The following deficiencies were noted during an unannounced standard Medicare/Medicaid recertification survey conducted 5/15-19/17. The sample included 10 residents, 1 closed record and 4 non-sampled residents.

F 166
483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES

(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the

Electronically Signed
06/15/2017

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

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

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED: 05/19/2017

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 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 166 Continued From page 1
facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the

(X5) COMPLETION DATE
F 166

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YBOQY11 Facility ID: KGHLTC If continuation sheet Page 2 of 42
Continued From page 2

Based on record review, interview and policy review the facility failed to ensure: 1) prompt efforts to resolve 2 residents (IDs 3 and 4) concerns over lost clothing that was laundered at the facility, 2) prompt efforts to resolve a resident’s (#9) concerns related to activities and lost items, and 3) residents (based on a census of 25) knew how to file a grievance with the

Residents Affected by the Finding

Missing Clothing

Resident #3

Complaint: Missing a white dress shirt.
Complaint: Unaware of the existence of a Grievance Officer and her contact information.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 166</td>
<td>Continued From page 3 grievance officer. Failure to ensure complaints and grievances were resolved and residents had access to accurate information on how to file a grievance, placed residents at risk for not having their concerns addressed in a timely manner. Findings: Missing clothing Resident #3 Record review from 5/16-19/17 revealed Resident #3 was admitted to the facility with diagnoses that included Parkinson's disease. During a group interview on 5/17/17 from 9:00 am - 9:50 am, Resident #3 stated he/she had a white dress shirt that went missing. The Resident stated the facility knew the shirt was missing and had looked for it. The item had not been found or replaced.</td>
<td>F 166</td>
<td>1) Facility staff will ascertain if the item is still missing - ask Resident #3 2) If the shirt continues to be missing, the facility will make an attempt to locate this shirt. Staff will assist Resident #3 to look in his closet and in his drawers, in an attempt to locate it. 3) If it can’t be located, a new shirt will be obtained for Resident #3, at no cost to him. 4) Staff will ensure that all of Resident #3’s clothing is discretely labeled with his name and is inventoried. 5) Resident #3 will be given the latest contact information for the Grievance Officer, with instructions of how to contact her.</td>
<td>F 166</td>
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<td>Resident #4 Record review from 5/16-19/17 revealed Resident #4 was admitted to the facility with diagnoses that included Parkinson disease and depression. During a group interview on 5/17/17 from 9:00 am - 9:50 am, Resident #4 stated he/she lost a pair of black pants. The Resident stated the pants went missing around 6 months ago and said &quot;at this point they will never show up.&quot; The Resident further stated the facility did not offer to replace the pants and told the Resident to make sure the clothing is labeled. During an interview on 5/19/17 at 10:00 am the Activities Staff (AS) #2 stated the facility tried their best to locate the pants. If they were not found, the staff would try to contact the Resident's husband.</td>
<td></td>
<td>1) The facility staff will ascertain if the pants are still missing - they will ask Resident #4. As Resident #4’s husband rotates her clothes, with clothes from home, he too will be asked about the missing pants. 2) If, at this point, Resident #4 and her husband feel the pants are still missing, staff will attempt to locate them. Staff will assist Resident #4 and / or her husband to</td>
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<tr>
<td>Prefix Tag</td>
<td>Summary Statement of Deficiencies</td>
<td>Prefix Tag</td>
<td>Provider's Plan of Correction</td>
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<td>F 166</td>
<td>Continued From page 4 best to find missing clothing, &quot;but we are not responsible [for missing clothing].&quot; Additionally, on 5/19/17 at 9:30 am, the facility provided a form titled &quot;Lost Item Report&quot;. The Charge Nurse (CN) stated activities staff kept track of the missing items using the lost item report form. The CN further stated the facility was only responsible to replace lost medical equipment. During an interview on 5/19/17 at 10:00 am, when asked where the residents lost item report forms were, AS #2 stated he/she &quot;did not use this form.&quot; Review on 5/19/17 at 9:30 am of the facilities policy, &quot;Clothing Labeling and Washing&quot; last reviewed 7/14/16, revealed &quot;...All clothing and/or personal bedding of a residents is labeled upon admission to the Transitional Care Unit...The resident and/or family member is informed that any new clothing and/or personal bedding brought into the facility must be labeled before being placed in resident's room...If a resident's family member elects to wash the resident's clothing and/or personal bedding the Transitional Care Unit is not respons</td>
<td>F 166 thoroughly search in her closets and drawers. 3) If the pants can't be located, at this point, a new pair of pants will be obtained for Resident #4. 4) Staff will ensure that all of Resident #4's clothing is discretely labeled with her name and inventoried. 5) Resident #4 and her husband will be given the latest contact information for the Grievance Officer, with instructions of how to contact her.</td>
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**Summary Statement of Deficiencies**

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<tr>
<th>ID Prefix Tag</th>
<th>Regulatory or LSC Identifying Information</th>
<th>ID Prefix Tag</th>
<th>Corrective Action Should Be Cross-referenced to the Appropriate Deficiency</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>F 166</td>
<td>Continued From page 5</td>
<td>F 166</td>
<td>Resident #9, that Resident #9 is allowed to do his crafts in his room, at the time of his choosing. 6) Resident #9 will be given the latest contact information for the Grievance Officer, with instruction of how to contact her. Identify other Residents These findings have the potential to affect all residents in the facility. Corrective Measure 1) Staff will receive in-servicing on the handling of complaints and grievances, in accordance with the facility Grievance Policy. 2) This in-servicing will be done during the next staff meeting and / or via electronic means. Meeting minutes and / or e-mail receipts will serve as verification of completion. 3) The Posting &quot;Notice to All Residents and Families&quot; has been modified to Put the Grievance Officers name and contact information at the top of the list of contacts, followed by the contact information for the Hot Line &quot;Hot Line to the Heart&quot; and then followed by contact information for facility Administrative staff. 4) All residents will receive a copy of this posting and a copy will be sent to families. Residents and families will also be informed.</td>
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Review of the care conference notes dated 5/2/17 revealed "ACTIVITIES...states that [he/she] wants to do [his/her] hobbies in [his/her] room instead of activities room...enjoys creating things out of anything [he/she] can find and boarders on hoarding. Staff discussed...what could be kept, how long things could be kept, and how the room must be clean. [He/she] is very satisfied when [he/she] creates [his/her] projects."

Review on 5/18/17 of Resident #10's comprehensive care plan last revised 5/3/17 revealed "Problem: Additional Psych/Social Problem...Goal...Resident will be able to maintain sense of well-being by working on crafts in room..."

During an interview on 5/17/17 at 10:05 am, Resident #9 stated when he/she was transferred to another facility for a few weeks some of his/her belongings were missing. The missing items were a box of craft supplies and a power cord for a digital camera. Additionally, Resident #9 stated the facility no longer allowed him/her to do his/her arts and crafts projects in his/her room. Resident #9 stated he/she sometimes awakes at night and wants to work on his/her crafts. Resident #9 stated he/she was told he could not have scissors or knives in his room and therefore needs to do his activities in the activity room. The Resident...
Continued From page 6

was unaware there was a grievance officer he/she could contact.

