

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 232 ROCKWELL AVENUE SOLDOTNA, AK 99669		
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F 000	INITIAL COMMENTS The following deficiencies were noted during an unannounced annual Medicare/Medicaid recertification survey conducted May 2-5, 2016. The sample included 13 active residents; 1 closed record, and 1 non-sampled resident. Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd, Ste. 24, Bldg. L Anchorage, AK 99503	F 000			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide care for 2 residents (#s 10 and 15) out of 48 Residents in a manner that maintained their dignity and self-esteem. This failed practice placed the residents at risk for psychological harm. Findings: Resident #15 Resident #15 was admitted to the facility with diagnoses that included an arterial ulcer to the left heel and toe.	F 241	1. Resident #15 was not harmed and the assessment was stopped. 2. All residents have the potential to be affected by deficient practice. 3. We will inservice all CNAs, Dietary Staff and Nurses on the deficient practice. All CNA's and Nurses will be reminded of the facilities accepted practice regarding assessment performed in a public area. This is not allowed. 4. Dietary manager and DON will do random checks and results will be reported at the quarterly QA meeting. All	5/25/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/18/2016

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.

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F 241	<p>Continued From page 1</p> <p>During an observation on 5/3/16 at 9:05 am, Licensed Nurse (LN) #3, walked into the dining room where Resident #15 and another Resident sat talking and eating their breakfast. LN #3 began asking Resident #15 about his/her toe, whether it hurt, was there drainage and whether it is healing or not? The LN filled out paperwork as s/he continued to ask about the current condition of the Resident's toe and heel. The other Resident at the dining table watched throughout the interview as the LN stooped down and removed the Resident's shoe. The LN stopped his/her assessment shortly thereafter.</p> <p>During an interview on 5/4/16 at 8:25 am Certified Nursing Assistant (CNA) #3, stated that it's been an ongoing problem where physicians conducted their assessments in the common area during activities. The CNA further stated that any type of assessment in public and or dining room was inappropriate and was reported to the administration.</p> <p>During an interview on 5/4/16 at 8:40 am the Dietary Supervisor stated that no assessments should be conducted in the dining room because it can be embarrassing to the Resident.</p> <p>Resident #10</p> <p>Observation on 5/2/16 at 8:50 am revealed Resident #10 ambulating while pushing his/her walker. The CNA was using the Resident's shirt as a supportive hold, inadvertently exposing several inches of the Resident's backside torso and undergarment. The Resident and CNA #1 walked past several residents through the common area. Several staff were in the area.</p>	F 241	<p>staff will be required to report if the deficient practice is witnessed.</p> <p>5. Inservices to be completed May 25th, 2016</p> <p>1. CNA # 1 has been coached regarding the deficient practice of holding residents pants while ambulating and not following the care plan.</p> <p>2. All ambulating residents have potential to be affected by the deficient practice.</p> <p>3. RA's and Nursing will be inserviced on the deficient practice. They will be instructed to report any deficient practice to the appropriate supervisor.</p> <p>4. We will add "Dignity Issues" to the QA agenda and discuss any trends or issues that have been observed post inservice.</p> <p>5. Compliance to be complete by May 25th, 2016</p>		

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F 241	<p>Continued From page 2</p> <p>During a second observation on 5/3/16 at 8:40 am revealed CNA #1 walking behind Resident #10. While the Resident pushed the walker for several feet, the CNA held onto the Resident's shirt and pants as a supportive hold causing the pants to pull high on the Resident's lower torso.</p> <p>During an observation of the noon meal on 5/3/2016 CNA #1 lifted Resident #10 out of his/her chair by the waistband of his/her pants revealing this skin of his/her lower back. There were several Residents and staff members in the dining area.</p> <p>During an interview on 5/3/16 at 8:40 am the Social Service Staff (SSS) stated that administration does not condone using the Resident's shirt or pants to lift or guide Residents as they walk or transfer. If this was witnessed, the staff should correct the situation. The SSS noted dignity as a concern.</p> <p>Further observation on 5/3/16 at 4:17 pm, CNA #1 was observed walking with Resident #10 through the common area and down the hall to the Resident's room. The Resident was pushing a walker as the CNA held the Resident's shirt and sweatpants.</p> <p>During an interview on 5/4/16 at 12:40 pm, CNA #2 stated Resident #10 walks very well and walks in his/her room and in the corridor without assistance. The CNA stated if a Resident needed support walking or transferring, then s/he would use a gait belt.</p> <p>Record review of the Resident's Care Plan on</p>	F 241			

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F 241	Continued From page 3 5/4/16 at 8:15 am revealed "...[Resident #15]'s dignity and self-esteem will be preserved and [his/her] quality of life will be improved." Further review revealed..."Restorative Messages documentation...5/3/16-MOBILITY: TRANSFERS AND AMBULATION WITH SUPERVISION AND USE OF WALKER...The RNA [Restorative Nursing Assistant] Practice Instructions/goals...Resident...is to receive restorative walking on Monday, Tuesday, Wednesday, Thursday and Friday for 10 minutes daily using the provisions listed below...use of gait belt, use of walker."	F 241			
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: . Based on record review and observation the facility failed to ensure 1 resident (#9) out of 9 sampled residents was provided the adaptive equipment needed to help him/her eat independently. This failed practice created a risk for psychosocial harm from lost independence and motivation. Findings: Record review on 5/3-5/16 revealed Resident #9 had diagnoses that included Parkinson's disease	F 369	1. CNA was coached regarding failure to read messages and dietary card 2. All residents using adaptive equipment could be a risk from deficient practice. 3. Nursing and CNA's will be inserviced on our practice requiring CNAs to check messages and the dietary cards prior to food service. In addition we will inservice all CNA's the need for teamwork. This is especially true in the Sitka Rose unit. 4. Dietary staff will do random observations of those residents requiring	5/25/16	

