reviewed 12/2024, revealed: Purpose: To ensure that residents have a quick and effect[ive] way to request assistance and that staff respond in a timely and professional manner. All resident rooms are equipped with a call light system that allows residents to request assistance. A visual and/or audible signal will alert staff to the resident's request . Further review of the policy revealed no procedure to ensure the call light was always within reach of the residents. .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. . Based on record review, interview, and observation, the facility failed to ensure care plans were individualized to meet the communication needs for 1 resident (#34), out of 15 sampled residents. Specifically, the care plan failed to: 1) address how staff should communicate with this nonverbal resident; and 2) contain interventions that were individualized or resident-centered for Resident #34. This failed practice placed the resident at risk for not receiving the necessary interventions to attain the highest practicable physical, mental, and psychosocial well-being. Findings: Record review on 3/23-27/25 revealed Resident #34 was admitted to the facility with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a nontraumatic intracerebral hemorrhage (brain bleed) affecting the left non dominant side. Resident #34 was nonverbal with contractures of all limbs and hands and relied entirely on staff for every aspect of cares and interactions. During an interview on 3/24/25 at 9:23 AM, Resident #34's Power of Attorney (POA) stated Resident #34 was unable to move any part of his/her body. The POA expressed concern that staff may have been misinterpreting Resident #34's facial expressions and sounds as signs of pain, leading to regular administration of non-scheduled pain medication. The POA preferred non-medication interventions to manage the resident's pain before considering the use of medication. During an interview on 3/25/25 at 10:10 AM, Certified Nursing Assistant (CNA) #3 stated there was no written guidance on how to communicate with Resident #34 or guidance on how to know if Resident #34 was not well. CNA #3 stated, You would have to know her. When asked if Resident #34 was able to use a call light, the CNA stated the resident could not. Review of Resident #34's care plan, last revised on 5/14/24, revealed: The resident is (high) risk for falls r/t [related to] hemiplegia/hemiparesis of left side . with the following interventions: Be sure The resident's call light is within reach and encourage the resident to use [it] for assistance as needed . Further review of Resident #34's care plan did not address communication for Resident #34. During an interview on 3/27/25 at 11:52 AM, the Director of Nursing (DON) stated the care plans should be individualized for each resident. The DON stated communication should have been included for Resident #34. The DON stated Resident #34 could not use a call light because the resident was non-reactionary. She further stated call light interventions for Resident #34 should not be on the care plan. Review of the facility policy Care Plans, Comprehensive Person-Centered, revised on 3/2022, 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. . Based on observation, interview, and record review, the facility failed to update and revise the care plan for 2 residents (#'s 47 and 54), out of 15 sampled residents. Specifically, the facility failed to update and revise the care plans to reflect: 1) Discontinuation of contact barrier precautions and antibiotic medication use for Resident #47; and 2) Initiation of anticonvulsant (medication used to prevent or control seizures) medication use and discontinuation of enteral feedings (process of delivering nutrition directly into the gastrointestinal tract, usually through a tube, for individuals who cannot eat enough by mouth but have a functioning digestive system) for Resident #54. These failed practices placed the residents at risk for not receiving appropriate and/or accurate care and services. Findings: Resident #47 Record review on 3/23-27/25 revealed Resident #47 was admitted to the facility with diagnoses that included quadriplegia (paralysis of all four limbs), orthopedic aftercare following surgical amputation, and a stage 4 pressure ulcer of the sacral region (most severe type of bedsore with full-thickness skin and tissue loss with exposure of muscle, tendon, or bone located near base of the spine). Contact Precautions An observation on 3/23/25 at 10:25 AM, revealed a magnetic sign posted by Resident #47's doorway that stated, Enhanced Barrier Precautions [EBP]. During an interview on 3/23/25 at 12:10 PM, Licensed Nurse (LN) #1 stated EBP's were implemented for residents who had wounds or indwelling medical devices. Review of Resident #47's care plan, revised on 3/4/25, revealed: Focus .The resident has MRSA [Methicillin-resistant Staphylococcus aureus- a type of staph bacteria that is resistant to many antibiotics] infection to stage 4 pressure injury to coccyx . Goal .The resident's infection will resolve with minimal complications . Interventions .Contact Isolation: Wear gowns and masks when changing contaminated linens. Placed soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry . During an interview on 3/23/25 at 12:15 PM, LN #2 stated Resident #47 was not on contact precautions. Discontinuation of Doxycycline (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #47's care plan, revised on 3/4/25, revealed: Focus .The resident is on antibiotic therapy Doxycycline r/t [related to] MRSA to stage 4 pressure injury to coccyx . Goal . The resident will be free of any discomfort or adverse side effects of antibiotic therapy . Interventions . Administer antibiotic medications as ordered by physician . Review of Resident #47's Orders revealed Doxycycline Hyclate Oral Tablet 100 MG [milligram] with directions of: Give 100mg by mouth two times a day for MRSA for 10 days . with a start date of 3/3/25 and end date on 3/13/25. During an interview on 3/27/25 at 12:18 PM, the Director of Nursing (DON) stated that Resident #47 was not on contact precautions or on doxycycline. The DON further added that after the discontinuation of the medication, the resident would have been monitored for 48 hours after the last dose, and the care plan should have been updated. Review of the facility's policy Care Plans, Comprehensive Person-Centered, last revised 3/2022, revealed: . 11. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change . Resident #54 Record review on 3/23-27/25 revealed Resident #54 was admitted to the facility with diagnoses that included anoxic brain damage (damage to the brain caused by a complete lack of oxygen, which may lead to serious and permanent neurological problems) and unspecified convulsions (sudden, involuntary muscle contractions or movements of unknown cause or type). Anticonvulsant Medication Use Review of Resident #54's provider's orders revealed: Keppra (Levetiracetam - an anti-epileptic used to treat seizures) Oral Tablet 750 MG . Directions Give 1500 mg by mouth two times a day for seizure activity . Start Date 11/27/24 21:00 [9:00 PM]. Further review of the provider's orders revealed: Clobazam (a medication used to treat seizures) Oral Tablet 10 MG . Give 10 mg by mouth two times a day for ANTICONVULSANTS .Revision 9/11/2024 09:00 [9:00 AM] . Review of the electronic Medication Administration Record (eMAR), from 11/2024 to 3/2025, revealed Resident #54 had received Keppra oral tablet 750 mg since 11/27/24 and clobazam oral tablet 10 mg since 9/11/24 as ordered. Review of Resident #54's care plan revealed it did not include care planning for anticonvulsant medication use. During an interview on 3/27/25 at 11:36 AM, the DON confirmed Resident #54's anticonvulsant use was not included on the care plan but should have been. Discontinuation of Enteral Feedings (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 3/23-27/25 revealed that Resident #54 was admitted with a PEG tube (percutaneous endoscopic gastronomy tube - a feeding tube that is inserted through the abdominal wall into the