During an interview on 5/17/17 at 3:45 pm Activity Staff (AS) #1 stated Resident #9 had a history of hoarding craft items in his/her room. Multiple items had to be boxed up when the Resident had been previously transferred and discharged to the hospital.

During an interview on 5/19/17 at 8:50 am the Grievance Officer (GO) stated she had not received any grievances related to Resident #9.

During an interview on 5/19/17 at 9:00 am, the Charge Nurse (CN) stated the facility was still working on the issue with Resident #9 being able to do his/her arts and crafts in his/her room. The CN stated there was concern over the health and safety of the Resident's use of carving knives. The CN confirmed the issue was not resolved and stated the issue was brought up at the last care conference meeting.

Grievance Officer Information

During a group interview on 5/17/17 at 9:00 am - 9:40 am, when asked about filing a complaint or grievance Resident #3 stated he/she was not sure how to file a complaint. Resident #4 stated he/she tells anyone who is handy if he/she has a concern.

During an interview on 5/18/17 at 3:00 pm, Resident #9 stated he/she did not know who to contact within the facility to resolve his/her concerns. The Resident stated he/she was not aware of the GO.

that they may contact the Grievance Officer any time they wish to make a complaint, and how to do so.

5) This updated information will be given to the residents and/or families at the time of admission

6) This update posting will replace all current postings, around the facility.

7) The current policy will be modified to identify the Grievance Officer and how the resident or family member can contact the GO directly.

8) All of the GO's contact information will be included in the policy revision, including e-mail address.

9) Staff will be made aware of how to contact the Grievance Officer and that if requested by a resident, they are to do so, right away.

Staff will also be informed that they may contact the Grievance Officer at any time they think it appropriate.

To Prevent Recurrence

1) Semi-annually the Grievance Officer will provide the New Horizons Quality Committee with a report as to grievances received and actions taken to resolve them.

2) Resident medical record review will be done quarterly to ensure that there is documentation that each resident has received information relative to filing a grievance and how to contact the Grievance Officer.
Continued From page 7

During an interview on 5/19/17 at 10:00 am Activities Staff (AS) #2 stated if a Resident issue cannot be resolved, it goes to the Director of Nursing (DON). The AS further stated he/she had never notified the GO.

During an interview on 5/18/17 at 8:00 am, the GO stated the process for filing a grievance was to call the grievance telephone number, "Hotline to the Heart". The GO further stated the grievance telephone line was managed by a staff member (Staff #1). The GO stated Staff #1 either entered the information in the grievance log or informed the GO of the concern.

Observation on 5/18/17 at 8:40 am revealed the facility's policy "Resident Grievance" page 5 was posted in the dining room and at the nurse's station. Review of the posting revealed "Notice to all Residents and Families" "You have the right to file grievances orally (meaning spoken) or in writing; and to file grievances anonymously; the contact information of the grievance official with who a grievance can be filed is..." The posting first listed the DON, then facility Administrator, and next the GO.

Review on 5/18-19/17 of the facility's policy "Resident Grievance" last revised 3/9/10 revealed "Resident Complaint...Calling and leaving a voice mail on the local Grievance telephone lines or any of the toll-free numbers titled, "Hotline to the Heart...Writing a letter or sending an email, expressing dissatisfaction to the LTC [long term care]...DON, Risk Management, or Administration..."

Additionally, the "Resident Grievances" policy Officer. This data will be reported to the DON who will include it in the report to the New Horizons Quality Committee

3) The Posting "Notice to All Residents and Families," which includes the contact information for the Grievance Officer, will, going forward, be given to residents upon admission. Further it will be given to all current residents at least annually and more frequently if necessary.
Continued From page 8 revealed "...Grievances are expressions of dissatisfaction or complaints that cannot be resolved to the resident's satisfaction...All Grievances and investigative review responses are documented..."

Review on 5/18-19/17 of the facility's "Resident Rights and Responsibilities" last revised 3/31/17 revealed the last page listed contact information "...IF YOU HAVE A COMPLAINT you may file a complaint...concerning resident abuse, neglect, and/or misappropriation of resident property in the facility with..." The telephone listed for the GO was different then for the "Hotline to the Heart" number listed in the "Resident Grievance" policy.

Additional review of the facility's "Resident Rights and Responsibilities" revealed, "Grievance Procedure You have the right to: Voice or write your concerns and complaints to the charge nurse about treatment of care we provide or the behavior of other residents". The Grievance Procedure did not identify that the Residents could contact the grievance officer.

483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY

(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident’s individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by:

- Personal Cares
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<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER’S PLAN OF CORRECTION</th>
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| F 241 | Continued From page 9 | Based on record review, observation, and interview, the facility failed to provide cares and services in a manner that maintained and promoted dignity for 3 residents (#'s 5, 14 and 15). Specifically, the facility failed to: 1) ensure personal care was provided in a manner to promote dignity and comfort for 1 resident (#5) out of 5 residents observed during personal cares, and 2) removed gait belts (devices used by caregivers to transfer residents with mobility issues from one position to another, from one location to another or while ambulating residents who have problems with balance) for 2 residents (#'s 14 and 15) out of 5 observed during a group meeting who required gait belt use for transfers. These failed practices had the potential to negatively affect the residents’ self-esteem and quality of life. Findings: Personal Cares: Resident #5 Record review from 5/16-18/17 revealed Resident #5 was admitted to the facility with failure to thrive, expressive aphasia, recurrent skin integrity issues, diabetes, stroke and flaccidity to left side of body. Review of the most recent MDS (Minimum Data Set) assessment, a quarterly assessment dated 5/9/17, revealed the Resident was coded as needing extensive assistance with 2 persons for bed mobility, dressing and personal hygiene. Observation on 5/16/17 at 11:18 am, revealed certified nursing assistants (CNA) #1 and 2 provided morning cares to Resident #5. During Action for Affected Residents Resident #5 The CNAs that cared for resident #5 on 05-16-2017 were reminded, via electronic means, how to provide personal care to a resident. They were reminded that they needed to bring everything required to his bedside at the same time, to keep him completely covered with the curtain drawn until the actual care tasks commenced and if one of them needed to leave, for any reason, they need to ensure that he was completely covered until the actual care tasks resumed. The Care Plan will be updated to reflect this. Resident # 5 continued The CNAs that provided afternoon care to Resident #5 were instructed, via electronic means, that they were required to be more alert and mindful to the possibility that the care being provide could cause him pain and if it was, they needed to find an alternative that did not cause Resident #5 any discomfort. When they attempt to assist Resident #5 to put his pants on, they should not need to lift his legs 12-14 inches off the bed, 2-4 inches, at most, should be sufficient. Further, as Resident #5 had wounds on his lower extremities, great care needs to be exercised to avoid causing him any discomfort by handling them. Again they are to be very alert to his reaction to the care being provided and modify, if it appears to be causing discomfort or distress, it needs to be stopped and...
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<th>F 241</th>
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<td>cares, CNA #2 rolled the Resident to the left side exposing his/her buttocks and genitals. During the observation CNA #2 left the bedside multiple times to obtain various items such as clothing, mechanical lift and sling. The CNAs did not cover the Resident while CNA #2 left to get supplies. As a result, the Resident was exposed while waiting for staff to obtain supplies.</td>
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Observation on 5/16/17 at 12:27 pm revealed CNA#s 1 and 3 were dressing Resident #5. During the observation both CNAs raised Resident #5's legs off the bed approximately 12 to 14 inches to place the Resident's pants on each leg. The Resident began to rapidly swing his/her upper right arm and meaningfully grimaced and attempted to yell in discomfort. Neither CNA noticed the Resident's reaction to the Activities of Daily Living (ADL) until prompted by the Surveyor. |