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F 369	<p>Continued From page 4</p> <p>(a progressive neurologic disease that can cause tremors/shaking and slowed movement) and dementia.</p> <p>Review of Resident #9's admission MDS (minimum data set-Federally required assessment) dated 9/16/15 revealed the Resident required supervision when eating. Review of the most recent quarterly MDS assessment, dated 2/24/16, revealed the Resident had required extensive assistance when eating.</p> <p>Review of the "Resident Messages," information used by the Certified Nursing Assistants (CNAs) to provided daily care, entered 9/11/15, revealed "Use weighted right handed utensils for meals, plate gripper pad, scoop plate, plastic cups with lids."</p> <p>The weighted utensil feature adds weight to help keep hands steady when eating and a gripper pad under the plate helps prevent sliding.</p> <p>During an observation at the Sitka Rose table on 5/3/16 at 7:30-7:45 am, CNA #5 served Resident #9 eggs and cut up pancakes on a white plastic plate directly on the table with a regular spoon.</p> <p>When the Resident used the spoon to scoop up a piece of the pancake, the pancake fell off the spoon onto his/her lap, the Resident attempted to pick up another piece, which s/he again dropped onto his/her lap. Resident #9 then attempted to pick up a third piece, as the Resident used the spoon, the plate slid on the table towards him/her.</p> <p>The Resident picked up a spoonful of eggs, then dropped them onto his/her lap when s/he attempted to bring them to his/her mouth. CNA #5</p>	F 369	<p>adaptive eating equipment. Any deficient practices will be reported to the supervisor and findings reported out in the quarterly QA meeting for the purpose of tracking trends and on going issues.</p> <p>5. To be complete by May 25th, 2016.</p>		

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F 369	<p>Continued From page 5</p> <p>sat down next to the Resident and fed him/her the remainder of the meal.</p> <p>Observation of the cabinets on Sitka Rose on 5/3/16 at 8:00 am revealed 2 red rubber mats in the cabinet and weighted spoons in the silverware drawer.</p> <p>Observation of the noon meal at the Sitka Rose table on 5/3/16 at 12:00 pm, CNA #5 served Resident #9 his/her lunch on a white plastic plate with a regular spoon. The CNA did not place a rubber mat under the plate or provide one of the weighted spoons. The CNA sat next to the Resident and fed him/her lunch.</p> <p>Review of the dietary card, used by staff to serve the correct food and adaptive equipment, revealed Resident #9 was to have weighted right handed utensils and a plate gripper pad with meals.</p> <p>None of the other staff in the area identified the Resident was missing his/her adaptive equipment and was now being fed by the CNA.</p> <p>Review of the facility's policy "Assistive Devices" revised 2/15 revealed " If the Therapy staff makes a recommendation for adaptive utensils or assistive devices, they will be provided to residents to help to maintain or improve their ability to eat independently. "</p>	F 369			

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F 369	Continued From page 6	F 369			
F 371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to handle ready-to-eat food in a safe manner for 1 resident (#15) out of 45 residents receiving food from the kitchen. This failed food handling practice placed the resident at risk of exposure to pathogens transmitted by unwashed and ungloved hands. Findings:</p> <p>During an observation on 5/3/16 at 8:30 am, Resident #15 was eating breakfast at the dining table with another Resident. Certified Nurse Assistant (CNA) #1 walked into the dining room without performing hand hygiene and greeted the residents. Resident #15 asked for a banana. The CNA walked over to the food counter and began to peel a banana, then held the banana in his/her bare hand using a knife to cut it into smaller pieces.</p>	F 371	<ol style="list-style-type: none"> 1. There was no harm to the resident. CNA #1 has been coached regarding food service policy. 2. All residents could be affected by deficient practice 3. All dietary, CNAs and Nursing will be inserviced on the food handling policy. Food service staff have been instructed to stop any service of food that has not been handled appropriately. This is also to be reported to the Dietary Manager who will follow up with the appropriate supervisor. 4. Dietary Manager will report out in the quarterly QA meeting. Any trends or continues issue will be addressed. 5. To be complete May25,2016 	5/25/16	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 7 During an interview on 5/4/16 at 11:00 am, the Dietary Manager stated s/he monitors staff for proper handling of all foods. If someone was observed not handling foods appropriately, s/he would have not allowed that food to be served. During an interview on 5/4/16 at 12:00 pm when asked about handling ready-to-eat food for residents, CNA #4 stated s/he would wash his/her hands and then wear gloves to handle any food that needed to be cut for a resident. Review of Heritage Place's policy on Holding, transporting, and serving food, revised 2/15, stated, "Procedure: ... D. No bare-hand contact with food that is ready-to-eat. Handle food with tongs, deli sheets, or gloves..."	F 371			