

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2026
NAME OF PROVIDER OR SUPPLIER Maple Springs of Palmer		STREET ADDRESS, CITY, STATE, ZIP CODE 12130 East Maple Springs Way Palmer, AK 99645	
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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview, and record review, the facility failed to ensure: 1) drugs and biologicals used in the facility were properly labeled; and 2) removed medications and supplies when expired in 3 medication carts, out of 5 total carts, and 1 medication room, out of 2 storage rooms inspected. Specifically, the facility failed to: 1) label opened glucometer test-strip containers used in four units (Willow, Susitna, Denali, and [NAME]); and 2) remove expired medications and supplies from three medication carts ([NAME], Denali, and Susitna) and one medication room ([NAME] Pass). These failed practices: 1) placed 13 residents (#'s 4, 7, 10, 11, 15, 18, 23, 24, 25, 31, 36, 44, and 46) at risk of inaccurate blood glucose results that could contribute to delayed or inappropriate treatment decisions; and placed all residents (based on a census of 43) at risk for receiving expired and ineffective medications or supplies, placing residents at risk of adverse drug reactions. Findings:Undated Opened Glucometer Test-Strip Containers Random observations with concurrent interviews on 8/12/26, revealed opened glucometer test-strip containers without opened dates labeled were found on multiple nursing unit medication carts: At 3:15 PM on the [NAME] unit, one opened glucometer test-strip container without a labeled open date. Certified Nursing Assistant (CNA) #1 stated the containers were normally labeled with the date opened and he/she would expect the date to be documented on the packaging; At 3:24 PM on the Susitna unit, one opened glucometer test-strip container without a labeled open date. CNA #2 stated he/she thought the container should have been labeled and confirmed he/she could not verify the date the strips were opened; At 3:25 PM on the Denali unit, two opened glucometer test-strip containers without labeled open dates. Licensed Nurse (LN) #3 stated the containers should have been labeled when opened and confirmed he/she did not see a label; and At 3:46 PM on the [NAME] unit, one opened glucometer test-strip container without a labeled open date. CNA #3 stated he/she could not identify the date the container was opened and stated he/she believed it should have been labeled. During an interview on 8/13/26 at 1:18 PM, the Director of Nursing (DON) stated the facility expected glucometer quality-control checks to be completed daily, including when a new container of test strips or quality-control solution was opened. When asked whether staff were expected to label glucometer test-strip containers when opened, the DON stated, Yes, the container should be labeled with the date, time, initials, and the date it was opened. The DON stated whoever opened the container was responsible for labeling it. The DON further stated the nightshift charge nurse was responsible for auditing medication carts, look for expiration dates, and glucometer strips. Review of the facility-provided manufacturer's guide EvenCare G2 Blood Glucose Monitoring System Healthcare Professional Operator's Manual, undated, revealed: . In Service Training. 2. Be familiar with the EvenCare G2 test strip bottle and location of the (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	lot number, expiration date, and control solution ranges. and staff were instructed EvenCare G2 Control Solution Testing, to check the expiration date printed on the test-strip bottle, not use expired test strips, and record the date opened on the bottle label. The manufacturer's guide further instructed that the bottle and remaining test strips be discarded six months after the date of opening. Review of the facility's policy Obtaining a Fingerstick Glucose Level, last revised 12/2025, revealed staff were to: .4. Ensure that the equipment and devices are working properly by performing any calibrations or checks as instructed by the manufacturer or facility. The procedure further directed staff to use test strips before their expiration date and not use test strips that were wet, bent, or otherwise damaged. Expired Medications and/or Supplies An observation on 8/11/26 at 11:52 AM, revealed the [NAME] Pass nurses' station medication room contained the following expired items: 1) 34 packets- Curad (brand) triple antibiotic ointment, expired on 4/2026;2) five- 92-inch IV (intravenous) administration sets, expired on 8/6/2026;3) one- EnteraFlo (brand) gastrostomy feeding tube (tube that provides direct access to the stomach for nutrition, fluids, and medications), 22FR (French), expired on 8/9/26; and4) one- EnteraFlo gastrostomy feeding tube, 16FR, expired on 6/27/26. During an interview on 8/11/26 at 12:43 PM, LN #1 verified the identified items were expired. An observation on 8/11/26 at 1:47 PM, revealed the [NAME] medication cart contained the following expired items: 1) one- Medihoney (medical grade honey product that supports wound healing) Gel, 1.5 fluid ounces, expired on 9/1/25;2) five packets- We Care (brand) Hydrocortisone Cream 1%, 0.9 grams, expired on 7/2026; and3) three- 5-mL (milliliter) saline bullets (single-use vials), expired on 6/2026. During an interview on 8/11/26 at 1:51 PM, LN #2 verified the identified items were expired. An observation on 8/11/26 at 2:10 PM, revealed the Denali medication cart contained the following expired items: 1) two- packages of lubricating jelly, 0.9 ounces, expired on 10/31/25; and2) one packet- of antibacterial ointment expired on 4/2026. During an interview on 8/11/26 at 2:10 PM, LN #3 verified the identified items were expired. An observation on 8/11/26 at 2:27 PM, revealed the Susitna medication cart contained the following expired item: 1) one- BD (brand) 1-mL syringe, expired on 2/28/23. During an interview on 8/14/26 at 2:28 PM, LN #4 verified the identified item was expired. During an interview on 8/12/26 at 9:17 AM, the DON was asked how the facility identified and removed expired medical supplies from medication rooms and carts. The DON stated charge nurses on night shift completed monthly audits of medications and supplies. The DON stated staff may have focused more on medications and forgotten other supplies, including products such as bacitracin. The DON further stated the person responsible for ordering tracked lot numbers and upcoming expiration dates was also responsible for sending internal messages to staff regarding items approaching expiration so they could be identified and removed. The DON stated, obviously that did not happen this time. When asked whether expired items should ever be present