During an interview on 5/17/17 at 2:49 pm the Administrator stated staff should cover residents during cares to decrease unnecessarily exposure. In addition, the Administrator stated staff should always be mindful of residents' response to cares and find adaptations to cares if causing pain. |

Gait Belts: |

Resident #14 |

Record review from 5/17-19/17 of Resident #14's care plan, dated 5/17/17, revealed "...Resident needs FWW [front wheeled walker] with gait belt and stand by assist for ambulation." |

Observation during a group interview on 5/17/17 from 9:00 am to 9:40 am revealed Resident #14 alternatives sought to accomplish the task. The Care Plan will be updated to reflect this. Identify other residents This finding has the potential to affect all residents. Corrective Measure 1) Policy number 302.287.67 "Resident Dignity," will be updated to include the maintenance of resident dignity and modesty during the provision of personal care. 2) Mandatory in-services will be held for all CNA staff, to reinforce those skills learned in training, including the maintaining of dignity and modesty of all residents, as well as, being mindful of residents responses to cares provided. 3) Record of this in servicing will be in the staff meeting minutes and e-mail delivery receipts. To Prevent Recurrence Auditing of CNAs will be done until three consecutive months of compliance of over 95% is shown. This auditing will be reported to the Quality Committee.  
Gait Belts Affected Residents Resident #14 CNAs were instructed, via electronic means, that Resident #14's gait belt should be removed and left off anytime it
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<td>F 241</td>
<td>Continued From page 11 arrived ambulating with a walker and had a gait belt on. The Resident sat in a chair during the meeting and had the gait belt on during the entire meeting.</td>
<td>F 241</td>
<td>wasn't in direct use to assist with the use of her walker. It had been left on during a resident meeting with the surveyors, when it should have been removed. This does not show respect for her dignity. The Care Plan will be so updated</td>
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<td>Record review from 5/17-19/17 revealed Resident #15 was admitted to the facility with diagnoses that included dementia.</td>
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<td>Resident #15 CNAs were instructed, via electronic means, that Resident #15's gait belt should be removed and left off anytime it wasn't in direct use to assist him with locomotion or transfers. This does not demonstrate respect his dignity. It had been left on during a resident meeting with the surveyors, when it should have been removed. The care plan will be up-dated to reflect this.</td>
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<td>Continuous observation on 5/17/17 from 9:05 am - 9:50 am revealed Resident #15 wearing a gait belt around his/her waist throughout the entire Resident group meeting.</td>
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<td>Identify other residents This finding has the potential to affect all residents that use gait belts.</td>
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<td>Review of Resident #15's most recent care plan, dated 4/20/17, revealed &quot;...Assist/supervise with transfers and ambulation&quot;</td>
<td></td>
<td>Corrective Measure 1) Policy number 302.287.67 &quot;Resident Dignity,&quot; will be updated to include the use of Gait Belts and their removal when not in direct use. 2) Staff will receive in servicing regarding these findings and Plan for Correction, both electronically and / or at the next staff meeting. Meeting minutes and / or e-mail receipts will serve as verification of completion.</td>
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<td>During an interview on 5/17/17 at 2:15 pm, CNA #s 3 and 4 stated gait belts should come off when not being used.</td>
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<td>To Prevent Recurrence</td>
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<td>During an interview on 5/19/17 at 10:10 am, the MDS Coordinator stated she understood the gait belts should come off when not transferring the Resident.</td>
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<td>Review on 5/16-19/17 of &quot;New Horizon Transitional Care Unit...Resident Rights and Responsibilities,&quot; revised 3/31/17, revealed &quot;...You have the right to...Be treated with</td>
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<tr>
<td>F 241</td>
<td>Continued From page 12 consideration, respect and dignity...‖</td>
<td>F 241</td>
<td>Auditing of CNAs will be done until three consecutive months of compliance over 95%. This auditing will be reported to the Quality Committee.</td>
<td>7/3/17</td>
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| F 242         | 483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES | F 242         | Action for Affected Residents - Resident #7  
- Staff were immediately instructed to offer resident #7 the opportunity to use the recliner as soon as she is finished with lunch. If the recliner was in use by another resident, other seating options were to be offered to Resident #7. Further, staff have been instructed to do this on a regular basis, whenever Resident #7 is up in her wheel chair.  
Resident #9 He will be allowed to do his craft projects | 7/3/17         |

(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

This REQUIREMENT is not met as evidenced by:

Based on record review, observation, and interview the facility failed to ensure 2 residents (#7 and 9) out of 10 sampled residents were provided the opportunity to make choices significant to them and consistent with his or her interests and plan of care. Specifically, the facility failed to provide opportunities for: 1) Resident #7 to sit in the recliner in the activities room, and 2) Resident #9 to do activities such as arts and crafts, in his/her room. This failed practice had the potential to affect the residents’ quality of life in general. Findings:
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<th>F 242</th>
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<td><strong>Resident #7</strong></td>
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<td>in his room, at any time of the day or night.</td>
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<td>Record review from 5/16-18/17 revealed the 94 year-old Resident was admitted to the facility with diagnoses that included Alzheimer’s disease and polymyalgia rheumatic (an inflammatory disorder that causes muscle pain and stiffness). The Resident had a Personal Representative (PR) to assist in making health care decisions for him/her.</td>
<td>He will be evaluated to determine his ability to use his knives and will be able to use his knives with the degree of supervision that the assessment indicates is necessary and when the facility is able to provide that supervision. A secure, locked cupboard or box will be provided for the storage of the knives when not in use.</td>
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<td>Review of the most recent MDS (Minimum Data Set) assessment, a quarterly assessment dated 3/20/17, revealed the Resident was coded as total dependence for transfers. Additionally, the Resident was coded as having short and long-term memory problems and was moderately impaired (decisions poor; cues/supervision required) for cognitive skills for daily decision making.</td>
<td>Identify other residents This could potentially affect all residents.</td>
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<tr>
<td>Review of the comprehensive care plan revealed the &quot;Problem: Alteration in cognition...Goal: Resident will be able to function to their highest level, as is compatible with their current cognition...Intervention: Offer resident choice (where to sit...)...&quot;</td>
<td>Corrective Measure 1) Staff will be educated on the need to provide alternative seating to residents in wheelchairs. This in-servicing regarding these findings and Plan for Correction, will be conducted electronically and / or at the next staff meeting. Meeting minutes and / or e-mail receipts will serve as verification of completion. 2) A policy will be created, that pertains to all residents, reflecting the use of knives for crafts to include a risk assessment. 3) The ability to practice arts and crafts separately from others, in the residents room will be added to the resident rights which is given to each resident upon admission. The risk assessment process will also be added to the resident rights.</td>
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<tr>
<td>Random observations from 5/15-18/17 revealed Resident #7 was sitting in the wheelchair for the lunch time meal and remained up until after dinner. During the observations facility staff did not offer the Resident an opportunity to relax in the recliner or other alternative seating.</td>
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<tr>
<td>During an interview on 5/18/17 at 11:40 am, Resident #7's PR stated he/she would like to see the Resident in the recliner in the activity room</td>
<td>To Prevent Recurrence</td>
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<tr>
<td>F 242</td>
<td>Continued From page 14</td>
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<td></td>
<td>more often. The PR stated the Resident was up in the wheelchair for a long time and sometimes fell asleep in the wheelchair. Resident #7’s PR stated Resident #7 enjoyed sitting in the recliner. The PR stated he/she had asked facility staff to transfer the Resident to the recliner in the afternoon.</td>
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<td></td>
<td>During an interview on 5/19/17 at 10:00 am, Activities Staff (AS) #2 stated the facility staff transferred Resident #7 to a recliner if the PR requested it. AS #2 further stated Resident #7 had last used the recliner a couple weeks ago.</td>
<td></td>
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<tr>
<td></td>
<td>As a result, the Resident was not constantly offered an alternative more comfortable option for seating between meals.</td>
<td></td>
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<tr>
<td>Resident #9</td>
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<tr>
<td>Record review on 5/17-19/17 revealed Resident #9 was admitted to the facility with diagnoses that included a history of depression. Further review revealed Resident #9 was previously transferred from the facility on 3/30/17 and then readmitted on 4/12/17.</td>
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<tr>
<td>Review of the admission MDS assessment dated 6/10/16, revealed the Resident was assessed for activity preferences. The Resident answered very important to the question &quot;how important is it to you to do your favorite activities?&quot;</td>
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<tr>
<td>Review of the care conference notes dated 5/2/17 revealed *ACTIVITIES ~ ...states that [he/she] wants to do [his/her] hobbies in [his/her] room instead of activities room...enjoys creating things out of anything [he/she] can find and boarders on hoarding. Staff discussed ...what could be kept,</td>
<td>F 242</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1) Activities staff will monitor the Activities room and dining room for residents that have remained in their wheelchairs longer than necessary and offer them the opportunity to relax in a chair, recliner or sofa, if they so wish.</td>
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<td></td>
<td>2) The Activities staff will monitor residents who express the desire to practice their crafts separately. They will monitor for when that resident does not avail themselves of that right and attempt to ascertain and correct the reason. Activities will involve the D.O.N. as necessary, to help resolve any issues identified.</td>
<td></td>
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<tr>
<td></td>
<td>3) Activities will maintain this information in a log and report to DON monthly</td>
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</tbody>
</table>
### SUMMARY STATEMENT OF DEFICIENCIES

- **F 242** Continued From page 15
  - how long things could be kept, and how the room must be clean. [He/she] is very satisfied when [he/she] creates [his/her] projects."
  
  Review on 5/18/17 of Resident #10's comprehensive care plan last revised 5/3/17 revealed "Problem: Additional Psych/Social Problem...Goal...Resident will be able to maintain sense of well-being by working on crafts in room..."

  Review of the social worker notes (SW) dated 4/17/17, revealed ".Concerns- When pt [patient] was discharged it was reported that pt had a lot of knives in [his/her] room, [he/she] does a lot of art work so currently [he/she] is able to use [his/her] knives in the activity room but [he/she] would like to have them in [his/her] room. [He/She] is still working with LTC management to clear these guidelines up."

  Further record review revealed the facility had not conducted an assessment on the Resident's ability to use scissors and/or carving knives in a safe manner, nor had the facility explored options for safer methods.

  During an interview on 5/17/17 at 10:05 am, Resident #9 stated he/she was transferred to another facility for a few weeks and when he/she returned the facility no longer allowed him/her to do his/her crafts in his/her room. Resident #9 stated he/she sometimes woke at night and wants to work on his/her crafts in his/her room. The Resident stated the facility stated he/she could not have scissors or knives in his/her room and needed to do the activities in the activity room.
### Statement of Deficiencies and Plan of Correction

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

- **Building:** ____________________________  
- **Wing:** ____________________________  
**Date Survey Completed:** 05/19/2017

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

- **Building:** ____________________________  
- **Wing:** ____________________________

**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>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
</table>
| F 242      | Continued From page 16  
During an interview on 5/19/17 at 9:00 am, the Charge Nurse (CN) stated the facility was still working on the issue with Resident #9 being able to do his/her arts and crafts in his/her room. The CN stated there was concern over the safety of the Resident's use of carving knives.  
Further record review revealed the facility had not conducted an assessment on the Resident's ability to use scissors and/or carving knives in a safe manner, nor had the facility explored options for safer methods.  
Review on 5/18/17 of the facility's "Resident Rights and Responsibilities" revealed "You have the right to...Have your needs and preferences accommodated..." | F 242        | F 242        | 7/3/17                                                  |
| F 278      | 483.20(g)-(j) Assessment Accuracy/Coordination/Certified  
(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.  
(h) Coordination  
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  
(i) Certification  
(1) A registered nurse must sign and certify that the assessment is completed.  
(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. | F 278        | F 278        | 7/3/17                                                  |
<table>
<thead>
<tr>
<th>F 278</th>
<th>Continued From page 17</th>
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</thead>
<tbody>
<tr>
<td>(j)</td>
<td>Penalty for Falsification</td>
</tr>
<tr>
<td>(1)</td>
<td>Under Medicare and Medicaid, an individual who willfully and knowingly-</td>
</tr>
<tr>
<td>(i)</td>
<td>Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or</td>
</tr>
<tr>
<td>(ii)</td>
<td>Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.</td>
</tr>
<tr>
<td>(2)</td>
<td>Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:</td>
</tr>
</tbody>
</table>

Base on record review and interview the facility failed to ensure MDS (Minimal Data Set), a Federally required nursing assessment, were accurately completed to reflect the status of 3 residents (#s 4, 5 and 6) out of 6 residents who's MDS's were reviewed. This failed practice resulted in inaccurate information about 3 residents and placed them at risk for inaccurate care planning and care. Findings:

Resident #4

Record review from 5/16-19/17 revealed Resident #4 was admitted to the facility with diagnoses that included Parkinson disease, depression and visual hallucinations.

Further review of Resident #4’s medication
Continued From page 18

administration record (MAR) revealed no antipsychotic medications on the Resident's medication list. Review of the discontinued and completed medication lists from 10/16/16 to 5/18/17 revealed no antipsychotic medications were listed.

Review of the most recent MDS comprehensive assessment, an annual assessment dated 2/15/17, revealed the assessment coded the Resident as receiving antipsychotic medications during the last 7 days.

During an interview on 5/17/17 at 2:30 pm the MDS Coordinator stated Resident #4 had not taken any antipsychotics should not have been coded as taking them on the 2/15/17 MDS assessment.

