**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 025010

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**(X3) DATE SURVEY COMPLETED:** 08/03/2018

**NAME OF PROVIDER OR SUPPLIER:** KETCHIKAN MED CTR NEW HORIZONS TRANSITIONAL CARE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

3100 TONGASS AVENUE

KETCHIKAN, AK 99901

**(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

**ID PREFIX TAG** | **ID PREFIX TAG** | **PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)** | **(X5) COMPLETION DATE**
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F 000 | | F 000 | |

**INITIAL COMMENTS**

The following deficiencies were noted during an unannounced recertification Medicare/Medicaid survey conducted on 7/30-31/18 - 8/1-3/18. The sample included 14 residents, 1 non-sampled residents and 2 closed records.

State of Alaska
Department of Health and Social Services
Division of Health Care Services
Health Facilities Licensing and Certification
4501 Business Park Blvd.
Ste. 24, Building L
Anchorage, AK 99503

F 578 | Request/Refuse/Dscntne Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(g)(12)(i)-(v) | F 578 | 9/17/18

§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).

(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

Electronically Signed 08/24/2018

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.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
KETCHIKAN MED CTR NEW HORIZONS TRANSITIONAL CARE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
3100 TONGASS AVENUE
KETCHIKAN, AK 99901

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</table>
| F 578  |     | Continued From page 1                                                                             | F 578         | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:  
|        |     | resident's option, formulate an advance directive.      
|        |     | (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.  
|        |     | (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.  
|        |     | (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.  
|        |     | (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.  
|        |     | This REQUIREMENT is not met as evidenced by:  
|        |     |  
|        |     | Based on record review and interview the facility failed to 1) have a written Advanced Directives (AD) policy and 2) ensure evidence AD information was provided for 5 residents (#s 2; 3; 7; 12 and 14) out of 14 sampled residents. This failed practice had the potential to deny the residents the right to choose and make end of life medical care decisions. Findings:  
|        |     | Resident #2  
|        |     | Record review on 7/30/18 - 8/3/18 revealed Resident #2 was admitted to the facility with diagnoses that included Parkinson's disease (a |        |  
|        |     |  

**ID**

SUMMARY STATEMENT OF DEFICIENCIES

- Resident #2
- Record review on 7/30/18 - 8/3/18 revealed Resident #2 was admitted to the facility with diagnoses that included Parkinson's disease (a...
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**
025010

**Centers for Medicare & Medicaid Services**
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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**State of Alaska**

**Ketchikan Med Ctr New Horizons Transitional Care**

**Street Address, City, State, Zip Code:**
3100 Tongass Avenue, Ketchikan, AK 99901

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**Summary Statement of Deficiencies**

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<td>F 578</td>
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- Degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination, cervical fracture (broken neck vertebrae), and high blood pressure.

- Review of the most recent MDS (Minimum Data Set - a Federally required assessment) assessment, a quarterly assessment dated 5/2/18, revealed Resident #2 has a BIMS (Brief Interview for Mental Status) score of 15 (a score of 13-15 means the person is cognitively intact).

- Review of Resident #2's medical record revealed an incomplete AD. Resident #2 only had 2 pages of a 9 page packet entitled "Five Wishes": Page 2 of the packet, "Wish 1," and page 8, "Signing the Five Wishes Form." Further review revealed no documentation that Resident #2 had completed an AD or was offered assistance to formulate an AD.

- Resident #3

- Record review on 7/30/18 - 8/3/18 revealed Resident #3 was admitted to the facility with a diagnosis that included cardiovascular accident (the sudden death of some brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain), hemiplegia or hemiparesis (weakness or paralysis of one side of the body), dementia.

- Review of the most recent MDS assessment, a quarterly assessment dated 5/4/18, revealed Resident #3 had a BIMS score of 0 (a score of 0-7 means the person is severely impaired).

- Review of Resident #3's medical record revealed no AD. A Power of Attorney was present. Further written information by Social Work regarding Advance Directive and will again, be offered the opportunity to complete an Advance Directive, by Social Work or designee, and his / her response will be appropriately documented in the EMR. Further this topic will be addressed at each care conference where the resident, if present, will again be offered the opportunity to modify his advance directive and this will be documented in the EMR.

- Resident-3

- This resident has a diagnosis of dementia and is and was on admission, confused and thus unable to complete an Advance Directive. She /he does have an executed General Power of Attorney (POA) in place. Though this is not construed as an Advance Directive, it does indicate that, at the time of its execution, she / he granted health care decision making authority to her / his daughter.

- This resident, at this time lacks the capacity to understand any teaching regarding Advance directive.

- If and when this resident regains the capacity to comprehend information regarding Advance Directives, she / he will be given this information and offered the opportunity to complete an advance directive, by Social Work or designee as per policy in place at that time. The status of this resident’s Advance Directive will be reviewed at each care conference and documented in the EMR.
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<td>As indicated above, this resident's daughter is designated Power of Attorney. Because she lives in a different community, on a different island and visits only infrequently, this resident's daughter will be given written information regarding Advanced Directives via US Mail. When she next visits she will be offered this information verbally face to face.</td>
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<td>review revealed no documentation that Resident #3's guardian was asked if Resident #3 had an AD or offered assistance to make one if desired.</td>
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<td>Resident-7</td>
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<td>Resident #7</td>
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<td>This resident has a court appointed State Guardian and is, therefore, unable to complete an Advance Directive until that guardianship is lifted. This resident has a POLST completed in another state and an Alaska MOST completed, neither of which are signed by the resident and neither of which can be construed as an Advance Directive.</td>
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<td>Record review on 7/30/18 - 8/3/18 revealed Resident #7 was admitted to the facility with diagnoses that included hypertension (high blood pressure) and cirrhosis (liver damage).</td>
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<td>This resident will be given, by the Social Worker, both verbal and written information regarding Advance Directives. Further, if and when her legally imposed guardianship is lifted, she will be offered the opportunity to complete an Advance Directive, by Social Work or designee. The status of her Advance Directive will be reviewed at each care conference and documented in the EMR.</td>
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<td>Review of the most recent MDS assessment, a significant change dated 5/28/18 revealed Resident #7 had a BIMS score of 15.</td>
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<td>Resident-12</td>
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<td>Review of Resident #7's electronic medical record revealed no AD. When asked for the residents AD, the facility produced a physician order for life-sustaining treatment (POLST) and no information the Resident was asked if they wanted to formulate an AD.</td>
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<td>This resident has a Durable Power of Attorney (DPOA), executed last year,</td>
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<td>Resident #12</td>
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<td>Review of the most recent MDS assessment, a quarterly assessment dated 6/18/18, revealed Resident #12 had a BIMS score of 15.</td>
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<td>Record review on 7/30/18 - 8/3/18 revealed Resident #12 was admitted to the facility with diagnoses of cancer, atrial fibrillation (an abnormal heart rhythm originating in the atria in which the normal rhythmical contractions of the cardiac atria are replaced by rapid irregular twitching of the muscular wall that can lead to blood clots forming in the atrium), high blood pressure, diabetes and stroke.</td>
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<td>Review of Resident #12's medical record</td>
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<td>Review of the most recent MDS assessment, a quarterly assessment dated 6/18/18, revealed Resident #12 had a BIMS score of 15.</td>
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<td>Resident-12</td>
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<td>Review of Resident #12's medical record</td>
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### Summary Statement of Deficiencies