in medication rooms or carts, the DON stated, No. Review of the facility policy Medication and Medical Supply Storage and Labeling, last revised 6/2026, revealed the facility required medications and supplies to be clearly and accurately labeled, rotated to remain within their expiration dates, and removed from use when discontinued, outdated, deteriorated, or compromised. The policy further required medications and medical supplies to be rotated on a first-in, first-out basis and storage areas to be checked on a scheduled basis for expired, deteriorated, or damaged items. The policy required expired or compromised medical supplies to be removed and discarded according to facility procedure. The policy also required point-of-care testing supplies, including test strips, to be stored clean and dry, maintained within their expiration dates, and stored according to manufacturer instructions		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to maintain complete and accurately documented medical records for 2 of 2 sampled residents (#s 32 and 40), and 2 of 2 unsampled residents (#'s 6 and 30), reviewed for Advance Directive (AD - A written instruction, such as a living will or durable power of attorney for health care, recognized under State law, that relates to the provision of health care when the individual is incapacitated) and Physician Orders for Life-Sustaining Treatment (POLST - a medical order that communicated a patient's wishes for emergency and end-of-life care) documentation. Specifically, the facility failed to ensure material differences between residents' documented treatment preferences in their ADs and POLSTs were identified and clarified in the medical record and failed to ensure staff accurately documented whether an AD had been reviewed when completing a POLST. This failed practice resulted in residents' medical records containing inaccurate and/or unreconciled treatment-preference information and placed the residents at risk for staff relying on inaccurate or incomplete information when making healthcare decisions. Findings:Resident #6 Review of Resident #6's AD, dated [DATE], revealed the resident selected an option directing that artificial nutrition and hydration be provided indefinitely unless it clearly increased the resident's suffering and was no longer in the resident's best interest. Review of Resident #6's POLST, dated [DATE], revealed the section for medically assisted nutrition documented: No decision made (standard of care provided). Further review of the POLST revealed the physician signed the document; however, the physician did not date the signature as required by the POLST form. Review of Resident #6's medical record revealed there were no revised POLST forms after [DATE] when the resident's AD was completed. During an interview on [DATE] at 11:30 AM, Licensed Nurse (LN) #1 reviewed Resident #6's POLST and confirmed his/her signature on the document. When discussing the section indicating the resident's AD had been reviewed to confirm there was no conflict with the POLST orders, LN #1 stated he/she did not believe Resident #6 had an AD at the time of admission and stated, I probably did that wrong. Resident #30 Review of Resident #30's AD, dated [DATE], revealed individualized instructions: It is my intent that artificial nutrition and hydration be part of comfort care. and not as a means of artificially extending life. Review of Resident #30's POLST, dated [DATE], revealed: No decision made (standard of care provided) was selected for medically assisted nutrition. Resident #32 Review of Resident #32's AD, dated [DATE], revealed: . END-OF-LIFE DECISIONS. Except to the extent prohibited by law, I direct my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below. Choice Not To Prolong Life. I want comfort care only and I do not want my life to be prolonged with medical treatment if, in the judgement of my physician. Further review of the AD revealed the resident selected an option indicating he/she did not wish to receive artificial nutrition and hydration. Review of Resident #32's POLST, dated [DATE], revealed: YES CPR: Attempt Resuscitation including mechanical ventilation, defibrillation and cardioversion. Full Treatments. Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care . was selected under Section A. Further review of the POLST revealed No decision made was selected for medically assisted nutrition. Resident #40 Review of Resident #40's AD, dated [DATE], revealed the resident selected an option indicating he/she wished to receive artificial nutrition and hydration indefinitely. Review of Resident #40's POLST, dated [DATE], revealed No decision made (standard of care provided). (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care provided) was selected for medically assisted nutrition. Further review of Resident #40's POLST revealed Advance directive not available was selected. Facility Process During an interview on [DATE] at 11:30 AM, LN #1 stated he/she completed POLST forms with residents during the admission process. LN #1 stated the POLST contained a section indicating whether the resident's AD had been reviewed to confirm there was no conflict with the POLST orders. LN #1 stated, I used to always check 'yes,' and now I'm not doing that because I don't have access to the Advance Directive. I shouldn't have been checking that. During an interview on [DATE] at 12:45 PM, the Resident Advocate (RA) stated she assisted residents with ADs but did not complete POLST forms. When asked whether she reviewed the POLST and AD to ensure the documents accurately reflected the resident's treatment wishes, the RA stated, I haven't been. I haven't been looking at the POLST. The RA stated she relied on information documented in PointClickCare (PCC - the facility's electronic charting system), which she believed reflected the POLST. When asked who was responsible for ensuring residents' POLSTs and ADs accurately reflected the residents' wishes, the RA stated she performed that review occasionally but did not know whether there was someone specifically responsible for reviewing all residents' documents. During an interview on [DATE] at 1:00 PM, the Director of Nursing (DON) stated responsibility for ensuring residents' ADs, POLSTs, physician orders, care plans, and other treatment-preference documentation were accurate and consistent was shared among staff who cared for the residents. The DON stated that, regarding quarterly AD and POLST reviews, she relied primarily on the RA. When asked about the facility's process for identifying and correcting conflicting or inconsistent AD and POLST information, the DON stated the IDT meeting should be the primary location where differences were identified and corrected. After reviewing an example in which an AD contained a specific artificial nutrition and hydration decision while the POLST documented that no decision had been made, the DON acknowledged there was a discrepancy between the documents. Review of the facility's policy Advance Directives, revised 11/2025, revealed: . 