stomach to provide nutrition, fluids and medications to individuals who cannot eat or swallow safely by mouth). Review of the Orders-Administration Note, dated 2/1/25 at 7:26 PM, revealed: Enteral Feed Order .no PEG. Review of Resident #54's Nurse's Note, dated 2/6/25 at 1:33 PM, revealed: New TO [telephone order] from [provider] for Peg site care every shift for peg tube care Remove old [gauze with] drainage. Cleanse peg-tube site with NS [normal saline], dry with gauze. Apply new drainage [gauze] with paper tape to secure. Due to removal of D/C [discontinue] promote [Fiber] Nutritional Supplementation. D/C order for meds given by peg tube as needed order. D/C [enteral] Feed orders. Updated all orders for peg tube. Review of Resident #54's written Physician's Orders paper slip, dated 2/6/25, revealed: Due to PEG tube removal D/C Promote [Fiber] Nutritional Supplementation. D/C Order for meds given by peg tube as needed order. D/C Enteral Feed orders. PEG site care: Remove old gauze [with] drainage, cleanse site with NS, dry with gauze. Apply new gauze [with] paper tape [and] secure. Review of Resident #54's General Surg[ery] Consult note, dated 2/10/25 at 7:01 PM, revealed: [Resident #54] was referred to surgery clinic for discussion of PEG tube removal. It was placed during a recent hospitalization .[on] 5/24[2024]. [He/she] is now eating well and [his/her] primary care providers feel that [he/she] could be ready for the tube to come out. Today [he/she] states that the tube fell out on its own 9 days ago. [He/she] has been eating well. The tube site has fully healed. Review of Resident #54's provider's order, dated 2/25/25 at 9:49 PM, revealed: Regular diet, 7 Regular/Easy to Chew texture, Thin/Regular consistency . Supervision. Cut all foods to bite size. Encourage dining room. Cue for small, single sips. Lipped plate at meals for intake Review of Resident #54's most current care plan, revised on 9/30/24, revealed: The resident requires tube feeding r/t [related to] physical deficits associated with anoxic brain damage . Q [every] Night Shift Tube Feeding: OPEN system bag or gravity feeding - Change feeding administration set and syringe daily. Label the formula container, syringe and administration set with date, time, and nurse's initials. During an interview on 3/27/25 at 11:36 AM, the DON stated that Resident #54 no longer had a PEG tube, and the care plan should have been updated. Review of the facility's policy Care Plans, Comprehensive Person-Centered, revised on 3/2022, 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 . 7. The comprehensive, person-centered care plan . e. reflects currently recognized standards of practice for problem areas and conditions . 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards. Specifically, the facility failed to: 1) Establish safety measures for proper cigarette disposal and the use of required adaptive devices, identified during smoking safety assessments, for residents who smoke tobacco on the facility's campus for 5 residents (#'s 9, 10, 21, 32, and 47), out of 7 total residents who smoked; 2) Complete annual smoking safety screening assessments for 4 residents (#'s 9, 21, 32, and 47), out of 7 total residents who smoked; 3) Complete smoking safety screening assessments for 3 residents (#'s 12, 25, and 54), out of 3 total residents who used electronic cigarettes (known as vapes); and 4) Secure lighters within the facility for 6 residents (#'s 9, 10, 21, 32, 47, and 53), out of 7 total residents who smoked. These failed practices placed all 9 residents at immediate risk of injury and/or death and placed all residents (based on a census of 60) at immediate risk for exposure to a smoke/fire environment which could have resulted in injury and/or death, which constituted an immediate jeopardy at CFR 483.25(d) Accidents. This situation was brought to the attention of the facility's administration on 3/26/25 at 1:30 PM, at which time the facility was notified of the identified immediate jeopardy. The facility submitted an acceptable removal plan on 3/26/25 at 6:17 PM. The State Agency verified onsite that the immediacy was removed on 3/26/25 at 8:30 PM. Following the removal of the immediacy, noncompliance remained at isolated actual harm that was not immediate. Findings: Campus Layout Observations on 3/23-27/25 revealed the facility campus was situated on a property with maintained grass around the front of the building within 6 feet of the entrances and within 1 foot of the building walls. Further observation revealed a rock border, with planted foliage, was positioned flush against the building's walls, which extended approximately one foot to the grass border and around the grass to the sidewalks that led to the entrances. The facility had two entrances, most often used, at the front of the building: the main entrance (which entered the main lobby of the building) and a secondary entrance (which entered a resident common space and dining room area for the facility). There was a third entrance as well, which lead directly into the hospice wing of the building. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surrounding the property, directly off the paved driveway, parking lot, and sidewalks of the building was tall, dry grass-like foliage and trees that were not maintained. It was observed that, due to the time of the year, this grass-like foliage was last year's growth and was yellow, dry and brittle in appearance. Further observation revealed no designated smoking area with a fire-proof receptable for cigarette butts on campus, nor was there any directly off the campus property. During an interview on 3/24/25 at 10:26 AM, the Director of Nursing (DON) stated the facility was a smoke-free facility and residents were to smoke off property. Facility Smoking Policy Review of the facility-provided smoking policy, received on 3/24/25, revealed: Smoking/Vaping Policy. Maple Springs is a smoke-free and vape-free campus. Smoking and vaping are not permitted on Maple Springs property. Employees and residents who wish to smoke or vape must do so off the property. There are no designated smoking times or locations. During an interview on 3/27/25 at 12:32 PM, the DON stated this smoking policy was signed by all residents upon admission. Tobacco Use During an interview on 3/26/25 at 1:52 PM, the DON stated when a resident was identified as a smoker, a smoking safety screening assessment was completed, and smoking interventions were placed in care plans. The DON further stated smoking safety screening assessments were to be completed annually. Resident #9 Record review on 3/23-27/25 revealed Resident #9 was admitted in the facility with diagnoses that included hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body), unspecified epilepsy (unprovoked seizures caused by abnormal electrical activity in the brain), GERD (gastric esophagial reflux disease) and major depressive disorder. Review of Resident #9's Smoking - Safety Screen (a screening assessment to determine if a resident was safe to smoke), revealed the resident was last assessed on 12/8/23. Further review revealed the resident had visual and dexterity problems and Resident #9 needed to use adaptive equipment of a smoking apron to smoke safely. An observation on 3/25/25 at 5:33 PM, revealed Resident #9 was smoking by the secondary entrance and was positioned by a handicapped parking space. Further observation revealed the resident was not wearing a smoking apron. Resident #9 was observed extinguishing his/her cigarette on the wheelchair's right wheel [NAME]. He/she discarded the cigarette by throwing it into the parking space. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation on 3/25/25 at 4:30 PM, outside, near the secondary entrance, revealed more than 200 cigarette butts, lying 6 feet from the right side of the entrance and 9 feet from the left side of the entrance, scattered on the grass and rock borders of the sidewalk to the entrance. Most of these butts were not flattened, or crushed, to indicate they were not extinguished prior to being discarded on the grass or rocks. Further observation revealed there was no fireproof receptacle in the vicinity to which cigarette butts could be deposited. Further observation revealed there was one non-fireproof trash can, with a lid that had a circular, uncovered hole at its center, with a non-fire proof black, plastic garbage bag in the trash can near the entrance. There was ignitable paper products within this trash can. Further observation revealed a sign on the entrance door Smoking on premises prohibited by law including vapes. Fine $50. Smokefree.alaska.gov AS [Alaska Statute] 18.35.301. During an interview on 3/26/25 at 10:10 AM, Resident #9 stated that he/she smoked nearly every day and that he/she kept his/her supplies (cigarettes and lighters) in the side pouch of his/her wheelchair or in his/her room. He/she stated that he/she usually smoked by the front of the main entrance or in front of the secondary entrance. Resident #9 stated that he/she put out his/her cigarette butts by extinguishing them on the wheelchair's control panel or on the wheelchair's [NAME]. He/she further stated he/she discarded the cigarettes by throwing them into the parking lot or the trash can by the entrances of the facility. Resident #9 stated that he/she had gotten burned before and proceeded to show two burn holes on the left side of the shirt he/she was wearing. He/she further stated that most of his/her clothing had these types of burn holes. Resident #9 further stated that he/she didn't like the apron because it flaps everywhere in the wind outside. Review of Resident #9's Behavior Note, dated 3/26/25 (the day the immediate jeopardy was issued), revealed: .Resident was smoking outside facility and somehow [his/her] fire fell off to [his/her] lap burning a hole in [his/her] jeans through to [his/her] brief and through the brief to [his/her] L [left] side scrotum. Small blister noted to skin, provider made aware as well . as nursing administration. Area dry without noted weeping, cleansed with soap and water LOA [left open to air]. Will evaluate area shift by shift to determine possible tx [treatment] options. Review of Resident #9's care plan, last revised 2/29/24, revealed: .Goal: The resident will not suffer injury from unsafe smoking practices through the review date . Interventions: Observe clothing and skin for signs of cigarette burns . resident safe to smoke without supervision as long as smoking apron is used when smoking. Resident #10 Record review on 3/23-27/25 revealed Resident #10 was admitted to the facility with diagnoses that included left leg below the knee amputation, type 2 diabetes, dementia, COPD (chronic obstructive pulmonary disease - a lung disease that blocks airflow making it difficult to breathe), and kidney disease. Review of Resident #10 Smoking - Safety Screen, dated 10/29/24, revealed the resident needed to use adaptive equipment of a smoking apron to smoke safely. Resident is able to get [himself/herself] outside to smoke on [his/her] own and can light [his/her] own cigarette to smoke. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview and concurrent observation on 3/26/25 at 9:25 AM, when asked about smoking, Resident #10 stated, I'm a smoker, and I've smoked here for longer than most people have worked here. I smoke outside and don't go with anyone. I put my cigarette butts in the trash can outside, there are several trash cans for that out there. I've never been told I can't smoke outside, but the staff have asked me to move away from the premises. I've also had problems getting back in the building because nobody would help me. I keep a full pack of cigarettes in my night drawer, but there's no lighter there. The doctor tells me I shouldn't smoke, but that's what I do. A full pack of [NAME] cigarettes was observed in the first drawer of the resident's nightstand. Review of Resident #10's care plan, last revised on 3/23/25, revealed: the resident is a cigarette smoker .will not suffer injury from unsafe smoking practices through the review date .interventions: instruct resident about smoking risks and hazards and about smoking cessation aids that are available; instruct resident about the facility policy on smoking: locations, times, safety concerns; notify charge nurse immediately if it is suspected resident has violated facility smoking policy; observe clothing and skin for cigarette burns; offer/encourage/assist resident with the use of smoking apron while smoking as resident allows; resident can smoke unsupervised; the resident is able to light own cigarette safely. Resident #21 Record review on 3/23-27/25 revealed Resident #21 was admitted to the facility with diagnoses that included hemiplegia and hemiparesis following a cerebral infarction (stroke that is caused by lack of blood flow to the brain) that affected the left non-dominant side, left above the knee amputation, and mild cognitive impairment. Review of Resident #21's Smoking - Safety Screen, revealed the resident was last assessed on 1/2/24. Further review revealed the resident had cognitive loss and Resident #21 needed to use adaptive equipment of a smoking apron to smoke safely. During an interview on 3/27/25 at 11:57 AM, the DON stated that all smokers in the facility should have a Smoking-Safety Screen completed annually. When asked if Resident #21's 2025 annual Smoking-Safety Screen was completed, the DON stated it was not. Resident #32 Record review on 3/23-27/25 revealed Resident #32 was admitted to the facility with diagnoses that included nontraumatic chronic subdural hemorrhage (a slow-developing collection of blood beneath the dura mater, the outermost layer of the brain's covering), dysphagia (difficulty swallowing), acute kidney failure, and repeated falls. Review of Resident #32's Smoking - Safety Screen, revealed the resident was last assessed on 1/2/24. Further review revealed the assessment indicated the resident was able to smoke safely independently. During an interview on 3/26/25 at 8:53 AM, Resident #32 stated he/she had been at the facility for about 5 years. He/she stated he/she smoked daily for the last 2 years here at the facility. Resident #32 stated he/she smoked outside by the handicap parking on the sidewalk in front of the building. Resident #32 stated staff have never told him/her he/she couldn't smoke on the facility's property. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	When asked how he/she deposited his/her cigarette butts, Resident #32 stated he/she crushed the butt and threw it into the trash can by the entrances to the building. Resident #32 further stated that other residents throw their butts all over the ground and residents have complained repeatedly to leadership about this and asked for a cigarette butt canister with sand in it. When asked how leadership had responded, Resident #32 stated leadership would not do it. An observation on 3/25/25 at 4:40 PM, outside near the main entrance, revealed more than 150 cigarette butts, lying 6 feet 8 inches from the right side of the entrance and 5 feet from the left side of the entrance, scattered on the grass and rock borders of the sidewalk to the entrance. Most of these butts were not flattened, or crushed, to indicate they were not extinguished prior to being discarded on the grass or rocks. Further observation revealed there was no fireproof receptacle in the vicinity to which cigarette butts could be deposited. Further observation revealed there was one non-fireproof trash bin, with a lid that had a circular, uncovered hole at its center, with a non-fire proof, black plastic garbage bag in the trash can. There was ignitable paper products within this trash can. Further observation revealed a sign on the entrance door Smoking on premises prohibited by law including vapes. Fine $50. Smokefree.alaska.gov AS 18.35.301. Resident #47 Record review on 3/23-27/25 revealed Resident #47 was admitted to the facility with diagnoses that included quadriplegia (paralysis of all four limbs), orthopedic aftercare following surgical amputation, stage 4 (deep wound that may impact muscle, tendons, ligaments and bone) pressure ulcer of the sacral region, unspecified neuromuscular dysfunction of the