- Provider/Supplier/CLIA Identification Number: 025010
- Date Survey Completed: 08/03/2018
- Name of Provider or Supplier: Ketchikan Med Ctr New Horizons Transitional Care
- Street Address, City, State, Zip Code: 3100 Tongass Avenue, Ketchikan, AK 99901

#### ID Tag Prefix

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**Resident #14**

- Record review on 7/30/18 - 8/3/18 revealed Resident #14 was admitted to the facility on 8/7/14 with diagnoses that included cardiovascular accident, hemiplegia or hemiparesis, diabetes, seizure disorder or epilepsy, and depression.
- Review of the most recent MDS, a quarterly assessment dated 4/6/18, revealed Resident #14 has a score of 9 (a score of 8-12 means the person is moderately impaired).
- Review of Resident #14's medical record revealed no AD. A Power of Attorney was on file. Further review revealed no documentation that Resident #14 or the guardian were asked if Resident #14 had an AD or offered information about an AD.
- During an interview on 8/1/18 at 2:10 pm, the Long Term Care Administrator stated there was no AD policy or system in place to ask residents on admission if they had an AD or to offer assistance or declination to formulate an AD.
- During an interview on 8/3/18 at 11:27 am, Social Worker #1 could not provide documentation where he/she asked the Residents if they had an AD or if they would like help making one. He/she stated they only document who the guardian is which gives the designee authority for health care decision making. This, however does not constitute an Advance Directive. This resident currently is able to and does make his own decisions regarding his health care.

Because this resident has the capacity to receive information regarding Advance Directives, he will be given both verbal and written information regarding Advance Directives, by Social Work or designee. Further, this resident will be offered, by Social Work or designee, the opportunity to complete an Advance Directive, as per current policy. This residents Advance Directive status will be reviewed at each care conference and, if he chooses to attend, will again be offered the opportunity to revise his Advance Directive.

**Resident-14**

- This resident has a General Power of Attorney (POA). Though this is not to be considered an Advance Directive (AD), it does give health care decision making authority to the delegates. These delegates are the resident's spouse and daughter. The resident is diagnosed with severe dementia and as such lacks the capacity to receive information relative to or complete an Advance Directive.
- This resident's POAs will be given, by Social Work or designee, written information regarding AD. One of these
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<td>and who makes medical decisions for the residents on their assessments.</td>
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<td>POAs, the daughter, lives out of state. If and when she visits, she will be given verbal information, by Social Work, regarding AD. The POA that is here is this resident's spouse, he / she will be given both verbal and written information regarding AD, by Social Work. This resident's AD status will be reviewed at each care conference. If and when this resident regains the capacity to receive information regarding AD, he / she will be given, by Social Work or designee, both verbal and written information regarding AD and will be offered the opportunity to complete an AD.</td>
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<td>If a resident does not, on admission, have an AD, information will be provided to the resident and / or their decision maker regarding ADs, both verbally and in writing by Social Work or designee.</td>
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<td>If the new resident is capable, Social Work or designee will offer them the opportunity to complete an AD. This will typically make use of either the &quot;5-Wishes&quot; or the State Advance Directive form.</td>
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<td>If necessary, the Social Worker or designee will assist in the completion of the form and assist with either having it notarized or assist the resident to contact the appropriate number of witnesses to witness their signature and sign the form. A paper copy will be placed in the paper chart and an electronic copy will be scanned to the EMR.</td>
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The resident, at this point, may decline to complete an AD. If they decline, the resident will be informed that this option remains open, as long as they are able to make that decision and may complete an AD at some point in the future.

The resident will be informed that whether or not they complete an AD, they have the right to accept or refuse any medical or surgical treatment.

The status of the resident’s AD will be reviewed at each care conference and, if present, the resident will be offered the opportunity to revise the AD, if the wish.

The LTC Unit will create a policy/protocol that will be implemented and include education and ongoing monitoring for the professional staff and the social work teams in regard to advance directives. The policy will encompass evaluation of advance directives; require sufficient documentation in the electronic medical record (EMR) and the identification of any existing advance directive to ensure compliance. All resident records for those currently in the facility, will be screened for the presence of an Advance Directive. If a deficiency is identified in any resident medical record, the resident and / or family-decision maker, will be offered the opportunity to receive more information and, the resident, to
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

025010

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ________________________________
B. WING ________________________________

(X3) DATE SURVEY COMPLETED

08/03/2018

NAME OF PROVIDER OR SUPPLIER

KETCHIKAN MED CTR NEW HORIZONS TRANSITIONAL CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

3100 TONGASS AVENUE
KETCHIKAN, AK  99901

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<td>Continued From page 7 potentially complete an advance directive, if they chose. Documentation of the process will be completed in the resident’s medical record.</td>
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How other residents having the potential to be affected by the same deficient practice will be identified:

All residents have the potential to be impacted.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

1. A log will be implemented to monitor the resident’s status, with regard to Advance Directives.  
2. Checking for the presence of an advance directive will be added to the Admitting Nurse’s checklist.  
3. A scan of the resident’s Advance Directives will be maintained electronically in the EMR and a paper copy will be maintained in the paper portion of the resident’s medical record.  
4. Advance Directive status will be reviewed at each resident’s quarterly care conference to determine or verify if the advance directive status or medical power of attorney changes and the residents advance directive status will be documented in the record of the care conference and in the care plan.

In accord with Alaska law, an Advance Directive may be modified at any time as requested by a resident or their medical power of attorney with input from the...
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How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

1. On-going Advance Directive compliance monitoring will be audited and tracked on the Quality Dashboard presented at the LTC Quality Committee (QAPI) meetings, by the Director of Nursing (DON) or his designee. (2) The data will be reported to Quality Committee of the Community Governing Board as a part of the D.O.N.'s annual in-person report.

The date(s) each corrective action will be completed:

September 17, 2018

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§483.21(b) Comprehensive Care Plans

§483.21(b)(2) A comprehensive care plan must be:

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.
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<td>Continued From page 9 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: . Based on interview and record review the facility failed to update and revise the care plan to reflect the current level of care and services for 3 residents (#s 3, 14, 16) out of 14 sampled residents. Failure to assess and revise care plan problems, goals, and interventions placed the residents at risk for not receiving appropriate and/or necessary care and services. Findings: Resident #3 Record review on 7/30/18 - 8/3/18 revealed Resident #3 was admitted to the facility with diagnoses that included cardiovascular accident (CVA - stroke), hemiplegia or hemiparesis (weakness or paralysis of one side of the body), diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), dementia and a wound infection.</td>
<td>F 657</td>
<td>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The findings for the three residents (3, 14, 16) were all found to be the result of constraints of the EMR and human error. These three care plans will be reviewed and corrected. Resident #3 The Care Plan will be reviewed by the MDS Coordinator and other members of the multi-disciplinary team to ensure that all interventions listed remain relevant and any newly required interventions are included. Further, dates listed for start and expected end dates will be reviewed for accuracy, to ensure that resident care staff are able to discern what are the latest interventions required by the</td>
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<td>F 657</td>
<td>Continued From page 10</td>
<td>Review of Resident #3's most recent care plan, undated, revealed 18 &quot;Multidisciplinary Problems (Active)&quot;. The expected end date, or target date, for all of these identified problems expired on 5/14/18. Review of the most recent MDS (Minimum Data Set - a federally required nursing assessment) assessment revealed a quarterly assessment was completed on 5/4/18 preceeding the expired dates on the careplan. Review of the &quot;Quarterly Team Conference,&quot; dated 5/10/18, revealed the team reviewed the &quot;current care plan for all identified problems and approaches.&quot; Resident #14 Record review on 7/30/18 - 8/3/18 revealed Resident #14 was admitted to the facility with diagnoses that included cardiovascular accident and hemiplegia or hemiparesis. Review of the most recent MDS assessment, an annual assessment dated 7/4/18, revealed Resident #14 required extensive assistance in bed mobility, locomotion on and off unit, toileting, and dressing. He/she was coded &quot;total dependence&quot; for transfers and personal hygiene. Review of Resident #14's care plan revealed a &quot;Problem: Impaired strength and/or mobility ...&quot; dated 10/17/17 and a &quot;Description: Related to left side hemiparesis and hemiplegia post CVA.&quot; Interventions for this problem were documented as restorative aid, range of motion exercises, with the goal &quot;needs to maintain current flexibility and prevent contractures.&quot;</td>
<td>F 657</td>
<td>resident.</td>
</tr>
<tr>
<td>ID TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>COMPLETION DATE</td>
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<tr>
<td>F 657</td>
<td>Continued From page 11</td>
<td>F 657</td>
<td>An education syllabus will be developed for the on-going training of the Multidisciplinary Team (IDT), including the bedside care staff, based upon the revised Care Planning policy / process.</td>
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<td></td>
<td>Further review of Resident #14’s medical record revealed Occupational Therapy (OT) added instructions for a palm protector with finger separators on 5/29/18 with the following interventions:</td>
<td></td>
<td>Review of care plan prior to Quarterly Care Conferences, with changes updated as needed. Evaluate the potential for a standardized Quarterly Care Conference form (either hard copy or electronic) that delineates each team members role, responsibilities and discussion points for planning the care of the resident.</td>
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<td></td>
<td>- Please place palm shield on [Resident #14] when in bed (in place of previous palm protector).</td>
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<td>After completion of each RAI assessment, (comprehensive and quarterly), the IDT will review and revise as appropriate, the Plan of Care. The IDT will include, at a minimum, the provider, the resident’s assigned nurse, food and nutrition services, the residents representative (if willing and if approved by the resident) and by the resident if they are willing.</td>
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<td></td>
<td>- If finger separators out of place, please fix them</td>
<td></td>
<td>How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</td>
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<tr>
<td></td>
<td>- Keeping left arm up on pillow for support will help keep it in place and provide comfort to left arm</td>
<td></td>
<td>The Charge Nurse will assign, daily, resident care plans to be reviewed and the nurse responsible to review. Reviews to include completeness, accuracy, or needed updates.</td>
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<td></td>
<td>- If [Resident #14] is having any discomfort with palm shield, please remove and give a break. Attempt to replace in 30 [minutes] - 1 hour.</td>
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<td>The Charge Nurse will monitor for</td>
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<td>Additional review of Resident #14’s care plan “Problem: Impaired strength and/or mobility ...” revealed no documentation of the palm protector recommended by OT.</td>
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<td></td>
<td>Residential #16</td>
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<td>Record review on 7/30/18 - 8/3/18 revealed Resident #16 was admitted to the facility with diagnoses that included Atrial Fibrillation (AF), (an irregular heartbeat that can lead to blood clots), diabetes, dementia and Parkinson’s disease.</td>
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<td>Record review revealed a physician order dated 7/11/18, for Eliquis (apixaban, an anticoagulant, blood thinning medication that does not require laboratory monitoring) 5 mg (milligrams) by mouth twice daily, for persistent AF.</td>
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<td>Review of the most recent MDS (Minimum Data Set, a federally required nursing assessment) assessment, a quarterly assessment dated 7/13/18, revealed the Resident was coded for</td>
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F 657 Continued From page 12
taking an anticoagulant medication during the last 7 days of the MDS assessment.

Review of Resident #16's most recent care plan, undated, revealed the problem "Potential for complication r/t bleeding (see description)"
"Description: I am on Coumadin...review of INR and warfarin dose adjustment."

Review of "MDS Nurse Note" dated 7/17/18, revealed "Care conference complete ..." There was no documentation regarding the change in Resident #16's medication change from Coumadin (warfarin, a blood thinning medication that requires diagnostic monitoring) to Eliquis.

During an interview on 8/2/18 at 7:46 am, Licensed Nurses (LN) #s 2 & 5 stated they do not use the care plan binders at the nurse's station and they do not regularly incorporate the care plans into their daily care for residents.

During an interview on 8/2/18 at 9:00 am, the interim MDS Nurse (MDSN) could not state why a revision to a care plan would not be done. She stated revisions are manually completed by the full-time MDSN, who was on vacation at the time of this survey.

Review of the facility's policy "Care Planning," dated 7/20/16, revealed: "The Care Plan is to be considered a dynamic document. It is to be kept up-to-date on a continual basis, and based on the assessed needs of the individual resident."

Further review of the policy revealed: "The MDS RN-Coordinator is in charge of and responsible for completing, reevaluating and revision of the Resident Care Plan." And "Each discipline is compliance by review of the event log in the Care Plan software.

Care planning compliance will be reported to the LTC Quality Committee (QAPI), by the LTC Director of Nursing and reported annually to the Quality Committee of the Ketchikan Medical Center/LTC Community Health Board.

The date(s) each corrective action will be completed:

September 17, 2018
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 025010

**Multiple Construction:**
- **Building:**
- **Wing:**

**Date Survey Completed:** 08/03/2018

**Name of Provider or Supplier:** Ketchikan Med CTR New Horizons Transitional Care

**Street Address, City, State, Zip Code:** 3100 Tongass Avenue, Ketchikan, AK 99901

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>F 657</td>
<td></td>
<td>Encouraged but not required to make changes on the care plan as necessary. These changes can be written on the paper copy of the care plan, in the care plan notebook, or this can be taken to the MDS RN-Coordinator...&quot;</td>
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<tr>
<td>F 684</td>
<td></td>
<td>Quality of Care&lt;br&gt;CFR(s): 483.25&lt;br&gt;§ 483.25 Quality of care&lt;br&gt;Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</td>
<td>9/17/18</td>
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</table>

Based on record review, interview, and observation the facility failed to provide nail care for a fungal infection that may have contributed to major nail deformity and discomfort for 1 resident (#14) out of 14 sampled residents. This failed practice placed the resident at risk for actual decline in physical, mental, and/or psychosocial well-being. Findings:

- Record review on 7/30/18 - 8/3/18 revealed Resident #14 was admitted to the facility with a diagnosis of diabetes mellitus (a chronic condition that affects the way the body processes blood sugar).

During an interview on 7/31/18 at 11:57 am, what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

9-4-18 Update for rejection of 9-4-18: Staff attempted to complete nail care which was rejected by resident #14. Appointment scheduled with alternative podiatrist, Dr. Mesdag from Juneau for 9-15-18. If podiatrist is unable to complete nail care Dr Pankow, residents primary care provider will be notified. Nail care will be added to residents plan of care as an area of concern.