1. If the resident or resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff.2. The director of nursing services (DNS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident's medical record and plan of care.3. The resident's wishes are communicated to the resident's direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the resident's wishes in care planning meetings.4. The plan of care for each resident is consistent with their documented treatment preferences and/or advance directive. 10. The interdisciplinary team will review annually with the resident their advance directives to ensure such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record. The interdisciplinary team will be informed of changes and/or revocations so that appropriate changes can be made in the resident's medical record and care plan. The policy defined a POLST as: . a form designed to improve patient care by creating a portable medical order form that records the resident's treatment wishes so emergency personnel know what treatments the resident wants in the event of a medical emergency, taking the resident's current medical condition into consideration. A POLST paradigm form is not an advance directive. Review of the facility's policy Do Not Resuscitate Order, revised 11/2025, revealed: . The interdisciplinary care planning team will review advance directives with the resident during annual care planning sessions to determine if the resident wishes to make changes in such directives.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. .Based on record review and interview, the facility failed to ensure a resident was provided the right to be informed in advance, by the physician or other professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred for 1 resident (#7), out 13 residents reviewed for informed consent and psychotropic medication use. Specifically, the facility failed to obtain and document informed consent before Duloxetine (an antidepressant used to treat depression, anxiety, nerve pain, and certain chronic pain conditions) was initiated. This failed practice denied the resident and/or resident representative the opportunity to be informed of the medication's intended benefit, potential risks and side effects, available alternatives, and the option to accept or refuse the treatment. Findings:Record review on 8/10-14/26 revealed Resident #7 was admitted to the facility with diagnoses that included unspecified anxiety disorder, unspecified depression, and chronic pain. Review of Resident #7's physician orders revealed an order for Duloxetine HCl (Hydrochloride) 30 milligrams (mg). The medication record showed Duloxetine was initiated on 4/15/26, subsequently discontinued and then reordered, and remained active as of 7/8/26. During an interview on 8/13/26 at 3:00 PM, the Director of Nursing (DON) stated there was no informed consent for Resident #7's Duloxetine, and further stated, We are working on it now. Review of the facility-provided policy Informed Consent, last revised 6/2026, revealed: .It is the policy of Maple Springs that no treatment, procedure, or service requiring informed consent is initiated without the informed consent of the resident, or of the resident's representative. Each resident has the right to be informed, in language he or she can understand.in advance, by the physician or other practitioner or professional, of the risk and benefits of proposed care, of treatment and treatment alternative options, and to choose the option he or she prefers. Further review of the policy revealed psychotropic medications as care, required documented informed consent before initiation. The policy further directed that, before initiating a psychotropic medication, the prescriber or designee must discuss the target symptom or condition, intended benefit, potential risks and side effects, and available alternatives with the resident or representative, and must obtain and document informed consent		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. .Based on record review and interview, the facility failed to ensure the resident and/or resident representative (RR) were able to exercise their right to participate in the development and revision of the person-centered plan of care for 1 resident (#40), out of 13 sampled residents. Specifically, the facility failed to provide Resident #40 and/or the resident representative the opportunity to participate in the development and revision of the person-centered care plan, including establishing expected goals, outcomes, preferences, and choices, when the facility reviewed and revised the resident's care plan between January and August 2026. This failed practice placed Resident #40 at risk of having the comprehensive care plan revised without the resident's or RR's input regarding the Resident's goals, preferences, choices, and desired outcomes of care. Findings:Record review from 8/10-14/26 revealed Resident #40 was admitted to the facility with diagnoses that included anoxic brain damage (injury to the brain caused by a significant or prolonged lack of oxygen), pulmonary hypertension (abnormally high blood pressure in the blood vessels of the lungs), and paraplegia (paralysis or severe loss of motor function affecting both lower extremities). Comprehensive Assessment Review Review of Resident #40's electronic medical record (EMR) revealed there were multiple Minimum Data Set (MDS - a federally required nursing assessment) assessments that were completed during 2026: 1) one MDS Significant Change Assessment, dated 2/2/26;2) one MDS Quarterly Assessment, dated 3/9/26; and3) one MDS Quarterly Assessment, dated 6/7/26. Care Plan Review Review of Resident #40's Care Plan initiated on 4/30/25, revealed: . The resident is at risk for a psychosocial well-being problem r/t [related to] Anxiety, depression, little interest/pleasure in doing things. History of trauma related experiences. Goal. The resident will have no indications of psychosocial well being problem by/through review date. Interventions. Encourage participation from resident who depends on others to make own decisions. Increase communication between resident/family/caregivers about care and living environment. Provide opportunities for the resident and family to participate in care. Further review revealed Resident #40's Care Plan was revised on 2/12/26. Review of Resident #40's EMR revealed documented Interdisciplinary Team (IDT) care conferences occurred on 1/15/26 and 8/13/26 