bladder, and GERD. Review of Resident #47's Smoking - Safety Screen, revealed the resident was last assessed on 1/19/24. Further review revealed the assessment indicated the resident had dexterity problems and Resident #47 needed to use adaptive equipment of a smoking apron and cigarette holder to smoke safely. Resident wears smoking apron and able to light up [his/her] cigarette independently and hold [his/her] cigarette his own as well . Resident is able to use electric wheelchair to ambulate outside and able to use holder to hold cigarette and light up cigarette [himself/herself]. An observation on 3/23/25 at 8:26 AM, as the survey team was entering the facility to initiate the survey, revealed Resident #47 sitting in his/her wheelchair approximately 15 feet from the main entrance of the building smoking a cigarette. Further observation revealed the resident had the cigarette between the tines of a plastic fork taped to the resident's hand brace. Further observation revealed no smoking apron was used. An observation on 3/25/25 at 4:40 PM, as surveyors were exiting the main entrance, revealed Resident #47 smoking approximately 20 feet directly in front of the entrance. Cigarette smoke entered the building on an incoming current of air from the outside as the sliding doors opened. Further observation revealed Resident #47 had the cigarette between the tines of a plastic fork taped to the resident's hand brace. Further observation revealed no smoking apron was used. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation on 3/25/25 at 8:05 AM revealed Resident #47 was smoking by the facility's emergency generator located off to the side of the secondary entrance. Further observation revealed the resident's cigarette was skewered on one of the tines of the plastic fork. He/she stated that he/she utilized the fork to keep the cigarette stable which was taped onto a small grey Velcro hand brace. Further observation revealed no smoking apron was used. Resident #47 further stated he/she declined using the smoking apron because the apron flaps in the wind. Resident #47 further stated it was very windy all the time. An observation on 3/26/25 at 8:20 AM, revealed Resident #47 was smoking by the facility's emergency generator located off to the side of the secondary entrance. Resident #47 was not wearing an apron, and the cigarette was lodged in the space between the tines of the plastic fork. During an interview on 3/25/25 at 3:15 PM, Resident #47 stated that he/she smoked daily. During a follow-up interview on 3/26/25 at 8:22 AM, Resident #47 stated that he/she kept his/her supplies in his/her own room by his/her nightstand. He/she stated he/she usually smoked by the front of the main entrance or by the secondary entrance where the generators were located. He/she extinguished and disposed of the cigarettes in his/her own ashtray that was located on the left side of his/her wheelchair. Resident #47 denied any injuries from smoking but further added due to his/her diagnoses, he/she waited on the wind to blow the cigarette ash away when it fell on his/her clothing. Review of Resident #47's care plan, last revised on 3/23/25, revealed: .Goal: The resident will not suffer injury from unsafe smoking practices through the review date . Interventions: .resident safe to smoke without supervision as long as smoking apron and cigarette holder is used when smoking . Smoking Aprons During an interview with a concurrent observation, on 3/26/25 at 2:52 PM, when asked how a resident could obtain a smoking apron, the MDS Nurse pulled a smoking apron from her desk drawer and stated residents would need to come to her office and ask for one. The MDS Nurse's office was in the main dining plaza area (by the secondary entrance). During an interview with a concurrent observation, on 3/26/25 at 2:57 PM, the receptionist stated she would be able to provide a smoking apron if a resident asked for one. The receptionist stated they were kept behind the receptionist's desk. She also stated if a resident from the second floor wanted to grab one on the way down, they could grab one from a drawer in the main plaza area by the elevator. Vapes Resident #12 Record review on 3/23-27/25 revealed Resident #12 was admitted to the facility with diagnoses that included type 2 diabetes, depression, chronic pain, atrial fibrillation (irregular heart rhythm), hepatic encephalopathy (brain dysfunction from liver failure) and alcoholic cirrhosis of the liver with ascites (liver scarring from alcohol with fluid buildup). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 3/26/25 at 9:08 AM, when asked about smoking, Resident #12 stated, I'd vape, but they (the facility) put me on a patch and weaned me off. I'd rather smoke indoors, but they won't let you. He/she said, Currently, I don't go out to smoke, but I have used the ashtrays by the front desk and another by the side door (referring to the trash cans outside). They just told me I had to stay away from the door. Resident #12 also stated that when he/she needed help getting back inside, he/she had to wait by the door (it locks if you go out). Otherwise, you just sit there and freeze in the winter. This happened to me about three or four months ago. Resident #12 also stated he/she does not currently have a vape in his/her room. Resident #12 stated that he/she vaped but no longer kept the vape in his/her room. He/she mentioned the doctor recently prescribed patches to help with smoking cessation, then discontinued the patch altogether. The resident further stated he/she, does not remember signing any waivers for smoking in the facility. Review of Resident #12's medical record revealed no smoking safety screening assessment. Review of Resident #12's care plan, last revised on 3/23/25, revealed: the resident is at risk for nicotine dependence r/t [related to] nicotine vape use. The resident will not suffer injury from unsafe vaping practices through the review date . interventions: instruct resident about smoking/vaping and hazards and about nicotine cessation aids that are available; instruct resident about the facility policy on smoking/vaping: locations, times, safety concerns; monitor oral hygiene; notify charge nurse immediately if it is suspected resident has violated facility smoking/vaping policy. Resident #25 Record review on 3/23-27/25 revealed Resident #25 was admitted to the facility with diagnoses that included paraplegia (paralysis of the lower half of the body), cellulitis of the lower limb (potentially serious bacterial skin infection), orthopedic aftercare following surgical amputation, and neuromuscular dysfunction of bladder (a condition where the bladder's ability to store and empty urine is impaired due to nerve damage or dysfunction). During an interview on 3/26/25 at 8:50 AM, Resident #25 stated that he/she quit smoking when he/she was admitted and switched to vape products. The resident stated that he/she usually went with his/her sister to the smoke shop to smoke. The resident further stated that he/she did not smoke while in the facility. The resident further added that his/her vaping products were kept near his/her nightstand. Review of Resident #25's medical record revealed no smoking safety screen assessment. Review of Resident #25's care plan, last reviewed 3/23/25, revealed: .Goal: The resident will not suffer injury from unsafe vaping practices through the review date .Interventions . Instruct resident about smoking/vaping risks and hazards and about smoking/nicotine cessations aids that are available . Instruct resident about the facility policy on smoking/vaping: locations, times, safety concerns . Notify charge nurse immediately if it is suspected resident has violated facility smoking/vaping policy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Food and Drug Administration article, Tips to Help Avoid Vape Battery Fires or Explosions, dated 4/12/23, at https://www.fda.gov/tobacco-products/products-ingredients-components/tips-help-avoid-vape-battery-fires-or-explosions, revealed: You may have heard that e-cigarettes, or vapes, can catch on fire or explode and seriously hurt