Resident #5:

Record review from 5/16-18/17 revealed Resident #5 was admitted to the facility with failure to thrive, expressive aphasia, depression, recurrent skin integrity issues, diabetes, stroke and flaccidity to left side of body.

Initial/Admission Assessment:

Review of the MDS assessment, an admission assessment, dated 2/14/17, revealed the Resident was coded as dressing did not occur under the activities of daily living (ADLs). In addition, the Resident was coded as having an unstageable pressure ulcer that was not present on admission and taking antipsychotic medication during assessment period.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREVIOUS STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| F 278 | Continued From page 19. During an interview on 5/17/17 at 1:34 pm the MDS Coordinator stated the ADL dressing did occur and it was a miscoding. The MDS Coordinator further stated the Resident did have a pressure ulcer on admission and the MDS was miscoded. The MDS Coordinator reviewed the medication the Resident took during the admission assessment period and confirmed the Resident did not an antipsychotic medication. Quarterly Assessment: Review of the most recent MDS (Minimum Data Set) assessment, a quarterly assessment dated 5/9/17, revealed Resident #5 was coded as not toileting. Further review revealed the Resident was coded as have taken antipsychotic medications during the quarterly assessment review period and had a diabetic foot ulcer. | F 278 | Continued From page 19. During an interview on 5/17/17 at 1:34 pm the MDS Coordinator stated the ADL toileting was miscoded as not occurring. In addition, the MDS Coordinator confirmed the Resident was not taking antipsychotic medications during the quarterly assessment review period. The MDS Coordinator further stated the Resident did not have a diabetic foot ulcer. Resident #6.

Record review from 5/16-19/17 revealed Resident #6 was admitted to the facility on 3/20/17 with diagnoses that included failure to thrive, history of prostate cancer and 3 - Stage 1 pressure injuries. Review of the hospital discharge summary dated 3/20/17 revealed the discharge diagnoses included "Decubitus ulcer [pressure injury] of... |
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| F 278 | Continued From page 20 sacral region, stage 2".  
Review of the nurse's progress note dated 3/22/17 revealed "...dressing to stage 1 pressure injuries..." No Stage 2 pressure injuries were identified.  
Review of the care plan for the problem "Alteration in skin integrity" revealed "Document comprehensive description of pressure ulcer ...Stage 1 x3, lt [left] hip, lt heel, and sacrum..."  
Review of the admission MDS assessment dated 03/27/17, revealed the Resident was coded as having 3 - Stage 1 pressure injuries.  
During an interview on 5/18/17 at 10:00 am, Licensed Nurse (LN) #3 stated pressure injuries are never downgraded. The LN stated the pressure injury on the sacrum should have been identified as a Stage 2.  
Review on 523/17 of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.14, dated October 2016, Chapter 3 Section M Page 1, revealed "Review the medical record for the history of the ulcer...Review for location and stage at the time of admission/entry or reentry..."  
Review on 5/23/17 of the National Pressure Ulcer Advisory Panel (NPUAP) website at http://www.npuaap.org/wp-content/uploads/2012/01/NPUAP-Position-Statement-on-Staging-Jan-2017.pdf, revealed, ",...The numerical staging system does NOT imply linear progression of pressure injuries from Stage 1 through Stage 4, nor does it imply healing from Stage 4 through Stage 1...The NPUAP has long maintained this | F 278 |
Continued From page 21

Review of the Centers for Medicare & Medicaid Services "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.14, dated 10/2016, revealed "It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment...The RAI process, which includes the Federally-mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated..."
Continued From page 22

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans
F 280 Continued From page 23
(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.

(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 resident 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 record review, observation and interview the facility failed to update and revise...
Continued From page 24

the care plan to reflect the current level of care and services for one resident (#3) out of 7 residents whose care plans were reviewed. Specifically, the facility failed to revise a care plan to reflect the need for a gait belt when the resident was out of bed. Failure to assess and revise care plan problems, goals, and interventions placed the resident at risk for not receiving appropriate and/or necessary care and services. Findings:

Record review from 5/16-19/17 revealed Resident #3 was admitted to the facility with diagnoses that included Parkinson's disease, progressive supranuclear palsy (a brain disorder that affects movement, control of walking [gait] and balance, speech, swallowing, vision, mood and behavior, and thinking,) and frequent falls.

Review of the comprehensive care plan, dated 4/26/17, revealed "...Use assistive device when assisting with transfers and ambulation ...1 person stand by assist with gait belt and FWW [front wheeled walker]"

Random observations throughout the survey from 5/15-19/17 revealed the resident had a gait belt on his waist while he/she sat in his/her wheelchair.

During an interview on 5/16/17 at 8:50 am certified nursing assistant (CNA) #5 stated, "We keep [his/her] gait belt on when [he/she] is out of bed, just in case [he/she] is impulsive and rises on [his/her] own."

Observation during Resident group meeting on 5/16/17 from 9:00 am to 9:50 am revealed Res #3 left the meeting briefly. On his/her return at 9:25 am, he/she wore a gait belt. Res #3 stated future, the process will be to remove unless resident specifically requests it be left in place. If the resident makes such a request, it will be documented in his medical record. This will also be noted on the Plan of Care.

Corrective Measure
1) Policy number 302.287.67 "Resident Dignity," will be updated to include the use of Gait Belts and their removal when not in direct use. If resident requests gait belt to be left on, this will be documented in the residents medical record and Plan of Care.
2) Staff will receive in servicing regarding these findings and Plan for Correction, both electronically and at the next staff meeting. Meeting minutes and / or e-mail receipts will serve as verification of completion.

To Prevent Recurrence Auditing of CNAs will be done until three consecutive months of compliance over 95%. This auditing will be reported to the Quality Committee.

Not providing a copy of care plan policy. The CarePlan Policy was provided to the surveyors when requested. It was contained in the note book which contained multiple policies and was
<table>
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<tr>
<th>F 280</th>
<th>Continued From page 25</th>
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<tbody>
<tr>
<td>&quot;have to leave gait belt on all the time so they can grab you I guess.&quot;</td>
<td>F 280</td>
</tr>
<tr>
<td>The facility did not provide a policy for care plans as requested.</td>
<td>provide for the surveyors. A copy of that policy is attached to this plan of correction.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F 314</th>
<th>483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</th>
</tr>
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<tbody>
<tr>
<td>(b) Skin Integrity -</td>
<td>F 314</td>
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<tr>
<td>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</td>
<td>7/3/17</td>
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| (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual’s clinical condition demonstrates that they were unavoidable; and | |

| (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: | |

| Action for Affected Residents | |
| 1) The Medical Director and the Director of Nursing Services will meet to discuss wound treatment options, for this resident, going forward (this took place on 9 June 2017). MD ordered Hydrogel to right heel twice daily and Tegaderm to left heel. These orders had been place 6 June 2017 and she asked that they be |

| 7/3/17 | |

Based on record review, interview, observation and policy review, the facility failed to: 1) prevent a pressure injury, and 2) follow treatment interventions for a pressure injury. Specifically, the facility failed to implement preventative measures in a timely manner and failed to provide the necessary treatment for a pressure...
Continued From page 26

injury for 1 resident (#5) out of 6 sampled residents who were identified by the facility for at risk for pressure injuries. This failed practice caused the resident to obtain an avoidable pressure injury and delayed treatment which resulted in pain with an increased risk for infection, delayed healing, and poor medical outcome. Findings:

Resident #5

Record review from 5/16-18/17 revealed Resident #5 was admitted to the facility with failure to thrive, recurrent skin integrity issues, diabetes, stroke and flaccidity to left side of body. Further review revealed, the Resident had a pressure injury on the left heel on admission.