and the documentation supported that the resident and RR were involved during these conferences. There were no other documented care conferences between 1/15/26 and 8/13/26. Further review of the EMR revealed no documentation that Resident #40 and/or the RR were notified of, invited to, or participated in any care conferences from 1/15/26 to 8/13/26. There was no documentation that the resident or RR participated in the development or revision of the care plan from 1/15/26 to 8/13/26. During an interview on 8/13/26 at 3:20 PM, the Resident Advocate (RA) stated she generally scheduled Resident #40's IDT care conferences and attempted to schedule the conferences around the RR's availability. The RA stated the RR generally attended Resident #40's IDT meetings and did attend the IDT meeting held on 8/13/26. When asked about the period between the 1/15/26 and 8/13/26 IDT meetings, the RA stated she reviewed the record and did not find notes documenting why the meetings had been pushed off or rescheduled. The RA stated she would normally enter a note in PointClickCare (PCC - the facility's electronic charting system) but did not find such documentation for Resident #40. During an interview on 8/14/26 at 10:30 AM, the Corporate Quality Assurance Nurse (CQAN) stated the facility's normal quarterly care-planning process included an IDT meeting and that the RA scheduled the meeting with the resident and/or RR. The CQAN stated meeting notes were completed and subsequently reviewed by the MDS Coordinator when the resident's care plan was updated. During the same interview, the CQAN stated the facility used a Care (continued on next page)		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan Summary Signature Page where the care plan was reviewed with the resident and the resident could acknowledge the review, ask questions, or request changes. The CQAN stated the Care Plan Summary Signature Page was supposed to be getting signed quarterly to prove the involvement with the resident or the resident representative. After reviewing Resident #40's medical record, the CQAN was unable to locate a Care Plan Summary Signature Page documenting that the care plan had been reviewed with Resident #40 and/or the RR. When asked whether documentation demonstrated Resident #40 and/or the RR participated in the development or revision of the care plan after January 2026, the CQAN stated, I also cannot find any evidence at the moment . During an interview on 8/14/26 at 11:00 AM, the MDS Coordinator stated she was responsible for completing quarterly care plan reviews. The MDS Coordinator stated she reviewed information obtained during the MDS chart review, the resident's order summary, nursing documentation, previous care plan information, and IDT notes when available. When asked how the resident's or RR's wishes were incorporated into quarterly care plan revisions, the MDS Coordinator stated if there was something specific the resident desired, the team would usually notify her so the information could be care planned. When asked how she completed a quarterly care plan review when an IDT meeting had not occurred, the MDS Coordinator stated, If an IDT hasn't been held, then I would assume there's nothing specifically that's changed significantly on their care plan. So I go by what's in the nurse's notes and what's on their orders. When asked about Resident #40's quarterly care plan revisions during the period when IDT conferences had not occurred, the MDS Coordinator stated, I do them quarterly regardless of whether an IDT's been held or not. Review of the facility-provided policy Resident Rights, dated February 2022, revealed: . Each Resident has the right to be fully informed in a language they can understand of their total health status, including but not limited to, their medical condition . Each Resident has a right to be fully informed in advance, about changes in care, treatment, medications, or any changes that may affect the resident's well-being. Each Resident has a right to participate in planning and choosing their care and treatment or changes in care and treatment unless incompetent or otherwise found to be incapacitated under the State of Alaska laws. Residents may grant permission for family members to help with care planning and the resident has the right to give permission for family members to make important decision on their behalf. Each resident has a right to choose activities, schedules and health care consistent with their interests, and plans of care including what time to rise in the morning, eat their meals and retire to bed at night. Each Resident has the right to reasonable accommodations of individual needs and preferences except where the health and safety of the resident or other residents would be endangered . Each Resident has a right to freedom of choice. Review of the facility-provided policy Care Planning - Interdisciplinary Team, revised June 2026, revealed: . The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan . The policy further revealed: . Care plan meetings are scheduled at the best time of the day for the resident and family when possible. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record .		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. .Based on record review and interview, the facility failed to ensure appropriate information was provided to a receiving health care institution or provider during a transfer for 1 resident (#40), out of 1 resident transfer reviewed. Specifically, the facility failed to provide Resident #40's Advance Directive (AD - A written instruction, such as a living will or durable power of attorney for health care, recognized under State law, that relates to the provision of health care when the individual is incapacitated) information to the receiving hospital, but instead provided an inaccurate Physician Orders for Life-Sustaining Treatment (POLST - a medical order that communicated a patient's wishes for emergency and end-of-life care) during the hospital transfer which failed to document the resident's choice to receive artificial nutrition and hydration treatment information if needed, which was documented within the resident's AD. This failed practice placed Resident #40 at risk for not receiving life-saving treatment that was consistent with his/her documented healthcare wishes. Findings:Record review on 8/10-14/26 revealed Resident #40 was admitted to the facility with diagnoses that included anoxic brain damage (injury to the brain caused by a significant or prolonged lack of oxygen), pulmonary hypertension (abnormally high blood pressure in the blood vessels of the lungs), and paraplegia (paralysis or severe loss of motor function affecting both lower extremities). Further review revealed Resident #40 was