For those residents that require the services of a Podiatrist, a Podiatry consult / appointment will be sought with any.
<table>
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<th>F 684</th>
<th>Continued From page 14</th>
<th>F 684</th>
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<tbody>
<tr>
<td></td>
<td>Resident #14 and his/her spouse stated there was a need for nail care due to a fungal infection. The spouse stated they have not been able to see a &quot;nail doctor&quot; and he/she has requested assistance to get Resident #14 to a &quot;nail doctor&quot; from staff, but it hasn't happened.</td>
<td>Podiatrist that comes into the community to conduct a short-term clinic (visiting Podiatrist).</td>
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<td></td>
<td>Resident #14 further states his/her nails &quot;hurt all the time,&quot; and they embarrass him/her, &quot;they make me feel like a witch,&quot; and he/she hides his/her hand under blankets.</td>
<td>If the resident is unable to see the Podiatrist, for any reason, an appointment will be made with the attending physician for the purpose of addressing the resident's need for podiatry care. A specific care regimen for these needs will be developed with the attending provider. The medical record will reflect the inability to secure a Podiatry appointment and the reason. It will further reflect what action was taken, i.e. an appointment with the attending provider to address this specific issue and that a specific plan of care was developed for this resident's podiatry needs.</td>
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<td></td>
<td>An observation on 7/31/18 at 11:57 am, revealed two nails (middle and ring finger) on Resident #14's left hand that were deformed, growing out and almost perpendicular to the nail bed. The nails themselves were extremely thick and overgrown, pushing into the nail bed of the finger.</td>
<td>The resident's nails will be assessed weekly during the weekly full body skin assessment or more often, as necessary. The findings of these assessments will be documented in the resident's electronic medical record.</td>
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<td></td>
<td>During an interview on 8/1/18 at 1:44 pm, the Infection Preventionist and Director of Nursing stated the charge nurse has been trying to get Resident #14 a podiatry (foot doctor) appointment with a traveling podiatrist. The facility could not provide documentation that a nail appointment is pending for Resident #14.</td>
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<td>During an interview on 8/3/18 at 11:19 am, the Social Worker indicated that they are not involved in making medical appointments.</td>
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<td></td>
<td>Review of Quarterly Team Conference notes, dated 10/27/17, 1/23/18, and 4/12/18, revealed no documentation of the need for nail care or any steps taken to get a podiatry consult made.</td>
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<td></td>
<td>Review of Resident #14's Care Plan revealed *Problem: Health Promotion, start date 6/1/18: - Appointment with Dr. Lam, Podiatry, Yearly</td>
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</tbody>
</table>
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 025010

**Multiple Construction:**
- A. Building
- B. Wing

**Date Survey Completed:** 08/03/2018

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**Name of Provider or Supplier:** Ketchikan Med Ctr New Horizons Transitional Care

**Street Address, City, State, Zip Code:** 3100 Tongass Avenue, Ketchikan, AK 99901

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<th>Completion Date</th>
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</thead>
<tbody>
<tr>
<td>F 684</td>
<td>Continued From page 15 diabetic foot [evaluation]/nail care. 6-30-18. - 6-28-18 Rescheduled by doctor however facility did not receive notification. Doctor evaluating whether he wants to continue to see resident. Office will call back. &quot;</td>
<td>F 684</td>
<td>The condition of the resident's nails and any related new findings will be reviewed as part of the resident's quarterly care conference and documented in the care conference record. How other residents having the potential to be affected by the same deficient practice will be identified: This has the potential to affect all residents in the facility. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A log will be created that tracks the following: Residents nails (fingers and toes) were assessed; concerns identified; interventions required and if so, did the issue require provider intervention; and if so, was provider informed; and if provider issue orders for intervention; and was the resident care plan modified to reflect the need for intervention and the intervention specified. How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The log will be monitored for compliance and completeness and findings will become part of the Quality Reporting Dashboard created and maintained by the</td>
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### Statement of Deficiencies and Plan of Correction

#### (X1) Provider/Supplier/CLIA Identification Number:

025010

#### (X2) Multiple Construction

A. Building ________________

B. Wing ________________

#### (X3) Date Survey Completed

08/03/2018

### Name of Provider or Supplier

Ketchikan Med Ctr New Horizons Transitional Care

### Street Address, City, State, Zip Code

3100 Tongass Avenue

Ketchikan, AK 99901

### (X4) ID Summary Statement of Deficiencies

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>(X4) ID Summary Statement of Deficiencies</th>
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<th>Prefix Tag</th>
<th>(X5) Completion Date</th>
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</thead>
<tbody>
<tr>
<td>F 684</td>
<td>Continued From page 16</td>
<td>F 684</td>
<td>LTC Director of Nursing or designee, and as reported at the LTC Quality Committee (QAPI), and annually to the Quality Committee of the PeaceHealth Community Health Board. The date(s) each corrective action will be completed: September 17, 2018</td>
<td></td>
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</tr>
<tr>
<td>F 689</td>
<td>Free of Accident Hazards/Supervision/Devices</td>
<td>F 689</td>
<td>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: One resident was found to be affected by this finding. A hazard vulnerability assessment will be conducted for this resident, of the environment, utilizing a tool based upon the guidance provided in the SOM Appendix PP, F-689. The Care Planning team will carry out this assessment</td>
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<tr>
<td>SS=E</td>
<td>CFR(s): 483.25(d)(1)(2)</td>
<td>9/17/18</td>
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### (X5) Date Survey Completed

08/03/2018

### LTC Director of Nursing or designee, and as reported at the LTC Quality Committee (QAPI), and annually to the Quality Committee of the PeaceHealth Community Health Board.

The date(s) each corrective action will be completed: September 17, 2018

### What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

One resident was found to be affected by this finding. A hazard vulnerability assessment will be conducted for this resident, of the environment, utilizing a tool based upon the guidance provided in the SOM Appendix PP, F-689. The Care Planning team will carry out this assessment

### Should the resident wish to leave the facility:

Based on observation, interview and record review the facility failed to ensure the adequate supervision for 1 resident (#7) out of 14 sampled residents. Specifically, the facility failed to conduct a safety assessment on one resident (#7) utilizing a wheelchair to leave the facility. This finding places the resident at a potential risk for an accident. Findings:

Resident #7

Record review on 7/30/18 - 8/3/18 revealed Resident #7 was admitted to the facility with

§483.25(d) Accidents. The facility must ensure that -

§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure the adequate supervision for 1 resident (#7) out of 14 sampled residents. Specifically, the facility failed to conduct a safety assessment on one resident (#7) utilizing a wheelchair to leave the facility. This finding places the resident at a potential risk for an accident. Findings:

Resident #7

Record review on 7/30/18 - 8/3/18 revealed Resident #7 was admitted to the facility with
Continued From page 17

diagnoses that include hypertension (high blood pressure) and cirrhosis (liver damage).

Observation on 7/31/18 at 7:00 am, revealed the Resident outside the facility in a wheelchair. The Resident was observed stationary in a wheelchair on the sidewalk at the top of a steep incline needing to be navigated in order to gain access to the facility.

Review of the most recent MDS (Minimum Data Set, a federally required nursing assessment) assessment, a significant change assessment dated 5/28/18, revealed Resident #7 had a BIMS (Brief Interview for Mental Status) score of 15 (a score of 13-15 means the person is cognitively intact).

Further review revealed the significant change MDS assessment dated 5/28/18 was a result of the resident experiencing a fracture from a fall.

During an interview on 8/2/18 at 15:35 pm, the Director of Nursing (DON) and Administrator (ADM) both stated no, when asked if the Resident had a safety assessment based on observations of the Resident behaviors.

Additionally the DON and ADM stated no when asked if the facility had a policy for safety assessments for residents leaving the facility in wheelchairs.

F 689

campus, a safe pathway off campus will be determined and will enable her to leave campus independently, if continued functional assessment(s) determine she remains functionally capable to leave independently.

How other residents having the potential to be affected by the same deficient practice will be identified:

This has the potential to affect all residents using a wheelchair independently.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

In the event that other residents in the future could independently leave the LTC facility without a guardian, friend or family member; the resident will be assessed by the interdisciplinary team using the developed tool.