Review of the admission MDS (Minimum Data Set) assessment dated 2/14/17 revealed the Resident was coded as:
1) Being at risk for pressure ulcers; and
2) Had an unhealed unstageable (slough/eschar) pressure ulcer on the left heel.

Further review of the admission MDS revealed the Resident coded as the following under Activities of Daily Living (ADLs):
1) Extensive assist with two staff during bed mobility and transfer.
2) Supervision with locomotion on the unit; and
3) Total assistance with bathing and hygiene.

Review of the medical record revealed Resident #5 had a new pressure injury to the right heel, identified on 4/27/17. The pressure injury was staged as - "Unstageable...Yellow; Brown; Eschar..."

continued. She also wanted bilateral Potus Boots and this order too had been entered on 6 June 2017. Hydrogel is not in House and is on order.

2) Foot rest is to be implemented and leg position maintained as per physician order of 04-11-2017

Identify other residents
This finding had the potential to affect any resident that is at increased risk for a pressure injury

Corrective Measure
1) A CNA in-service will be held that will include training regarding the proper care of wounds, and wound dressings, and the proper application of the Potus boots. Further, the importance of reporting, to the Nurse, issues with wounds, wound dressings, Potus Boots or any other resident care implement or form of treatment, the resident may be receiving.

2) A wound task force will be created to address the needs of patients who are at risk of or have wounds. This multidisciplinary task force will include the Director of Nursing, Charge Nurse, Medical Director, MDS Nurse, and other staff as appropriate and available.

Prevention of Recurrence
The Task Force will review residents, with or at increased risk for, a wound, including pressure injuries. This task force will recommend best practice treatment and
### F 314
Continued From page 27

Review of the most recent MDS quarterly assessment, dated 5/9/17, revealed the Resident was at risk for pressure ulcers and had two unhealed pressure ulcers: an unstageable deep tissue ulcer to the left heel and a new unstageable (slough/eschar) ulcer to the right heel.

Further review revealed the Resident's required assistance with Activities of Daily Living (ADLs):
1. Total assistance with two staff during bed mobility;
2. Extensive assistance with two staff during transfers;
3. Extensive assistance with one staff during locomotion on unit;
4. Extensive assist with one staff during hygiene; and
5. Total assistance with bathing.

Record review of the Resident's comprehensive care plan, with various revision dates, revealed the Resident had an alteration in skin integrity with a start date of 5/3/17. Interventions included: follow treatment plan as ordered by provider, bilateral pressure relieving boots. The boots to relieve pressure were implemented after the discovery of the second pressure injury on the right heel.

Avoidable pressure ulcer - right heel.

Record review of a physical therapy note, dated 4/3/17, revealed "Reiterated recommendations of repositioning [Resident] correctly in [wheelchair] throughout the day, angled foot rest or elevating leg rest."

Review of a physical therapy note, dated 4/27/17,

F 314 monitoring implementation and progress of treatment of these residents.

Prevention of Recurrence
Summary reports, from this task force, will periodically be forwarded to the LTC Quality Committee.
### F 314

Continued From page 28

revealed the Resident had developed an unstageable pressure ulcer to the right heel. The note described the wound as black, eschar, fragile tan and slough.

During an interview on 5/17/17 at 9:46 am, Charge Nurse (CN) stated Resident #5 had an extensive history of recurrent pressure ulcers and poor sensation in the lower extremities. The CN continued to state the Resident had flaccidity to the left side and was only able to use the right side for mobility in and out of bed. The CN added, the Resident had self-propelled in a wheelchair with the right foot while wearing house shoes prior to the discovery of the pressure ulcer to the right heel. The Resident was described as using the right heel to "dig" on the floor to gain momentum to propel self in the wheelchair.

During an interview on 5/17/17 at 10:45 am, Physical Therapist (PT) #1 stated Resident #5 currently had a pressure ulcer to the right heel. The PT further stated the wound was most likely caused by the Resident using right heel to perform bed mobility adjustments and propelling self in wheelchair. The PT stated house shoes were not an appropriate form of footwear for this resident to propel self, the house shoes could have contributed to development of the ulcer. PT #2 then joined the interview. PT #s 1 and 2 stated there were other options the facility could have tried prior to the pressure ulcer development to decrease the Resident's chance of developing an ulcer within the facility.

During an interview on 5/17/17 at 12:57 am the Medical Director stated the cause of the pressure ulcer could have been associated to Resident #5 wearing house shoes while using the right heel to...
During an interview on 5/17/14 at 2:22 pm the MDS Coordinator stated it would have been best practice to have placed pressure relieving boots on Resident #5 since admission due to the Resident's history of recurrent pressure ulcers.

Pressure Injury care

Review of the Resident #5's comprehensive care plan, with various revision dates, revealed the Resident had a plan of care for alteration in skin integrity with a start date of 5/3/17. Interventions included: follow treatment plan as ordered by provider, bilateral pressure relieving boots.

Record review of physical therapy note, dated 5/12/17, revealed dressing to right heel "santly to wound bed on right side, not on left, covered by foam dressing cut to approximate size...Lantiseptic heavily applied to entire leg, foot and toes, kerlex gauze wrap and secure with coban..."

During an observation on 5/16/17 at 11:18 am Resident #5 had hard-framed foam and Velcro pressure relief boots on both feet.

During an observation on 5/16/17 at 12:27 pm,
Continued From page 30

certified nursing assistant (CNA) #1 removed the hard-framed foam and Velcro pressure relief boot from the right foot to dress the Resident. At that time, the bandage fell off the Resident's right heal, exposing the wound to the exterior environment. When the CNA reapplied the boots, he/she gathered the excess pant material and wadded the material around the top of each boot.

Random observations on 5/16/17 from 12:27 pm to 2:47 pm (2 hours) revealed the Resident's wound was still uncovered.

During an interview on 5/16/17 at 2:27 pm Licensed Nurse (LN) #1 was asked by the Surveyor if the uncovered bandaged was reported by CNA #1. The LN stated he/she was unaware of the wound being uncovered until the Surveyor informed him/her. The LN further stated the wound was not to be uncovered. During the same interview the LN went to assess the Resident and noted the pants fabric rolled up on the top of each boot and stated the area was too constricted by the wadded up excess material. The LN added this was concerning because of the Resident's poor circulation.