transferred to a hospital on 7/25/26 due to a medical emergency. Review of the Nurse Progress Note, dated 7/25/26 at 6:33 PM, revealed: . resident with seizure type activity in w/c [wheelchair], eyes closed and generalized twitching that lasted approx [approximately] 4 mins 20 sec. Immediately after, res [resident] tearful and disoriented for approx 10-15 mins [minutes]. Further review revealed the Nurse Practitioner (NP) was notified and directed staff to continue to monitor Resident #40 and send the resident to the hospital for worsening symptoms. Review of the Nurse Progress Note, dated 7/25/26 at 10:47 PM, revealed: . At approximately 2020 [8:20 PM], this nurse was alerted by CNAs [certified nursing assistants] that the resident was having a seizure. This nurse immediately went to the resident's room and found the CNA and resident in the room, where the resident was having a seizure. The resident was lying on [his/her] side to prevent aspiration. This nurse immediately began timing the seizure and asked the CNA how long the seizure had been occurring, to which the CNA said ?about 30. seconds'. this nurse continued to time the seizure. The seizure lasted about 2 minutes and 30 seconds before ceasing, however the resident was not responsive to verbal or tactile stimuli for 3 more minutes. Further review of the Nurse Progress Note revealed the on-call NP was notified and ordered Resident #40 sent to the emergency room for further evaluation. The charge nurse called 911, notified the resident representative, and Resident #40 was transferred by ambulance to Mat-Su Regional Medical Center. During the course of this survey, the medical record paperwork that was sent with Resident #40 on 7/25/26 to the receiving hospital was reviewed. The resident's POLST was sent along with additional paperwork. The AD was not sent to the receiving hospital. Review of Resident #40's AD, dated 11/24/24, revealed Resident #40 selected: . I wish to receive artificial nutrition and hydration indefinitely. Review of Resident #40's POLST, dated 12/30/25, revealed the section for medically assisted nutrition documented: . No decision made (standard of care provided) . Further review of the POLST revealed Advance directive not available was selected despite Resident #40 having an executed AD maintained in the facility's medical record. During an interview on 8/12/26 at 2:40 PM, the Director of Nursing (DON) reviewed the documentation associated with Resident #40's facility transfer. The DON stated the facility generally sent the POLST during hospital transfers and not every (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2026
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had an AD. After reviewing Resident #40's transfer documentation and confirming Resident #40 had an AD in the facility record, the DON acknowledged the documentation showed the POLST was sent and stated, . the advanced directive did not [get sent to the receiving facility]. Review of the facility's policy Advance Directives, revised November 2025, revealed: . The nurse supervisor is required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of the advance directive or POLST when transferring from the facility via ambulance or other means . Review of the facility's policy Transfer or Discharge, revised June 2026, revealed: . When the facility transfers or discharges a resident. appropriate information is communicated to the receiving health care institution or provider.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. .Based on record review and interview, the facility failed to coordinate assessments with the Preadmission Screening and Resident Review (PASRR) program. Specifically, the facility failed to follow the directives of the PASRR Level I determination to notify the State of Alaska Division of Senior and Disability Services (SDS) for 1 resident (#4), out of 13 residents reviewed, when the resident stayed beyond their approved convalescent care period. This failed practice resulted in Resident #4 remaining in the facility without the required PASRR Level II evaluation to determine whether the resident required specialized services, which had the potential to adversely affect the resident's ability to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. Findings:Record review on 8/10-14/26 revealed Resident #4 was admitted to the facility with diagnoses that included vascular dementia(dementia resulting from impaired blood flow to the brain), post-traumatic stress disorder (PTSD), and unspecified depression. Review of Resident #4's Level 1 PASRR, dated 4/10/25, revealed: .Convalescent care for a period of 90 days or less, as certified by the physician. If the individual stays beyond the 90 days, an individualized PASRR Level II evaluation must be completed. The facility shall notify SDS on day 85 that it anticipates the resident will need services more than 90 days. Day 85 is: 7/4/25. During an interview on 8/12/26 at 10:08 AM, the Director of Nursing (DON) stated the facility was unable to locate any record that indicated Resident #4 received a PASRR Level II evaluation and that SDS has been contacted to continue the process for the assessment. Review of email correspondence between the surveyor and SDS, dated 8/11/26 at 3:49 PM, revealed: SDS was not notified of ongoing LTC [Long Term Care] [stay] by 07/04/2025 - as indicated on the admission PASRR (page 4). Unfortunately, this case [is] non-compliant with PASRR process and no, [he/she] never got a PASRR level II evaluation. The facility notified us today of this case. SDS requested a new PASRR form and recent records. Once, submitted, we'll do a resident review and update the client's PASRR determination vs. refer for a level II evaluation. The facility failed to notify SDS by 7/4/25 and did not initiate corrective contact until 8/11/26, more than one year later. Review of the facility's policy Preadmission Screening And Resident Review (PASRR), last revised 6/2026, revealed: .The facility coordinates its assessment and care-planning activities with the PASRR program to the maximum extent practicable. incorporates all Level II recommendations into the resident's comprehensive assessment and person-centered care plan, and promptly refers any resident. to the appropriate State-designated authority for resident review.The facility ensure the individual is referred to the appropriate State-designated authority for a Level II evaluation.the facility follows the specific screening, referral, and notification procedures, forms, and contacts of the State in which it operates. Staff are familiar with their State's PASRR program requirements and know how to locate current PASRR contact information for the State-designated authorities and the State Medicaid Agency.		