people. Although these incidents are uncommon, vape fires and explosions are dangerous to the person using the vape product and others around them . The exact causes of fires or explosions are not yet clear, but some evidence suggests that battery-related issues may be a cause . Until all vapes and vape batteries conform to strong and consistent safety standards, your best protection against vape battery fires or explosions may be knowing as much as possible about your device and how to properly handle and charge its batteries . Charge your vape on a clean, flat surface, away from anything that can easily catch fire and someplace you can clearly see it - not on a couch or pillow where it may more easily overheat or get turned on accidentally . Protect your vape from extreme temperatures by not leaving it in direct sunlight . Don't vape around flammable gasses or liquids, such as oxygen . Make sure you know how to safely dispose of e-cigarettes . Resident #54 Record review on 3/23-27/25 revealed Resident #54 was admitted to the facility with diagnoses that included anoxic brain damage (damage to the brain caused by a complete lack of oxygen, which may lead to serious and permanent neurological problems), unspecified convulsions (sudden, involuntary muscle contractions or movements of unknown cause or type), alcoholic cirrhosis of the liver without ascites (chronic liver disease caused by excessive alcohol use where the liver becomes scarred and impairs liver function), and pulmonary hypertension (high blood pressure in the artery of the lungs that makes the heart work harder to pump blood and can lead to heart failure). Review of Resident's #54's care plan, last revised on 3/23/25, revealed: Focus .The resident is at risk for nicotine dependence r/t [related to] nicotine vape use .Goal .The resident will not suffer injury from unsafe vaping practices through the review date .Interventions . Instruct resident about smoking/vaping risks and hazards and about smoking/nicotine cessations aids that are available . Instruct resident about the facility policy on smoking/vaping: locations, times, safety concerns . Notify charge nurse immediately if it is suspected resident has violated facility smoking/vaping policy. Review of Resident #54's medical record revealed no smoking safety screening assessment. Review of Resident #54's Plan of Care Note, a late entry note effective 12/20/24 at 3:20 PM, but was created on 3/26/25 at 3:25 PM, revealed: CNA [Certified Nursing Assistant] brought to this writer's attention that Resident frequently goes outside with significant other to use [his/her] nicotine vape. This writer had discussion with resident and provided to education to resident about the risks of nicotine dependence and the option for nicotine cessation if [he/she] would like. Resident declines nicotine cessation at this time. During an interview on 3/26/25 at 1:26 PM, the DON stated that residents who vape should have smoking safety assessments performed. During an interview on 3/26/25 at 4:05 PM, the DON stated Resident #54 did not smoke or vape on admission. Resident #54 was observed on 12/20/24 to have family putting a cigarette to his/her lips during visits outside. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 3/27/25 at 11:36 AM, the DON stated Resident #54 should have had a smoking safety assessment performed earlier. Lighters in the Building During an interview on 3/26/25 at 1:52 PM, the DON stated that resident lighters were allowed to stay with the residents who smoked cigarettes. The DON stated the facility did not maintain accountability of these lighters because the facility was a smoke-free campus. Resident #9 Review of Resident #9's Smoking - Safety Screen, dated 12/8/23, revealed: . Does resident need facility to store lighter and cigarettes? Answer: No. During an interview on 3/26/25 at 10:11 AM, Resident #9 stated that his/her cigarettes and lighters were all self-purchased. He/she further stated that these were typically stored in the side pouch of his/her wheelchair and proceeded to show the pouch containing his/her cigarettes and 4 pocket style BiC (brand name) lighters. He/she also stated that there were extra lighters stored in his/her room. Resident #10 Review of Resident #10 Smoking - Safety Screen, dated 10/29/24, revealed: . Does resident need facility to store lighter and cigarettes? Answer: No. Resident #21 Review of Resident #21's Smoking - Safety Screen, dated 1/2/24, revealed: . Does resident need facility to store lighter and cigarettes? Answer: No. Resident #32 Review of Resident #32's Smoking - Safety Screen, dated 1/19/24, revealed: . Does resident need facility to store lighter and cigarettes? Answer: No. During an interview on 3/26/25 at 8:53 AM, Resident #32 stated he/she purchased his/her own cigarettes and lighters and has them hidden in his/her bedroom. Resident #47 Review of Resident #47's Smoking - Safety Screen, dated 1/19/24, revealed: . Does resident need facility to store lighter and cigarettes? Answer: No. An observation on 3/25/25 at 3:15 PM, revealed Resident #47's electric arc lighter and cigarettes were unsecured on his/her nightstand. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 3/25/25 at 3:16 PM, Resident #47 stated his/her cigarettes and lighters were all self-purchased. He/she further added these were usually stored by his/her nightstand or by the wheelchair for ease of access as he/she smoked daily. Resident #53 Review of Resident #53's Smoking - Safety Screen, dated 2/19/25, revealed: . Does resident need facility to store lighter and cigarettes? Answer: No. During an interview and concurrent observation on 3/26/25 at 9:27 AM, revealed Resident #53 indicated he/she kept his/her cigarette and lighters in his/her coat pocket. Resident #53 also indicated to the surveyor that he/she kept his/her coat in his/her wardrobe. While talking with Resident #53 an empty [NAME] cigarette pack was lying on the floor of Resident #53's room. Observations on 3/23-27/25 revealed the facility had 69 resident rooms. These rooms were unsecure an often the bedroom doors were left open and accessible to all current 60 residents of the facility. Resident room doors were left open when the residents who resided in them were elsewhere in the facility. Review of the MDS Resident Matrix (a form used to identify pertinent care categories during a survey), completed by the facility on 3/23/25, revealed 17 residents in the facility had some form of Alzheimer's or dementia (increasing the risk of exposure to unsecure lighters and introducing a smoke/fire environment within the facility). .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. . Based on observation and interview, the facility failed to ensure nursing staff had the appropriate skill sets to administer medications accurately for 1 resident (#8), out of 9 residents observed for medication administration. Specifically, the Licensed Nurse (LN) removed and administered a medication from a blister pack (a 30-day supply of medications in a card with bubbled packaging for individual doses of the medication) that was not labeled for the intended recipient. This failed practice placed the resident at risk for potential adverse outcomes of medication errors, or the possibility of running out of medications that were borrowed. Findings: Resident #8 Record review on 3/23-27/25 revealed Resident #8 was admitted to the facility with diagnoses that included unspecified injury at C1 level of cervical spinal cord, sequela (past injury at the top of the spinal cord in the neck that has resulted in long term or residual effects, such as weakness, paralysis, or other neurological impairments) and quadriplegia, unspecified (partial or complete paralysis of all four limbs, often caused by spinal cord injuries or diseases, without specifying the level of injury or the completeness of the paralysis) and GERD (Gastric Esophagial Reflux Disease). During a concurrent observation of medication administration and interview, on 3/26/25 at 7:41 AM, LN #3 stated Resident #8's scheduled pantoprazole (a proton pump inhibitor used to treat GERD) was not available so he/she would borrow the medication from someone else's blister pack. LN #3 then removed a pantoprazole tablet from a blister pack that was labeled for Resident #28. LN #3 then proceeded to administer it to Resident #8. LN #3 stated when a resident was out of a medication, he/she would see if he/she could borrow the medication from another resident that was also prescribed the same medication. When asked how the LNs would keep track of medications that were taken from another resident's blister pack, LN #3 stated he/she would tell the oncoming nurse so they could replace it once the medication was restocked, or he/she would give it back the next day if he/she were scheduled to work the next day. Review of Resident #8's physician's orders revealed: Pantoprazole Sodium Oral Tablet Delayed Release (Pantoprazole Sodium) Give 20 mg [milligrams] by mouth one time a day for GERD .Start Date .12/22/2023 09:00 [9:00 AM]. Review of Resident #28's physician's orders revealed: Pantoprazole Sodium Oral Tablet Delayed Release 20 MG (Pantoprazole Sodium) Give 1 tablet by mouth one time a day for GERD . Start Date . 