Review of the facility's policy entitled "Skin Assessment and Pressure Ulcer Management," dated 5/14/15, revealed "The following risk factors increase resident's risk for skin breakdown: The presence of cardiac, vascular, renal, metabolic or respiratory impairment[,] Advanced age [,] Obesity[,,] Infection[,] Dementia[,] Edema ...[,] Presence of previously healed pressure ulcer[,] ...receiving ...steroid therapy. NOTE: A resident with one or more of these factors should be considered at the next higher risk ...Preventive measures will be utilized..."
F 314. Continued From page 31
to decrease the risk of pressure ulcer
development and improve health of existing
ulcers. Existing pressure ulcers will receive
appropriate therapeutic and preventive
interventions."

F 332. 483.45(f)(1) FREE OF MEDICATION ERROR
RATES OF 5% OR MORE
(f) Medication Errors. The facility must ensure
that its-

(1) Medication error rates are not 5 percent or
greater;
This REQUIREMENT is not met as evidenced by:

Based on record review, observation, and
interview the facility failed to ensure 2 residents
(#s 12 and 13), out of 5 residents observed
during medication administration, received
medications per physician's orders and
manufacturer's recommendations. Specifically, 1
resident, (#12) was given a medication without
measuring blood pressure prior to administration
per physician's order, and 1 resident, (#13) was
given a medication that was administered
contrary to manufacturer recommendation and
physician order, specifically crushed vs. whole.
This failed practice placed the facility's
medication error rate above 5% and placed the
resident at risk for not receiving therapeutic
benefits from the medications. Findings:

Resident #12
Record review on 5/16-18/17 revealed Resident

Action for Affected Residents
1) An electronic Communication to all
Nurses, instructing them to take blood
pressures immediately prior to
administering medication where the
provider has given blood pressure
parameters for that administration.
2) An electronic Communication to all
Nurses, instructing them to not crush
enteric coated medication or any
medication with a warning against
crushing.

Identify other residents
Any resident taking a med that has
defined blood pressure parameters prior
to administration or a med that carries a
warning against crushing.

Corrective Measure
"1) An electronic communication was sent
<table>
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>DATE</th>
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</thead>
</table>
| F 332 | Continued From page 32 | #12 was admitted to the facility with diagnoses that included hypertension. | F 332 | to all nurses, instructing them to take blood pressures immediately prior to administering medication where the provider has given blood pressure parameters for that administration.  
2) An electronic communication was sent to all nurses, instructing them not to crush enteric coated medication or any medication with a warning against crushing. " 
Medication administration inservicing will be provided to all nurses, that includes the necessity for checking blood pressures within an appropriate time-frame when there is blood pressure parameters for that administration. It will also address crushing medications that have a warning against crushing. This inservicing will be done during the next staff meeting and / or via electronic means. Meeting minutes and / or e-mail receipts will serve as verification of completion. 
To Prevent Recurrence Random audits will be performed on nurses doing medication administration. This audit will be reported to the Quality Committee until three months of over 95% compliance is shown. | | |
| | | Review on 5/16/17 revealed Resident #12's medication regime included the Resident had an order for: Hydralazine 20 mg 4 times daily with "Admin [administration] Instructions: Hold dose for SBP (systolic blood pressure) less than 110 mmHg." | | | | |
| | | Observation during a medication pass on 5/16/17 at 12:00 noon, revealed LN #2 entered Resident #12's blood pressure results in the medication administration record (MAR) for the medication hydralazine. The blood pressure was taken earlier that day at 8:25 am. | | | | |
| | | During an interview on 5/16/17 at 12:00 noon, licensed nurse (LN) #2 stated he/she only takes Resident #12's blood pressure in the morning and the afternoon. The LN further stated Resident #12's blood pressure was always high. | | | | |
| | | During an interview on 5/18/17 at 8:30 am, LN #3 reviewed the order and stated Resident #12's blood pressure should be taken prior to giving hydralazine. | | | | |
| | | During an interview on 5/17/17 at 3:30 pm, Pharmacist (PH) #2 stated the blood pressure should be taken within 1 hour of giving the blood pressure medication hydralazine. He/she further stated the blood pressure reading from the prior dose should not be used for the current dose. | | | | |
| | | Resident #13 | | | | |
| | | Record review on 5/16-19/17 revealed Resident #13 was admitted to the facility with diagnoses | | | | |
### Statement of Deficiencies and Plan of Correction

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

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

**Date Survey Completed:** 05/19/2017

**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>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
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<tbody>
<tr>
<td>F 332</td>
<td>Continued From page 33 that included Alzheimer's disease.</td>
<td>F 332</td>
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<tr>
<td></td>
<td>Record review on 5/18/17 revealed Resident #13's medication regime included &quot;Aspirin EC [enteric coated] 81mg [milligrams] po [by mouth] QD [every day]....Admin [Administration] Instructions: Do not crush&quot;.</td>
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<td>Observation of a medication pass on 5/16/17 at 10:30 am revealed, LN #1 crushed Resident #13's medications which included the enteric coated aspirin.</td>
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<tr>
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<td>During an interview on 5/17/17 at 3:15 pm, PH #2 stated that enteric coated aspirin &quot;shouldn't be crushed.&quot;</td>
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<th>Prefix Tag</th>
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<tr>
<td>F 492</td>
<td>7/3/17</td>
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483.70(b)(c) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD

(b) Compliance with Federal, State, and Local Laws and Professional Standards.

The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

(c) Relationship to Other HHS Regulations.
In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (45 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by:

Based on observation, document review and interview the facility failed to ensure blood glucose testing competencies for 16 active certified nursing assistants (CNAs) out of 18 reviewed were conducted in compliance with Alaska Nursing Statutes and Regulations. This failed practice placed 4 residents (#s 2, 5, 9 and 12) out of 14 active residents who required blood glucose monitoring, at risk for improper technique of obtaining blood glucose. This failed practice had the potential for complications such as infection or inaccurate reading. Findings:

Random observations from 5/15-17/17 revealed various CNAs completing blood glucose testing on residents.

Review on 5/17/17 at 3:47 pm of the CNA

Action for Affected Residents
All CNAs that do not have a current Glucose monitoring competency evaluation completed will have this done forthwith.

Identify other residents
This has the potential to affect all residents for whom blood glucose monitoring is done.

Corrective Measure
1) The current practice shall be modified to ensure compliance with AAS 44.950 thru 44.960. A policy will be created that defines the requirement for CNA Glucose Monitorin competency. An audit will be done to ensure that all CNAs have a Glucose Monitoring evaluation completed.
## Statement of Deficiencies and Plan of Correction

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

### Multiple Construction

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

### Date Survey Completed:

**05/19/2017**

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### Summary Statement of Deficiencies

#### F 492

Continued From page 35

Glucometer Competency packet, last updated 4/2017, revealed the following:

- CNA #s 1, 10, 12, 13 and 14 had no initial competency or 90-day evaluation;
- CNA #s 2, 3, 4, 5, 6, 7, 9, 15 and 16 did not have a 90-day evaluation completed; and
- CNA #s 8 and 11 90-day evaluations were completed late.

During an interview on 5/17/17 at 3:47 pm the Charge Nurse (CN) stated it was his responsibility to complete the CNA glucometer competencies. The CN confirmed some competencies had been either late or not completed.