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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 record review and interview, the facility failed to ensure the comprehensive person-centered care plan was reviewed and revised by the interdisciplinary team (IDT) after quarterly assessments for 1 resident (#40), out of 1 resident reviewed for care plan revision. Specifically, the facility's IDT failed to review Resident #40's quarterly care plan reviews and revisions, following the resident's quarterly assessments. This failed practice placed Resident #40 at risk for changes in his/her comprehensive care plan without the involvement of individuals who have knowledge of the resident's needs, placing the resident at risk for inappropriate or subtherapeutic care interventions that could adversely affect his/her health and well-being. Findings:Record review on 8/10-14/26 revealed Resident #40 was admitted to the facility with diagnoses that included anoxic brain damage (injury to the brain caused by a significant or prolonged lack of oxygen), pulmonary hypertension (abnormally high blood pressure in the blood vessels of the lungs), and paraplegia (paralysis or severe loss of motor function affecting both lower extremities). Review of Resident #40's care planning documentation revealed an IDT care conference was completed in January 2026. Review of Resident #40's MDS assessments revealed a Significant Change Assessment was completed on 2/2/26 and Quarterly Assessments were completed on 3/9/26 and 6/7/26; however, no other IDT care conferences were documented until 8/13/26. Review of Resident #40's most recent Care Plan revealed revisions were completed on the following dates after January 2026 but before 8/13/26: - 2/12/26; 2/17/26; 2/22/26; 2/23/26; 2/25/26; 3/25/26; 4/6/26; 4/15/26; 4/21/26; 5/4/26; 5/13/26; 6/9/26; 7/30/26; 8/7/26; and 8/10/26. During an interview on 8/14/26 at 10:30 AM, the Corporate Quality Assurance Nurse (CQAN) stated when a resident's quarterly Minimum Data Set (MDS - a federally required nursing assessment) assessment was due, the MDS Coordinator opened the care plan for review. The CQAN stated the facility's quarterly care planning process also included an IDT meeting, and the MDS Coordinator reviewed the quarterly meeting notes, MDS look-back period, current physician orders, treatments, and information provided by other IDT members to determine whether information should be added or discontinued from the care plan. During the same interview, the CQAN stated the IDT generally included therapy or restorative nursing, a Certified Nursing Assistant (CNA) who cared for the resident, a nurse who cared for the resident, a Licensed Clinical Social Worker (LCSW), Resident Advocate (RA), dietary staff, and the resident's healthcare provider. The CQAN stated the IDT meeting notes were subsequently reviewed by the MDS Coordinator when updating the resident's care plan. When asked whether the IDT significantly influenced the information incorporated into the quarterly care plan, the CQAN stated, Correct. The CQAN reviewed Resident #40's record during the interview and confirmed the resident's quarterly care plan reviews had continued to be completed. When asked about the absence of an IDT care conference between January 2026 and the IDT care conference conducted during the survey in August 2026, the CQAN stated the facility's assessment information supported that finding. The CQAN stated that when a formal quarterly care conference did not occur, the MDS Coordinator could obtain information from other sources, including weekly Connections meetings, therapy meetings, resident assessments, provider documentation, and psychotropic medication meetings. The CQAN stated these sources provided some interdisciplinary information used by the MDS Coordinator when updating a resident's care plan. During an interview on 8/14/26 at 11:00 AM, the MDS Coordinator stated she was responsible for completing quarterly care plan reviews and revisions. The MDS Coordinator stated she reviewed the resident's MDS information, physician orders, nursing documentation, (continued on next page)		

Department of Health & Human Services
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Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	previous care plan information, and available IDT documentation when completing the quarterly care plan review. When asked how the quarterly care plan was reviewed when an IDT meeting had not occurred, the MDS Coordinator stated, If an IDT hasn't been held, then I would assume there's nothing specifically that's changed significantly on their care plan. I go by what's in the nurse's notes and what's on their orders . When asked about completing Resident #40's quarterly care plan reviews during the period in which IDT care conferences had not occurred, the MDS Coordinator stated, I do them quarterly regardless of whether an IDT's been held or not. Review of the facility's policy Care Planning - Interdisciplinary Team, revised June 2026, revealed: . The interdisciplinary team is responsible for the development of resident care plans. Resident care plans are developed according to the timeframes and criteria established by S483.21. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). The IDT includes but is not limited to: . the resident's attending physician. a registered nurse with responsibility for the resident. a nursing assistant with responsibility for the resident. a member of the food and nutrition services staff. [and] other staff as appropriate or necessary to meet the needs of the resident.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. .Based on observation, interview, and record review, the facility failed to ensure food was served at a safe temperature for 2 residents (#15 and #24), out of 2 residents reviewed for reheated food. Specifically, the facility failed to ensure that food temperatures were checked after reheating food in the microwave. The facility served microwave-reheated chicken noodle soup to Resident #15 at 190.4 F (degrees Fahrenheit) and almond milk to Resident #24 at 182 F without ensuring the food and beverage had cooled to a safe temperature before being served. This failed practice placed Residents #15 and #24 at risk for scalding and burn injuries from consuming excessively hot food and beverages. Findings:During a meal service observation on 8/12/26, the following were revealed: At 11:52 AM, [NAME] #1 reheated a cup of almond milk in the microwave for Resident #24. After reheating, [NAME] #1 placed the milk on the counter without measuring the temperature. Dietary Aide (DA) #2 then served the milk to Resident #24. Upon the surveyor's request, DA #2 checked the temperature and stated it measured 182 F. During an interview on 8/12/26 at 11:53 AM, when asked if 182 F was a safe temperature, DA #2 stated the safe temperature should not exceed 165 F. At 12:13 PM, [NAME] #1 reheated a bowl of chicken noodle soup for Resident #15. The soup was microwaved for two minutes, stirred, reheated for an additional minute, and stirred again. [NAME] #1 