How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

At each quarterly care conference, if the resident has had the hazard vulnerability assessment, they will be reassessed to determine if they are still capable of independent use of a wheelchair. The percentage that are assessed to no longer
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tr>
<td>025010</td>
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<td>08/03/2018</td>
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NAME OF PROVIDER OR SUPPLIER

KETCHIKAN MED CTR NEW HORIZONS TRANSITIONAL CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

3100 TONGASS AVENUE
KETCHIKAN, AK  99901

<table>
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<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 689</td>
<td>Continued From page 18</td>
<td>F 689</td>
<td>be capable, when they had previously been capable will be reported to the LTC Quality Committee (QAPI), by the LTC Director of Nursing and reported at the LTC Quality Committee (QAPI), and annually to the Quality Committee of the Ketchikan Medical Center/LTC Community Health Board. The date(s) each corrective action will be completed: September 17, 2018</td>
<td>9/17/18</td>
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</table>
| F 755              | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)                                             | F 755         | §483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. | 9/17/18 |
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<tr>
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| F755 | Continued From page 19 | §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to have consistent safeguards in place for appropriate disposition of controlled substance medications within the medication storage room. Specifically, the Cactus Smart Sink (a secured, closed cartridge for controlled substance medication disposal) was overfull with disposed medication to the point the medications were accessible. This failed practice had the potential to affect all residents (based on a census of 18), disrupt facility reconciliation of disposed controlled substance medication and/or cause potential loss, diversion, or accidental exposure. Findings: During an observation of the medication storage room on 8/2/18 at 9:45 am, it was noted the Cactus Smart Sink was overfull. Multiple pills and powder were visible and accessible by hand. It was further observed that the red light was blinking on the Smart Sink system. During an interview on 8/2/18 at 10:10 am, Pharmacist #1 stated when the red light blinks on the Cactus Smart Sink it needs to be emptied. | F755 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The facility will create a policy / protocol detailing the responsibilities with regard to monitoring the Cactus Smart Sink. The protocol will include the staff member primarily responsible for this monitoring, frequency of checking the Cactus sink and action to be taken when the device is found to be almost full or full. How other residents having the potential to be affected by the same deficient practice will be identified: This has the potential to affect all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A log will be created, that will serve as documentation of compliance with the...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
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<tbody>
<tr>
<td>025010</td>
<td>A. BUILDING ____________________</td>
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<td>B. WING ___________________________</td>
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**NAME OF PROVIDER OR SUPPLIER**

KETCHIKAN MED CTR NEW HORIZONS TRANSITIONAL CARE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

3100 TONGASS AVENUE KETCHIKAN, AK 99901

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</table>
| F 755         | Continued From page 20  
During an interview on 8/2/18 at 10:20 am, Pharmacy Tech #1 visualized the Cactus Smart Sink in the medication storage room and stated the cartridge was overfull. He/she further stated the pills and powder should not be visible within the sink.  
During an interview on 8/2/18 at 10:30 am, Licensed Nurse (LN) #4 stated when the red light blinks, it means the cartridge within the Cactus Smart Sink need to be changed because it is full. LN #4 had not called the pharmacy for them to replace the cartridge prior to this observation.  
Review of facility's policy "Cactus Smart Sink Use Policy," dated 3/9/18, revealed: "Cactus Smart Sink: Cactus Smart Sink is a secure pharmaceutical waste container that accepts the disposal of solids and liquids converting them into an unusable and unrecoverable state." Further review revealed: "When a cartridge is full, the unit will notify the pharmacy to replace it." | F 755 | policy for checking the Cactus Smart Sink as well as what action was taken if it is found to be full. This log will be completed by the staff member designated to check the Cactus sink. The Pharmacy will assist with the removal of the drug products when the sink is full. The Pharmacy has a system policy for the Cactus sink and the LTC Unit will be reflected in the system policy.  
How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:  
This data will be collected and included on the New Horizons LTC Quality Dashboard, by the Director of Nursing (DON) or his designee. This aggregate information will be reported to the New Horizons LTC Quality Committee (QAPI) by the DON or his designee. It will, from there, be reported to the Quality Committee of the Ketchikan Medical Center/LTC Community Health Board, by the DON.  
The date(s) each corrective action will be completed:  
September 17, 2018 | 9/17/18 |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  
§483.45(e) Psychotropic Drugs.  
§483.45(c)(3) A psychotropic drug is any drug that | F 758 | 9/17/18 |
F 758 Continued From page 21 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.
## F 758 Continued From page 22

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:

Based on record review, interview, and policy review the facility failed to ensure 1) PRN (as needed) psychotropic (any drug capable of affecting the mind, emotions, and behavior) medication was limited to a 14 day duration in compliance with federal regulation and 2) was re-evaluated by a physician with appropriate documentation for continued use in 2 residents (#5 & #14), out of 6 sampled residents. This failed practice placed the residents at risk for receiving unnecessary medication and for experiencing potentially severe and debilitating side effects of psychotropic medication. Findings:

### Resident #5

Record review on 8/1/18 of Resident #5 most recent MDS (Minimum Data Set-a federally required nursing assessment), a significant change assessment dated 5/16/18, revealed diagnoses that included Huntington's disease (an abnormal hereditary condition characterized by progressive involuntary purposeless, rapid motion of body and mental deterioration that results in dementia), anxiety, and depression.

Review of Resident #5's medication administration record (MAR) revealed an order for "Ativan 0.5 mg [by mouth] every 4 hours [as

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<th>ID</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

For Resident # 5 and # 14
- Pharmacy recommendation of discontinuing or reducing PRN psychotropic sent to provider.
- Information provided to provider on PRN anti psychotropic regulations.

PRN psychotropic medications will have duration indicated and rationale for use in resident’s chart. How other residents having the potential to be affected by the same deficient practice will be identified:

All residents have the potential to be impacted.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

Provider (physicians) will order PRN psychotropic medication specifying
NAME OF PROVIDER OR SUPPLIER
KETCHIKAN MED CTR NEW HORIZONS TRANSITIONAL CARE

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<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
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| F 758              | Continued From page 23 needed] for anxiety." Further review revealed this medication started on 11/29/17 with an end date of 11/29/18 (a 1 year order). Ativan is a medication used to relieve anxiety. Review of Resident #5's medication administration history revealed the following PRN use for anxiety: - January 2018: 5 doses received - February 2018: 8 doses received - March 2018: 5 doses received - April 2018: 5 doses received - May 2018: 6 doses received - June 2018: 3 doses received - July 2018: 2 doses received Additional review of the MAR revealed an order change on 7/29/18 to "Ativan 0.5mg [by mouth] at bedtime [as needed]" with no end date indicated. Review of the physician's notes, dated 12/1/17, 2/5/18, 4/2/18, and 6/4/18, revealed no documentation of the number of times Ativan PRN was used, or the efficacy of the Ativan PRN use. Further review revealed no documentation of a possible dosage reduction or projected duration of Ativan PRN use. Review of the Pharmacist's 30 day Drug Regimen Reviews, dates December 2017 through July 2018, revealed no recommendation on the Ativan PRN use, nor any recommendation to attempt a dosage reduction or elimination. Review of Quarterly Team Conference notes, dated 10/19/17 and 1/11/18, revealed no documentation of psychotropic PRN drug use for anxiety: "BEHAVIORAL SYMPTOMS: None." Further review revealed no discussion on indication and length of use. Psychotropic medications include antipsychotic, antidepressant, anti-anxiety and hypnotic classes. PRN Antipsychotic medications can only be ordered for 14 days. A new antipsychotic PRN order may be re-written for 14 days again, but the provider must document re-evaluation of the resident. Other PRN psychotropics may be longer than 14 days but the rationale will be documented in the resident's progress notes. The LTC Pharmacist will verify orders for PRN psychotropic medications. If the indication, a stop date or rationale is not specified, the Pharmacist will obtain clarification from the provider.