3/30/2024 09:00. During an interview, on 3/26/25 at 2:41 PM, LN #4 stated he/she often worked as a charge nurse in the facility. When asked if it was appropriate to take medication from another resident's blister pack to administer it to another resident that was out of that same medication, LN #4 stated, Absolutely not. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/27/25 at 11:36 AM, the Director of Nursing (DON) stated nurses should not take medications from a resident's blister pack and administer it to another resident. Review of the facility's policy Administering Medications, revised 4/2019, revealed: 26. Medications ordered for a particular resident may not be administered to another resident . .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, record review, and interview, the facility failed to ensure: 1) concentrations of kitchen sanitizing solutions were maintained within acceptable parameters to ensure it adequately cleaned kitchen surfaces; and 2) concentrations of fruit and vegetable cleaning solution was maintained within acceptable parameters to ensure produce was appropriately cleaned prior to being served to residents. These failed practices created a potential for food borne illness and/or cross contamination for 57 residents who received food from the kitchen. Findings: Sink & Surface Cleaner Sanitizer An observation on 3/25/25 at 11:15 AM, revealed three red buckets that were labeled on the front that stated, Ecolab Sanitizing Solution Only. One bucket was located on the bottom shelf of the food preparation line table used by the cooks while plating meals, one was located by the dishwashing station, and one bucket was located by the food preparation sinks. During an interview on 3/25/25 at 11:25 AM, [NAME] #1 stated the red buckets contained a solution that was located by the dishwasher. He/she stated this solution was called, Ecolab SMARTPOWER Sink & Surface Cleaner Sanitizer. He/she further stated this solution was used to clean surfaces in the kitchen. [NAME] #1 stated the solution in the red buckets were to be changed .every hour . and when the solution was tested with the test strips, there was no log that documented when those tests were completed and/or the results of the tests. Review of Ecolab Sink & Surface Cleaner Sanitizer FAQ [Frequently Asked Questions], accessed at https://www.ecolab.com/offerings/sink-surface-cleaner-sanitizer, revealed the active ingredients in the solution were Dodecylbenzenesulfonic Acid (DDBSA) and Lactic Acid. When the mixed solution was tested, the recommended color on the test strip would be a dark to bright green color which indicated the target concentration of 272-700 ppm (parts per million) of DDBSA and [PHONE NUMBER] ppm of Lactic Acid. Further review revealed: .Are the ingredients approved for food-contact surface sanitizing? .all ingredients in Sink & Surface Cleaner Sanitizer have been reviewed .for use in food-contact surface sanitizing solutions and are approved for use on food-contact surfaces . Review on 3/25/25 of the Ecolab Sink & Surface Cleaner Sanitizer Test Strip used by the facility, with an expiration date of November 2026, revealed the following instructions: .Immerse the test strip in sample for 5 seconds. Excess sample should be shaken off of strip .Evaluate the color 10 seconds after removing the test strip from the sample .Match the center of the test strip pad to the color chart to determine concentration . During an interview on 3/25/25 at 11:49 AM, [NAME] #2 stated that the buckets were to be changed .every two hours . He/she further added that it was tested intermittently but there was no log that could be reviewed for times when tested or the results of the tests. (continued on next page)

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	025039	A. Building B. Wing	03/27/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/26/25 at 7:40 AM, Dietary Aide (DA) #2 stated that the buckets were to be changed . every two hours . and further added that the test strips were used to check the concentration level. He/she stated that it was checked when the buckets were made. DA #2 stated that the results were not logged. Sanitation Bucket by Food Preparation Line An observation on 3/25/25 at 11:49 AM, revealed [NAME] #2 used the red sanitizing bucket's solution to clean a kitchen knife that was being utilized to chop food on the line for the lunch service. Review of the test strip results, on 3/25/25 at 11:51 AM, of the red sanitizing bucket used by [NAME] #2, revealed a bright blue color. According to the Sink & Surface Cleaner Sanitizer Test Strip color chart located on the test strip kit, a bright to dark blue color would be indicative of 0-170 ppm DDBSA and 0-452 ppm Lactic Acid (below the required target concentration level). During an interview 3/25/25 at 11:52 AM, [NAME] #1 stated that the red sanitizing bucket was last replaced an hour ago. Sanitation Bucket by the Dishwashing Station An observation on 3/25/25 at 12:07 PM, revealed DA #3 used the red sanitizing bucket's solution to clean a black, wheeled cart from the kitchen. DA #3 washed down the handles and surfaces of the cart. Review of the test strip results, on 3/25/25 at 12:08 PM, of the red sanitizing bucket used by DA #3, revealed a bright blue color (which was below the required target concentration level). Sanitation Bucket by the Food Preparation Sinks An observation on 3/25/25 at 4:32 PM, revealed [NAME] #3 stated the red sanitizing buckets on the line and by the preparation sink, was just changed, and [NAME] #1 stated, about 30 or so minutes ago. Review of the test strip results on 3/25/25 at 4:33 PM, revealed a bright blue color, which was again below required target concentration level. During a follow up interview on 3/26/25 at 1:05 PM, the Kitchen Manager (KM) attempted to try to test the solution that was labeled, Ecolab SMARTPOWER Sink & Surface Cleaner Sanitizer and found that the container of the solution was empty. He then replaced the solution, instructed staff in the vicinity to monitor, and change accordingly. An observation on 3/26/25 at 1:07 PM, DA #1 came back to the kitchen with a red sanitizing bucket which he/she stated was just made 30 minutes ago. When asked what the red sanitizing bucket was used for, DA #1 stated it was used to wipe the table surfaces in the main dining room. The solution in the bucket was tested with the Sink & Surface Cleaner Sanitizer Test Strips and the result was a bright blue color which indicated it was below the target concentration level. The KM then instructed DA #1 to throw away the solution in the bucket. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/27/25 at 9:33 AM, the KM stated the sanitation solution .should be changed every two hours or when visibly soiled . Review of a wall poster next to the ECOLAB dispensing device in the kitchen, on 3/25/25 at 10:30 AM, revealed the device was identified as an Ecolab SMARTPOWER Sink & Surface Sanitizer. The poster indicated to use Ecolab SMARTPOWER Sink & Surface Cleaner test strips to test the concentration levels of sanitation solution. The poster indicated the sanitation solution should be tested at or above room temperature of 65 degrees F [Fahrenheit], and the test paper strip should be placed in solution for 5 seconds, and the acceptable range for sanitation solution concentration is .between 272-700 ppm DDBSA and [PHONE NUMBER] ppm Lactic Acid . Review of facility's Sanitation Bucket Policy, undated, revealed: .Purpose .the policy establishes procedures for maintaining and using sanitation buckets to prevent cross-contamination and effectiveness to ensure a safe and sanitary environment . The sanitizer solution must be changed every two (2) hours or sooner if it becomes visibly soiled . A test strip should be used to verify that the sanitizer concentration is within the appropriate range as per manufacturer guidelines .Supervisors or designated personnel will perform routine checks to ensure compliance with this policy .Any non-compliance must be reported and corrected immediately . Antimicrobial Fruit & Vegetable Treatment An observation on 3/25/25 at 11:18 AM, revealed a produce wash solution dispenser labeled, Ecolab Antimicrobial Fruit & Vegetable Treatment to the right side of the food preparation sinks. It was also observed that there were test strips on top of the dispenser, and it was noted that a blue water pipe was on the right side of the dispenser with a water line connecting to the dispenser. During an interview on 3/25/25 at 11:25 AM, [NAME] #1 stated this solution was used to wash produce prior to being prepared and served to the residents. Review on 3/26/25 of the Ecolab Antimicrobial Fruit & Vegetable Treatment Test Strip, used by the facility, with an expiration date of February 2026 and November 2026, revealed the following instructions: .Immerse the strip in sample .Evaluate the color .Match the center of the test strip pad to the color chart to determine Antimicrobial Fruit & Vegetable Treatment concentration . Further review of the Antimicrobial Fruit & Vegetable Treatment Test Strip, revealed the manufacturer's target result for recommended concentrations was a green color, and the manufacturer indicated on the bottom of the green color that this result had a dilution ratio (a proportion of the solution's concentration to water) of 1:170. During an observation and concurrent interview, on 3/26/25 at 12:55 PM, the KM tested the running solution of the Ecolab Antimicrobial Fruit & Vegetable Treatment, straight from the dispenser with a test strip. The test strip's color result was bright blue with a dilution ratio of 0, according to the test strip kit. The KM stated a bright blue color result meant that the Antimicrobial Fruit & Vegetable Treatment solution was not at the recommended concentration per the manufacturer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The KM tested the dispensed solution three more times and received the same color result. Afterwards, the KM looked underneath the sink and realized that the produce wash solution was empty. He then replaced the empty container with a new container of Antimicrobial Fruit & Vegetable Treatment solution. The KM tested the solution again, which resulted in bright blue. This result was identical to all the previous results. Next, the KM opened the dispenser to troubleshoot and upon inspection, he stated that he believed there was air in the line which was preventing the solution from dispensing. The KM further stated that there were no logs kept for testing the solution to ensure the proper concentration of the produce wash solution was completed. He stated that he would periodically come in during each dining service to test the solution for compliance. He further added that an Ecolab technician came in every one to one and a half months to conduct maintenance on the Ecolab products to include the produce wash solution dispenser. During an interview on 3/26/25 at 3:35 PM, the KM stated the vegetable wash dispenser is working properly and was serviced by an Ecolab technician. He stated the technician found the motor was not properly functioning, which caused the solution to not cycle through the dispenser. During an interview on 3/27/25 at 3:29 PM, the KM was asked if the facility had a policy or process to monitor the solution. He deferred to the Maintenance Director, who stated that staff should be following the manufacturer's wall poster located on the kitchen wall to the left of the preparation sink. Review of a facility poster Ecolab Antimicrobial Fruit & Vegetable Treatment, undated, revealed: . Periodically check wash solution for proper concentration . use test strip or test kit supplied . .

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. . Based on observation and interviews, the facility failed to ensure state laws were followed regarding posting variance decisions. Specifically, the facility failed to ensure variance decisions were displayed in a conspicuous location where the posting could be readily viewed. This failed practice violated 7 Alaska Administrative Code (AAC) 10.940 and denied all residents (based on a census of 60) and resident representatives the right to the knowledge of criminal history of facility employees. Findings: Random observations on 3/23/25, revealed there were no visible variance decision postings in areas that were readily accessible to residents and/or the public throughout the facility. During an interview and concurrent observation on 3/25/25 at 3:31 PM, when asked about the location of the variance decision posting, the Human Resource (HR) Director pointed out its location on a wall beside the office supply shelves, which were located at the end of a back hallway by the Administration offices (which consisted of, but not limited to, the Administrator and Human Resource offices). Access to this location was restricted to either walking behind the receptionist's desk or through a conference room. When asked if this location by the office supply shelves was conspicuous and open to the public, she stated that it was. During an interview on 3/25/25 at 5:13 PM, the Director of Nursing (DON) stated the variance decision posting, located near the office supply shelves was not accessible to the public. During an interview on 3/26/25 at 1:57 PM, the HR Director stated the variance decision posting was relocated to a wall in the main plaza area by the dining room entrance. Review of 7 AAC 10.940, accessed at https://www.akleg.gov/basis/aac.asp#7.10.940, and effective 6/29/17, revealed: Posting of variance decision required . if the department grants a variance under 7 AAC 10.935, the provider shall post a copy of the variance decision with the copy of the license, certification, approval, or finding of eligibility to receive payments. The posting must be in a conspicuous place where the copy of the variance can be readily viewed by persons interested in obtaining the services offered by the provider . .