placed the soup on the counter without checking the temperature. DA #1 transported the food cart that contained Resident #15's lunch tray to the [NAME] Unit, where Certified Nursing Assistant (CNA) #4 served the reheated soup to Resident #15. When asked if the temperature had been checked before serving, CNA #4 stated, . the kitchen does that. At 12:23 PM, the surveyor requested CNA #4 to measure the temperature; CNA #4 stated it was 190.4 F. During an interview on 8/12/26 at 12:23 PM, CNA #4 stated the safe reheating temperature was 165 F, but that there is no maximum temperature listed in the log. When asked if 190 F was a safe temperature, CNA #4 stated, Yes. CNA #4 then served the soup to Resident #15. During an interview on 8/12/26 at 12:48 PM, [NAME] #1 stated that his/her microwave reheating process involved heating food for two minutes and continued to reheat until it's hot. When asked if he/she checked temperatures after reheating, [NAME] #1 stated, no. [NAME] #1 stated the milk and soup had been reheated until steaming and bubbly, acknowledging the temperatures were very hot. [NAME] #1 stated he/she assessed temperature by stirring and reheating, and also by dipping a gloved finger into the food to check hotness. [NAME] #1 stated he/she would tell staff to leave hot food at the counter to cool before serving. During an interview on 8/13/26 at 8:33 AM, the Kitchen Manager (KM) confirmed that food reheated in the microwave must reach at least 165 F. He stated this was the standard temperature for items such as milk and soup. When asked about the risk of scalding or burns, the KM stated that food cools rapidly once served to the resident. Review of the facility's policy Summary of Chart for Minimum Food Temperatures and Holding Times for Reheating Foods for Hot Holding, dated 2019, revealed that microwave-reheated foods must reach 165 F. The policy did not instruct staff to check temperatures after reheating to ensure food was not excessively hot before serving, nor did it address prevention of resident burns or scalding. Review of the Food and Drug Administration (FDA) Food Code 2022, 3-403.11 Reheating for Hot Holding, accessed on 8/14/26 at this link: https://www.fda.gov/media/164194/download?attachment, revealed Time/Temperature Control for Safety (TCS) foods reheated in a microwave for hot holding must reach at least 74 C (165 F), be stirred or rotated, covered, and allowed to stand covered for 2 minutes after reheating. Commercially processed ready-to-eat TCS foods must be reheated to at least 57 C (135 F) for hot holding. Review of the American Burn Association's Scald Injury Prevention Educator's Guide, undated, accessed on (continued on next page)		

Department of Health & Human Services
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Form Approved OMB
No. 0938-0391

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/19/26 at this link: https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/ABA%20Scald%20Injury%20Prevent revealed: . The severity of a scald injury depends on the temperature to which the skin is exposed and how long it is exposed. When the temperature of a hot liquid is increased to 140 F/60 C it takes only five seconds or less for a serious burn to occur. High risk Groups. Older Adults. have thinner skin so hot liquids cause deeper burns with even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications. Microwave Scald Prevention. Microwaved foods and liquids may reach temperatures greater than boiling without the appearance of bubbling. Stir and test food thoroughly before serving or eating.		

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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. .Based on record review, observation, and interview, the facility failed to establish and maintain an effective infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections for 1 resident (#43), out of 13 sampled residents reviewed for transmission-based precautions. Specifically, the facility failed to ensure appropriate infection control practices were consistently implemented for Resident #43 while the resident was being evaluated for Clostridioides difficile (C. difficile - a bacterial infection that can cause diarrhea and inflammation of the colon), including appropriate transmission-based precaution signage, appropriate hand hygiene, availability and use of an appropriate disinfectant, and staff knowledge of the precautions required. This failed practice placed residents, staff, and visitors at risk for the transmission of infectious organisms through contaminated hands, resident-care equipment, and environmental surfaces. Findings:Record review on 8/10-14/26 revealed Resident #43 was admitted to the facility with diagnoses that included anoxic brain damage (injury that occurs when the brain is completely deprived of oxygen, leading to rapid and often irreversible injury to brain cells), neuromuscular dysfunction of bladder (condition where nerve or muscle problems impair bladder control), and disorder of the autonomic nervous system. Review of Resident #43's medical record, on 8/11/26 at 9:39 AM, revealed a laboratory test for C. difficile had been ordered for Resident #43. Further review revealed the specimen had not yet been collected because the resident had not produced stool. An observation on 8/11/26 at 9:40 AM, revealed Dental Hygienist (DH) #1 provided dental care to Resident #43 while wearing a gown and gloves. A sign posted outside Resident #43's room identified the transmission-based precautions as Contact Precautions. Review of the Contact Precautions transmission-based precautions sign on Resident #43's door, undated, revealed: Contact Precautions Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. During an interview on 8/11/26 at 10:05 AM, DH #1 stated he/she had been informed that he/she could enter the resident's room and needed to wear gown and gloves; however, no one informed him/her of the suspected C. Difficile infectious organism. The dental hygienist further stated no one had instructed him/her regarding the use of bleach for disinfection or the need to wash his/her hands with soap and water. During an interview on 8/11/26 at 9:54 AM, the Infection Preventionist (IP) stated the sign outside Resident #43's room should have identified the precautions as contact enteric. The IP stated that when C. difficile was suspected, the resident should have been placed on the appropriate precautions when the order to obtain the specimen was initiated. An observation on 8/11/26 at 10:02 AM, revealed a Contact Precautions. Special Enteric sign, bleach wipes, gowns, and gloves were observed outside the resident's room. Review of the Contact Precautions. Special Enteric sign on Resident #43's door, dated 12/26/24, revealed: Contact Precautions. Visitors must report to nursing station before entering. Special Enteric Perform hand hygiene before entering room AND wash hands with soap and water before leaving room. Wear gloves when entering room or cubicle, and whenever touching the patient's intact skin, surfaces, or articles of close