How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

The Pharmacist will monitor compliance each month through the end of the year by running an audit of psychotropic medications ordered and to assure that time-based orders are not missed for reevaluation and/or discontinues. Audits will be run monthly through the end of 2018.

A letter to all LTC providers will be formulated, by the LTC Pharmacist to remind providers of the duration of PRN psychotropic medications as well as an accompanying medication list for antipsychotics, anti-anxiety,
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<td>F 758</td>
<td>Continued From page 24</td>
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<td>possible reduction or elimination of the medication.</td>
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<td>Review of the Annual Team Conference note, dated 4/17/18, revealed no documentation of psychotropic PRN drug use for anxiety: &quot;BEHAVIORAL SYMPTOMS: None.&quot; Further review revealed no discussion on possible reduction or elimination of the medication.</td>
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<td>Resident #14</td>
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<td>Review of Resident #14 most recent MDS, an annual assessment dated 7/4/18, revealed diagnoses that included dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking), anxiety, and depression.</td>
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<td>Review of Resident #14's MAR revealed a Physician's order for &quot;Ativan 1mg [by mouth] nightly [as needed] for anxiety.&quot; Further review revealed this medication started on 1/30/18, with an end date of 7/29/18 (a 6 month order).</td>
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<td>Review of Resident #14's medication administration history revealed the following PRN use for anxiety:</td>
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<td>- January 2018: 2 doses received</td>
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<td>- February 2018: 11 doses received</td>
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<td>- March 2018: 14 doses received</td>
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<td>- April 2018: 13 doses received</td>
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<td>- May 2018: 15 doses received</td>
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<td>- June 2018: 11 doses received</td>
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<td>- July 2018: 14 doses received</td>
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<td>Review of the Physician's Progress notes, dated 2/12/18, 4/9/18, 5/31/18, and 7/27/18, revealed no assessment of anxiety, the number of times antidepressants, and sedatives to help inform the provider. The communication, by the Pharmacist to physicians, will occur by September 14th, 2018.</td>
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<td>Deviations in practice will be taken to the LTC Medical Director as necessary, by the Pharmacist. Results will be reported to the LTC Quality Committee (QAPI), by the LTC Pharmacist and reported annually to the Quality Committee of the Ketchikan Medical Center/LTC Community Health Board, by the Director of Nursing (DON).</td>
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<td>The date(s) each corrective action will be completed:</td>
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<td>ID</td>
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<td>F 758</td>
<td>Continued From page 25</td>
<td>Ativan PRN was used, or the efficacy of Ativan PRN use. Further review revealed no documentation of a possible dosage reduction or projected duration of Ativan PRN use. Review of the Pharmacist's 30 day Drug Regimen Reviews, dates January through July 2018, revealed no recommendation on Ativan PRN use, nor any recommendation to attempt a dosage reduction or elimination. Review of Quarterly Team Conference notes, dated 10/24/17, 1/23/18, and 4/12/18, revealed no documentation of psychotropic PRN drug use for anxiety: &quot;BEHAVIORAL SYMPTOMS: None.&quot; Further review revealed no discussion on possible reduction or elimination of the medication. Review of the Annual Team Conference note, dated 7/17/18, revealed no documentation of psychotropic PRN drug use for anxiety: &quot;BEHAVIORAL SYMPTOMS: None.&quot; Further review revealed no discussion on possible reduction or elimination of the medication. During an interview on 8/2/18 at 11:20 am, Pharmacist (RPH) #1 stated only antipsychotic medication used to treat delusions, hallucinations, paranoia, or disordered thoughts) medication needed a 14 day limit on orders. When regulation was reviewed with RPH #1, he/she stated he/she missed this and was not monitoring for this limitation. During an interview on 8/2/18 at 11:20 am, Medical Director (MD) #1 stated the only protocol in place for psychotropic PRNs was they were to be re-evaluated every 6 months. He/she was</td>
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### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 025010

**Date Survey Completed:** 08/03/2018

**Provider Name:** Ketchikan Med Ctr New Horizons Transitional Care

**Address:** 3100 Tongass Avenue, Ketchikan, AK 99901

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Tag</th>
<th>Description</th>
<th>Completion Date</th>
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<tr>
<td>F 758</td>
<td></td>
<td>Continued From page 26 unaware of the 14 day limit on psychotropic PRN use.</td>
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Review of facility's policy "Pharmacy Medication Reviews for [Long Term Care] Patients," dated 6/1/18, revealed no monitoring for psychotropic PRN orders to be limited to 14 days, unless specific documentation from the attending physician is present within the resident's medical record.

Review of the facility's policy "Psychotherapeutic Medications," dated 8/1/14, revealed: "Procedure: Attending Medical Staff: c. if the provider determines that it is clinically contraindicated for the psychotherapeutic medication therapy dose to be tapered or discontinued, they must document the reason in the resident's medical record."

Further review revealed: "e. 1. PRN orders for psychotropic drugs are limited to 14 days. 2. if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order."

<table>
<thead>
<tr>
<th>F 812</th>
<th>SS=F</th>
<th>Food Procurement, Store/Prepare/Serve-Sanitary</th>
<th>9/17/18</th>
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CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must:

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained directly
### F 812

**Continued From page 27**

- From local producers, subject to applicable State and local laws or regulations.
- (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
- (iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review of the central kitchen area, the facility failed to prepare food under proper sanitation and food handling practices. Specifically, the food service staff failed to perform hand hygiene according to accepted professional practices during the provision of food care and services. This failed practice placed all residents (based on a census of 18) at risk for the development of disease and infection in a vulnerable population.

**Findings:**

Observation on 7/30/18 at 16:40 pm, revealed Kitchen Staff (KS) #s 2 & 3 preparing meal trays for the long term care residents. Continual observations revealed KS #3 not performing hand hygiene between glove changes during tray assembly. The assembly of the meal trays included handling the food with gloved hands. Observations further revealed KS #2 with gloves on, going to the freezer, opening the door and pulling out a loaf of frozen bread. KS #2 continued to open the bag, reach in, break the

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**

- The Food and Nutrition Services (FNS) Manager will implement an audit to monitor hand washing and gloving.
- The Food and Nutrition Services (FNS) Manager with the assistance of the Infection Preventionist (IP) will audit/monitor and initiate an education/inservice for all kitchen staff.
- For the first month, the FNS Manager will perform weekly hand hygiene audits.
- Each month thereafter, the Manager will select four randomly chosen staff who will be assigned to participate monthly in the Hand Hygiene Audit. The four staff will be rotated so that all kitchen staff have the opportunity to participate in the audits/monitors.

- How other residents having the potential to be affected by the same deficient
Continued From page 28

loaf apart and grab a piece of bread from the middle of the loaf. KS #2 then put the piece of bread in toaster and continued back to the tray line to assemble meals without glove changes or hand hygiene.

During an interview on 8/3/18 at 7:20 am, KS #4 stated yes when asked if hand hygiene should be performed between glove changes.

During an interview on 8/3/18 at 10:05 am, the Dietary Manger stated yes when asked if hand hygiene should be performed between glove changes.

Review of the facility policy "Washing Hands-Ketchikan Medical Center Food Service Department - SOP", undated, revealed "7. Wash Hands: Before putting on or taking off gloves."