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a sanitary environment to help prevent the development of infections. Specifically, the facility failed to ensure: 1) Suction tubing and a yankauer tip (a hard plastic handle, placed on the suction tubing, with a rounded, open tip for suctioning in a resident's mouth) remained clean and sanitary for 1 resident (#29), out of 15 sampled residents; and 2) A urinary catheter (a medical device that helps drain urine from the bladder) bag was hung in a manner to remain clean and sanitary for 1 resident (#55), out of 14 residents with catheters. These failed practices placed the residents at risk for infection which could have affected his/her overall health and wellbeing. Findings: Resident #29 Record review on 3/23-27/25 revealed Resident #29 was admitted to the facility with diagnoses that included central pontine myelinolysis (a neurological condition involving severe damage to the myelin sheath of nerve cells in the [NAME], characterized by acute paralysis, dysphagia [difficulty swallowing], dysarthria [difficulty speaking] and other neurological symptoms), contractures (an abnormal and usually permanent shortening of a muscle, resulting in distortion or deformity; stiffness of the joints that causes deformity and prevents full extension), and muscles spasms. An observation on 3/24/25 at 10:42 AM, revealed a suction canister on Resident #29's wall, hooked up to the suction valve of the facility, with 500 milliliters (mL) of a light brown liquid (in an 1100 mL container). Further observation revealed the suction canister's tubing was looped around the canister with the yankauer suction tip attached to the tubing. The tubing had brown colored staining throughout the inside of the tubing and the yankauer tip was not covered and was touching the wall. An observation on 3/26/25 at 10:02 AM, of Resident #29's suction canister and tubing, revealed it was in the same state as originally observed. The canister was still holding 500 mL of light brown liquid and the tubing and yankauer was hung in the same position and condition. During an interview on 3/26/25 at 12:00 PM, the Infection Preventionist (IP) stated tubing for oxygen and suction canisters was changed monthly. The IP further stated the tubing should also be changed when soiled and nurses could change this when needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When informed of Resident #29's suction tubing condition, the IP stated the expectation would have been to change the tubing when soiled and should have been changed. When asked about how the yankauer tip of the suction tubing should be stored, the IP stated the yankauer should be kept in the packaging it came in or stored in a canister of water. When told the yankauer was unpackaged and touching the wall, the IP stated this was not a standard used in the facility. When asked when the last time Resident #29's suction tubing and yankauer were changed, the IP stated it was changed on 3/7/25. Review of the facility policy Suctioning the Upper Airway (Nasopharyngeal [upper part of the throat behind the nose] or Oropharyngeal [middle part of the throat behind the mouth] Suctioning), last revised 2024, revealed: . Oropharyngeal suctioning is performed using aseptic technique [any health care procedure in which added precautions, such as the use of sterile gloves and instruments, are used to prevent contamination of a person, object, or area by microorganisms]. Suction tubing and yankauer should be replaced every 7 days or when visibly soiled . Resident #55 Record review on 3/23-27/25 revealed Resident #55 was admitted to the facility with diagnoses that included quadriplegia (paralysis of all four limbs), cerebral palsy (a neurological condition that affected muscle movement and development), neuromuscular dysfunction of the bladder (a condition where the bladder's ability to store and empty urine was impaired due to nerve damage or dysfunction), and major depressive disorder. An observation on 3/23/25 at 9:48 AM, revealed Resident #55 had a urinary catheter. During this observation, it was noted the drainage bag was on the floor. During an interview on 3/23/25 at 12:10 PM, Licensed Nurse (LN) #1 stated urinary catheters were assessed each shift. He/she further stated this could include the positioning of the bag and also ensured that it was free of kinks. LN #1 also stated drainage bags were usually positioned on the side of the resident's bed to ensure it was below the bladder and should not be positioned on the floor. During an interview on 3/25/25 at 8:30 AM, Certified Nursing Assistant (CNA) #1 stated drainage bags should not be on the floor. He/she further stated if the resident preferred to have the bed lowest position, closest to the floor, where it would have caused the drainage bag to hit the floor, a basin must be placed underneath. During an interview on 3/26/25 at 12:07 PM, the IP and the Director of Nursing (DON) stated a drainage bag on the floor would be an infection control concern and it should not be placed on the floor. Review of the facility's policy Catheter Care, Urinary, last revised August 2024, revealed: . Use aseptic technique when handling and manipulating the drainage system .Be sure the catheter tubing and drainage bag are kept off the floor . .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. . Based on observation, record review, and interview, the facility failed to ensure a produce wash solution dispenser was in operating condition. This failed practice placed 57 residents that received food from the kitchen at risk for foodborne illnesses and communicable diseases from subquality cleaning of fresh produce. Findings: An observation on 3/25/25 at 11:18 AM, revealed a produce wash solution dispenser labeled, Ecolab Antimicrobial Fruit & Vegetable Treatment to the right side of the food preparation sinks. It was also observed that there were test strips on top of the dispenser, and it was noted that a blue water pipe was on the right side of the dispenser with a water line connecting to the dispenser. During an interview on 3/25/25 at 11:25 AM, [NAME] #1 stated this solution was used to wash produce prior to being prepared and served to the residents. Review on 3/26/25 of the Ecolab Antimicrobial Fruit & Vegetable Treatment Test Strip, used by the facility, with an expiration date of February 2026 and November 2026, revealed the following instructions: .Immerse the strip in sample .Evaluate the color .Match the center of the test strip pad to the color chart to determine Antimicrobial Fruit & Vegetable Treatment concentration . Further review of the Antimicrobial Fruit & Vegetable Treatment Test Strip, revealed the manufacturer's target result for recommended concentrations was a green color, and the manufacturer indicated on the bottom of the green color that this result had a dilution ratio (a proportion of the solution's concentration to water) of 1:170. During an observation and concurrent interview, on 3/26/25 at 12:55 PM, the KM tested the running solution of the Ecolab Antimicrobial Fruit & Vegetable Treatment, straight from the dispenser with a test strip. The test strip's color result was bright blue with a dilution ratio of 0, according to the test strip kit. The KM stated a bright blue color result meant that the Antimicrobial Fruit & Vegetable Treatment solution was not at the recommended concentration per the manufacturer. The KM tested the dispensed solution three more times and received the same color result. Afterwards, the KM looked underneath the sink and realized that the produce wash solution was empty. He then replaced the empty container with a new container of Antimicrobial Fruit & Vegetable Treatment solution. The KM tested the solution again, which resulted in bright blue. This result was identical to all the previous results. Next, the KM opened the dispenser to troubleshoot and upon inspection, he stated that he believed there was air in the line which was preventing the solution from dispensing. The KM further stated that there were no logs kept for testing the solution to ensure the proper concentration of the produce wash solution was completed. He stated that he would periodically come in during each dining service to test the solution for compliance. He further added that an Ecolab technician came in every one to one and a half months to conduct maintenance on the Ecolab products to include the produce wash solution dispenser. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/26/25 at 3:35 PM, the KM stated the vegetable wash dispenser is working properly and was serviced by an Ecolab technician. He stated the technician found the motor was not properly functioning, which caused the solution to not cycle through the dispenser. During an interview on 3/27/25 at 3:29 PM, the KM was asked if the facility had a policy or process to monitor the solution. He deferred to the Maintenance Director, who stated that staff should be following the manufacturer's wall poster located on the kitchen wall to the left of the preparation sink. Review of a facility poster Ecolab Antimicrobial Fruit & Vegetable Treatment, undated, revealed: . Periodically check wash solution for proper concentration . use test strip or test kit supplied . .