proximity. Wear gown when ever entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environment surfaces. Use patient-dedicated or single-use disposable shared equipment or clean and disinfect shared equipment (BP cuff, thermometers) between patients. Further review revealed the contact-enteric precaution sign did not identify the disinfectant required for equipment or (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environmental disinfection. An observation on 8/13/26 at 8:40 AM, revealed bleach wipes were not available outside Resident #43's room. During an interview on 8/13/26 at 8:52 AM, Certified Nursing Assistant (CNA) #5 stated he/she had never heard of contact enteric and did not know what contact-enteric precautions required. CNA #4 stated he/she believed enteric precautions required a gown, goggles, and gloves. CNA #4 stated he/she had heard that handwashing and bleach wipes were required. An observation on 8/13/26 at 3:00 PM, revealed CNA #6 and CNA #7 entered Resident #43's room without performing hand hygiene before donning Personal Protective Equipment (PPE). During cares, CNA #7 removed his/her gloves and handled and used a hand-held radio that was under his/her PPE gown without performing hand hygiene. After donning new gloves, CNA #7 returned the radio to his/her clothing under the PPE gown. CNA #6 was noted to have used the alcohol-based hand sanitizer during glove changes when he/she provided care to Resident #43, who was being evaluated for C. difficile. During an interview on 8/14/26 at 9:03 AM, CNA #8 stated that Resident #43 was on precautions due to an airborne pathogen and to wash hands with soap and water. When asked which disinfectant should be used on equipment when removed from the resident's room, CNA #8 stated either the purple disinfectant wipes (Ecolab Disinfectant 1 Wipe - active ingredient dodecylbenzenesulfonic Acid 0.29%, other ingredients 99.71%) or bleach wipes could be used. The CNA stated he/she would personally use bleach because he/she believed bleach killed more. Review of the Ecolab Disinfectant 1 Wipe container revealed there was no documentation on the container to state it killed the C. Difficile bacteria: . Kills SARS-Related Coronavirus 2, SARS-CoV-2 [a COVID-related illness: a severe acute respiratory syndrome coronavirus 2], in 30 seconds. Kills HIV-1, HBV [Hepatitis B Virus], HCV [Hepatitis C Virus] on pre-cleaned environmental surfaces/objects previously soiled with blood/body fluids. During an interview on 8/14/26 at 9:26 AM, Licensed Nurse (LN) #5 stated soap and water and bleach wipes should be used when caring for a resident with C. difficile. When asked the required contact time for the bleach wipes, LN #5 stated he/she did not know and stated the information should have been available on the resident's door sign. An observation on 8/14/26 at 9:28 AM, revealed the required disinfectant contact time was not identified on Resident #43's precaution sign. After staff reviewed the disinfectant container, the required contact time was identified as four minutes. During an interview on 8/13/26 at 11:35 AM, the IP stated Resident #43's suspected C. difficile infection arose at approximately 3:00 AM and the IP sent staff a message the following morning informing them the resident was on C. difficile precautions and reminding staff of the required infection control practices. The IP stated LNs should already know the required procedures through their standard training and were responsible for notifying and reminding CNAs of the required precautions. The IP stated staff received annual C. difficile training and confirmed LNs were expected to ensure staff implemented the appropriate precautions until the IP was available to provide additional education or reminders. Review of the facility's policy Isolation - Initiating Transmission-Based Precautions, dated 6/2019, revealed: .Transmission-Based Precautions were to be initiated when a resident developed signs and symptoms of a transmissible infection; arrives with symptoms of an infection; or has a laboratory-confirmed infection; and is at risk of transmitting the infection to other residents. Further review revealed the IP was responsible for identifying the type of precautions, necessary PPE, and appropriate notification so staff and visitors were aware of the required precautions. Review of the facility's policy Clostridium difficile, dated 6/2019, revealed: .Measures are taken to prevent the occurrence of Clostridium difficile infections (CDI) among residents. Precautions are taken while caring for residents with C. difficile to prevent transmission to other[s] residents. The primary reservoirs for C. difficile are infected people and surfaces. Spores can persist on resident-care items and surfaces for several months and are (continued on next page)		

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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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resistant to some common cleaning and disinfection methods. Further review revealed: . Steps toward prevention and early intervention include. Increasing awareness of symptoms and risk factors among staff, residents and visitors. Frequent hand washing with soap and water by staff and residents. Disinfection of items with potential fecal soiling. using a disinfecting agent recommended for C. difficile (e.g., household bleach and water solution or an EPA registered germicidal agent against C. difficile spores). Resident with diarrhea and suspected with C. difficile are placed on Contact Precautions while awaiting laboratory results. When caring for residents with CDI, staff is to maintain vigilant hand hygiene. Hand washing with soap and water is superior to ABHR [alcohol-based hand rub] for the mechanical removal of C. difficile spores from hands. Review of the facility's policy Isolation - Categories of Transmission-Based Precautions, dated 6/2026, revealed: .Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection. Transmission-Based Precautions may include Contact Precautions, Droplet Precautions, or Airborne Precautions. When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee): Clearly identifies the type of precautions, the anticipated duration, and the personal protective equipment (PPE) that must be used; Explains to the resident (or representative) the reason(s) for the precautions; Provides and/or oversees the education of the resident, representative and/or visitors regarding the precautions and use of PPE; Determines the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and type of precautions; The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. Ensure that protective equipment and supplies needed to maintain precautions during care are in the resident's room. Review of the facility's policy Hand Hygiene and Equipment Cleaning, undated, revealed: . Hand hygiene should be performed. before and after direct contact with residents. Before and after entering isolation precaution settings. Before and after adjusting any worn PPE including mask, face shield, and gown.		