All residents have the potential to be impacted.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

The audits, performed by the FNS Manager and designees will document both the number of opportunities for hand hygiene and the number of hand hygiene observations that were compliant. The completed audits will be returned to the FNS Manager, who will work with the Infection Preventionist. The metric will be: a minimum of 10 observations, per person/per month (40 observations). Immediate education will be provided to FNS staff who have observed/known missed opportunities identified by the audits.

How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

The Hand Hygiene Monitoring will be an ongoing for three continuous months; beginning by September 4th, 2018. When the FNS Department achieves 90% compliance, (Goal for 90% is 10/31/18) the monitoring rate will drop to 20 total observations per month, on an ongoing basis. Findings from this inspection will
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<th>(X5) COMPLETION DATE</th>
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<td>F 812</td>
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<td>F 812</td>
<td>be monitored and reported by the FNS Manager and all data gathered from the audits will be reported through the LTC Quality Management Committee (QAPI) to ensure follow-thru and resolution of findings. Data will also be reported annually to the Quality Committee of the Ketchikan Medical Center/LTC Community Health Board, by the Director of Nursing (DON). The date(s) each corrective action will be completed: September 17, 2018</td>
<td>9/17/18</td>
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(i) A facility may not release information that is resident-identifiable to the public.  
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.  
§483.70(i) Medical records.  
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-  
(i) Complete;  
(ii) Accurately documented;  
(iii) Readily accessible; and  
(iv) Systematically organized | 9/17/18         |
§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
   (i) To the individual, or their resident representative where permitted by applicable law;
   (ii) Required by Law;
   (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
   (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
   (i) The period of time required by State law; or
   (ii) Five years from the date of discharge when there is no requirement in State law; or
   (iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
   (i) Sufficient information to identify the resident;
   (ii) A record of the resident's assessments;
   (iii) The comprehensive plan of care and services provided;
   (iv) The results of any preadmission screening and resident review evaluations and
Continued From page 31
determinations conducted by the State;
(v) Physician’s, nurse’s, and other licensed professional’s progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:

Based on record review and interview the facility failed to ensure resident information was accurately documented for 3 residents (#s 2, 3, 14) of 14 sampled residents. This failed practice placed the residents at risk for not receiving services needed to address medical conditions. Findings:

Resident #2

Record review on 7/30/18 - 8/3/18 revealed Resident #2 was admitted to the facility with diagnoses that included Parkinson’s disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), cervical fracture (broken neck vertebrae), and hypertension (high blood pressure).

Review of Resident #2’s most recent care plan, undated, revealed 13 "Multidisciplinary Problems (Active)". Additional review of the individual problems revealed the following omission and/or discrepancies:
1) Review of the "Problem: Difficulty swallowing ..." revealed no start date to the problem or the 4 interventions.
2) Review of the "Problem: Alterations in comfort ..." revealed a start date of 4/26/17. This problem describes a cervical fracture that occurred on

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

The findings for the three residents (2, 3, 14,) were all found to be the result of constraints of the EMR. These three care plans will be reviewed and corrected.

Resident – 2

Dates in the software for this particular issue can’t be changed, due to EMR software constraints. Therefore, the entire Care Plan will be reevaluated for completeness and accuracy. Problems listed will be resolved and a new Care Plan problem “Pain and Discomfort” will be created, as appropriate for current status.

Resident – 3

This was a human error assigning dates. The Care Plan will be reevaluated and interventions that do not apply, will be discontinued, i.e. 1) Monitor resident’s blood sugars, as ordered 2) Monitor A1c level as ordered.

Resident – 14

The Care Plan will be reviewed by the MDS Coordinator, to ensure that all noted...
continued from page 32

4/8/18 (start date is almost one year before incident occurred). All 8 interventions to this problem also have a start date of 4/26/17.

Resident #3

Record review on 7/30/18 - 8/3/18 revealed Resident #3 was admitted to the facility with diagnoses that included cardiovascular accident (CVA - stroke), hemiplegia or hemiparesis (weakness or paralysis of one side of the body), and diabetes mellitus (a chronic condition that affects the way the body processes blood sugar).

Review of Resident #3’s care plan, undated, revealed 18 "Multidisciplinary Problems (Active)". Additional review of the individual problems revealed the following discrepancy: 1) Review of the "Problem: Elevated A1C ... " [A blood test that reflects your average blood glucose levels over the past 3 months] revealed a start date of 5/10/16 and an expected end of 5/14/18. Two interventions to this problem are 1) "Monitor resident's blood sugars as ordered" and 2) "Monitor A1c level as ordered."

During an interview on 8/3/18 at 11:20 am, Licensed Nurse (LN) #4 stated there are no current orders for blood sugar or A1C monitoring. The last blood sugar on Resident #3 was 2/22/16. The last A1C drawn was 7/17/15.

Resident #14

Record review on 7/30/18 - 8/3/18 revealed Resident #14 was admitted to the facility with diagnoses that included cardiovascular accident and hemiplegia or hemiparesis.
Review of Resident #14's most recent care plan, undated, revealed 19 "Multidisciplinary Problems (Active)". Additional review of the individual problems revealed the following discrepancy: 1) Review of the "Problem: Impaired strength and/or mobility ..." revealed a start date of 10/17/17 and a "Description: Related to left side hemiparesis and hemiplegia post CVA." Interventions for this problem were documented as restorative aid, range of motion exercises, with the goal "needs to maintain current flexibility and prevent contractures."

Further review of Resident #14's medical record revealed Occupational Therapy (OT) added instructions for a palm protector with finger separators on 5/29/18 with the following interventions:
- Please place palm shield on [Resident #14] when in bed (in place of previous palm protector).
- If finger separators out of place, please fix them
- Keeping left arm up on pillow for support will help keep it in place and provide comfort to left arm
- If [Resident #14] is having any discomfort with palm shield, please remove and give a break. Attempt to replace in 30 [minutes] - 1 hour.

Additional review of Resident #14's care plan "Problem: Impaired strength and/or mobility ..." revealed no documentation of the palm protector as recommended by OT.

During an interview on 8/2/18 at 7:46 am, Licensed Nurses (LN) #2 & #5 stated they do not use the care plan binders at the nurse's station and they do not regularly incorporate the care plans into their daily care for residents. They had no knowledge of how care plans were updated.

The MDS Coordinator will review current care plans for appropriate date of problem start/resolved, and will be corrected as appropriate.

How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

The Charge Nurse will assign, daily, resident care plans to be reviewed and the nurse responsible to review. Reviews to include completeness, accuracy, or needed updates.

The Charge Nurse will monitor for compliance by review of the "event log" in the Care Plan software.

Care planning will be reported to the LTC Quality Committee (QAPI), by the LTC Director of Nursing or his designee and reported annually to the Quality Committee of the Ketchikan Medical Center/LTC Community Health Board.

The date(s) each corrective action will be completed:

September 17, 2018
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<th>F 842</th>
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<td>During an interview on 8/2/18 at 9:00 am, the interim MDS Nurse (MDSN) could not state why a revision to a care plan would not be done. She stated revisions are manually completed by the full-time MDSN, who was on vacation at the time of this survey.</td>
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| Review of the facility's policy "Care Planning," dated 7/20/16, revealed: "The Care Plan is to be considered a dynamic document. It is to be kept up-to-date on a continual basis, and based on the assessed needs of the individual resident."

Further review of the policy revealed: "The MDS RN-Coordinator is in charge of and responsible for completing, reevaluating and revision of the Resident Care Plan." And "Each discipline is encouraged but not required to make changes on the care plan as necessary. These changes can be written on the paper copy of the care plan, in the care plan notebook, or this can be taken to the MDS RN-Coordinator ..."

<table>
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<th>F 880</th>
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<tr>
<td>SS=D</td>
<td>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</td>
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<tr>
<td>§483.80 Infection Control</td>
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<tr>
<td>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</td>
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<tr>
<td>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention</td>
<td>9/17/18</td>
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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv) When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi) The hand hygiene procedures to be followed
Based on record review, observation, and interview the facility failed to ensure staff performed hand hygiene according to accepted professional practices during the provision of care and services for 1 resident (#4) out of 14 sampled residents. This failed practice increased the risk for the development and transmission of disease and infection in a vulnerable population. Findings:

- Resident #4 was admitted to the facility with a diagnosis of Huntington's disease (an abnormal hereditary condition characterized by progressive involuntary purposeless, rapid motion of body and mental deterioration that results in dementia).

- Review of Resident #4 most recent MDS (Minimum Data Set—a federally required nursing assessment), a quarterly assessment dated 5/7/18, revealed he/she was assessed as totally dependent on staff assistance to eat.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

- 9-4-18 Addendum to plan of correction for rejection 9-4-18
  Activities Coordinator will be scheduling additional mandatory classes for staff to complete hand hygiene education using the 5 moments of care. Those staff members who miss these opportunities will receive mandatory 1:1 education by charge nurse on the unit. This education is to be completed by 9-17-18.

- Hand Hygiene education will be provided to LTC caregivers at a staff meeting on August 29, 2018 date.

How other residents having the potential to be affected by the same deficient practice will be identified:
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 880</td>
<td>Continued From page 37</td>
<td></td>
<td></td>
<td>F 880</td>
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<td>All residents have the potential to be impacted.</td>
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<td>During an observation on 7/30/18 at 5:20 pm, Certified Nursing Assistant (CNA) #2 prepared to assist Resident #4 with dinner. The CNA entered the room, washed his/her hands, and donned a pair of gloves. Further observation revealed CNA #2 then went to the bedside picked up a safety mat off the floor, folded it, and placed it against the wall. With the same gloves on, CNA #2 then positioned the Resident's head of bed up and positioned Resident #4 for eating dinner.</td>
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<td>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</td>
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<td>Further observation revealed CNA #2 positioned Resident #4's food tray on the bedside table and began handling the food and food items without changing the gloves he/she had used to handle the floor mat. CNA #2 mixed all of Resident #4 pureed food together as well as prepared the rest of the tray before he/she changed gloves to assist Resident #4 to eat dinner.</td>
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<td>The Infection Prevention Department/Infection Preventionist (IP) and Director of Nursing (DON) and/or designee will provide education using the World Health Organization tools; The five moments of hand hygiene to include: 1. Before touching the patient, 2. Before clean/aseptic procedures, 3. After body fluid exposure/risk, 4. After touching the patient, 5. after touching the patient's surroundings.</td>
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<td>During an interview on 7/30/18 at 5:32 pm, CNA #2 stated he/she should have changed gloves and completed hand hygiene prior to making contact with the Resident #4's bed and before preparing his/her food.</td>
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<td>The Infection Prevention Department/Infection Preventionist (IP) and Director of Nursing (DON) and/or designee will provide education on how and when to perform hand hygiene with soap and water and when to use hand sanitizer.</td>
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<td>Review of the facility's competency training &quot;Your 5 Moments for Hand Hygiene,&quot; no date, revealed: &quot;clean your hands after touching a patient and her/his immediate surroundings ...&quot;</td>
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<td></td>
<td>The Infection Prevention Department/Infection Preventionist (IP) and Director of Nursing (DON) and/or designee will provide education on hand hygiene and medical glove use.</td>
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</tbody>
</table>
| | | Review of the facility's competency training verification "Hand Hygiene Verification," dated 3/30/17, revealed when to wash hands: " ...to perform work in any health care settings are required to clean their hands ...also when touching any object or furniture in a patient's immediate surroundings ..." | | | | How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur, i.e., what quality assurance
### Summary of Deficiencies

#### F 880

- **Description:** Continued From page 38.
- **Correction:** Auditing hand hygiene will be put into place:
  - Auditing hand hygiene five moments: 1) Before touching the patient, 2) Before clean/aseptic procedures, 3) After body fluid exposure/risk, 4) After touching the patient, 5) After touching the patient's surroundings.) and wash in/wash out compliance will occur monthly by selected LTC caregiver observers totaling 30 observations per month, half of which must be using the 5 moments technique.
  - After achieving compliance rates of greater than or equal to 90% for 3 months, observations may be decreased to 20 per month, ongoing.
  - Hand Hygiene audit rates will be reported to LTC Quality Committee (Quality Assurance/Process Improvement); which reports to the KMC Community Health Board. If rates drop below 90%, re-education will occur until monitoring reaches 90% compliance again.
  - All education will be completed and the monthly observations/auditing will begin by September 17, 2018.
  - The date(s) each corrective action will be completed: September 17, 2018.

#### F 908

- **Tag:** SS=F
- **Description:** Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)
- **Correction:** §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.
<table>
<thead>
<tr>
<th>ID PREFIX</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 908     |     | Continued From page 39 condition. This REQUIREMENT is not met as evidenced by:  
Based on observation and interview the facility failed to ensure patient care equipment was maintained in safe operating condition. Specifically, the plate warmer in the kitchen, SECO model 4731166 lacked a preventive maintenance or inventory sticker placing all residents (based on a census of 18) at risk for receiving foods at inconsistent and/or potentially dangerous temperature ranges. Findings:  
Observations on 7/30 - 8/3/2018 revealed kitchen staff retrieving plates from a SECO model 4731166 plate warmer. Further observation revealed the equipment lacked a preventive or any type of maintenance or inventory sticker.  
During an interview on 8/1/18 at 12:25 pm with the Dietary Manager (DM) when asked how maintenance on the plate warmer was completed, the DM reported when the machine breaks we submit a work order and it gets fixed. When asked to see the policy for maintenance/use and owner's manual for the plate warmer the DM was unable to produce these documents.  
During an interview on 8/1/18 at 2:30 pm with Environmental Services (ES) employee #s 1 and 2, when asked to produce a policy or any documentation for maintenance/use or the owner's manual for the plate warmer they were unable to produce these documents.  
 | F 908 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:  
The older-style unit with a scaled numeric setting is being replaced with an induction base warming system. The old system used metal bases to hold the plates. This induction system for keeping plates warm is in place in other Food and Nutrition Services (FNS) PeaceHealth facilities.  
How other residents having the potential to be affected by the same deficient practice will be identified:  
All residents have the potential to be affected.  
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:  
The new unit uses the induction method and the plates are held in place by what is called a "pellet." The plate fits into the plastic pellet; cool to the touch and there is no exposed metal for a residents or others to potentially burn themselves. The replacement of the unit with the induction unit will bring the FNS Department into best practice and the PeaceHealth System standard.  
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<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 908</td>
<td>Continued From page 40</td>
<td>F 908</td>
<td>How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The FNS Manager will follow a Preventative Maintenance (PM) at the frequency recommended by manufacturer. The PM can be added to the Facilities PM scheduled if needed. The date(s) each corrective action will be completed: NOTE TO STATE/CMS: We have confirmation that the unit will ship 9/20 (from the East Coast) and be delivered to the freight forwarder in Seattle by 9/27. Shipping is then barge-dependent. September 17, 2018</td>
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