Review of the Alaska Nursing Statues and Regulations, dated 9/2016, revealed "12 AAC 44.960 ...Specialized nursing duties may be delegated to another person under the standards set out in 12 AAC 44.950. (b) Specialized nursing task that may be delegated include...(3) obtaining blood glucose levels...(8) A nurse who delegates a nursing duty to another person under this section shall develop a nursing delegation person. The delegating nurse shall evaluate a continuing delegation as appropriate, but must perform an evaluation on-site at least every 90 days after the delegation was made. The delegating nurse shall keep a record of the evaluations conducted."

### Provider’s Plan of Correction

- If they do not, one will be done.
- 2) A staff member will be assigned to monitor those that require a ninety day re-evaluation for blood glucose determination, weekly and report this to the charge nurse for completion.
- 3) The charge nurse or designee will assess the competency of those CNAs requiring a ninety day re-evaluation for blood glucose determination and document the result of that competency assessment.
- 4) If a CNA fails competency evaluation, remedial training will be provided to the point of competency.
- 5) If compliance is less than 100%, immediate action will be taken to ensure that before any CNA, with expired competency will be allowed to perform blood glucose monitoring, their competency will be assessed.

### To Prevent Recurrence

- 1) A staff member will be assigned to assess compliance with this policy / procedure and forward a report to the D.O.N., weekly.
- 2) The D.O.N. will include these findings as a part of the D.O.N.’s report to LTC Quality Committee.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID**

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**MULTIPLE CONSTRUCTION**

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**NAME OF PROVIDER OR SUPPLIER**

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<th>KETCHIKAN MED CTR NEW HORIZONS TRANSITIONAL CARE</th>
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<tr>
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<tr>
<td>3100 TONGASS AVENUE KETCHIKAN, AK 99901</td>
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<td>F 514 Continued From page 36</td>
<td>F 514 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBILITY</td>
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**DEFICIENCY**

(i) Medical records.
(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

(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 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:

**Action for Affected Residents**
Based on record review, interview, and observation the facility failed to maintain accurate and complete medical records. Specifically, the facility failed to: 1) document the indication of use for medications in the residents’ medical record for 4 residents (#s 1; 3; 4 and 10) out of 10 sampled residents whose medical records were reviewed, and 2) accurately document the current medical treatment (saline lock flush and pain medication) for 1 resident (#5) out of 7 sampled residents. These failed practices placed the residents at risk for not receiving services needed to address medical conditions.

**Indications for Use of Medications:**

**Resident #1**

His medication order profile will be reviewed and the 11 scheduled medications, that require an indication for use or an associated diagnosis will be identified. The MAR will be reviewed and those scheduled medication that lack either an indication for use or an associated diagnosis will be identified. When these medications are identified, facility management will work with the Medical Director and the primary provider to modify the order to include either the indication for use or associated diagnosis. Management will work with pharmacy and/or IT to ensure that either the indication for use or the associated diagnosis is reflected in the MAR. The Care Plan will then be reviewed to ensure it too contains this information.

**Resident #3**

His medication order profile will be reviewed and the 15 scheduled medications, that require an indication for use or an associated diagnosis will be identified. The MAR will be reviewed and those scheduled medication that lack either an indication for use or an associated diagnosis will be identified. When these medications are identified, facility management will work with the Medical Director and the primary provider to modify the order to include either the indication for use or associated diagnosis.
### Summary Statement of Deficiencies

**ID**: Continued From page 38 detail, revealed no documentation of diagnoses or indications of use for 15 scheduled medications.

**Resident #4**

Record review on 5/16-19/17 revealed Resident #4 was admitted to the facility with diagnoses that included Parkinson's disease, depression, cardiomyopathy (disorder of the heart muscle), chronic kidney disease, and lower leg edema.

Further review revealed Resident #4's medication regime included:
1. Atorvastatin (Lipitor) - used to treat high cholesterol
2. Citalopram (Celexa) - an antidepressant
3. Mirtazapine (Remeron) - an antidepressant
4. Furosemide (Lasix) - a diuretic

Review of the current MAR and medication order detail, revealed no documentation of diagnoses or indications for the above 4 medications.

**Resident #10**

Record review on 5/18-19/17 revealed Resident #10 was admitted to the facility with diagnoses that included Huntington's disease.

Further review of Resident #10's medication regime revealed Resident #10 was taking the antipsychotic medication olanzapine 10 mg nightly.

Review of the current MAR and medication order detail, revealed no documentation of diagnoses or indications of use for olanzapine.

### Provider's Plan of Correction

**Resident #4**

Facility Management will work with the Medical Director and the primary provider to modify the order to include either the indication for use or associated diagnosis, for the use of Atorvastatin, Citalopram, Mirtazapine and Furosemide for Resident #4.

Further, Facility management will work with Pharmacy and / or IT to ensure that the indication for use or associated diagnosis, for the use of Atorvastatin, Citalopram, Mirtazapine and Furosemide is included in the MAR. The Care Plan will then be reviewed to ensure it too contains this information.

**Resident #10**

Facility Management will work with the Medical Director and the primary provider to modify the order to include either the indication for use or associated diagnosis, for the use of Olanzapine for Resident #10.

Further, Facility management will work with Pharmacy and / or IT to ensure that the indication for use or associated diagnosis, for the use of Olanzapine is included in the MAR. The Care Plan will then be reviewed to ensure it too contains this information.

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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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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</table>
| F 514             | Continued From page 39  
During an interview on 5/18/17 at 1:00 pm, Pharmacist #1 stated the indication for use for all medications should be on the MAR and order details. The Pharmacist confirmed the facility was missing the indications for use on some of the Resident's medications.  
Review of the website "Institute for Safe Medication Practices", accessed on 5/30/17 at http://www.ismp.org/tools/guidelines/SCEMI/SCEMIGuidelines.aspx, revealed, "Provide a field to enter the purpose/indication for all medications communicated electronically...Communicating the drug's indication reduces the risk of improper drug selection and offers clues to proper dosing when a medication has an indication-specific dosing algorithm."  
Documented Accuracy of Medical Treatment:  
Resident #5  
Saline Flush  
Record review from 5/16-18/17 revealed Resident #5 was admitted to the facility with failure to thrive and gastrointestinal hemorrhaging.  
Random observations from 5/15-18/17 revealed, Resident #5 had a saline-locked intravenous (IV) access located in forearm.  
Record review from 5/16-18/17 of the most current physician's order revealed no order for saline administration through the IV access.  
Record review from 5/16-18/17 of the current MAR revealed no documentation or order for the administration of saline through the IV access. | F 514 | reviewed to ensure it too contains this information.  
Resident #5  
Saline Flush  
As this resident's IV access has been discontinued, Facility Management will work with Pharmacy to determine the best method to reflect that this was approved by the provider and what the indication was for it.  
Pain Medication Order  
The Medication orders and MAR now reflect to use the Norco with dressing changes and wound care.  
Identify other residents  
This has the potential to affect all residents.  
Corrective Measure  
1) New Horizons staff will review all current records to identify those that contain the deficiencies noted under F-514  
2) When identified, New Horizons Administration will work with the Medical Director to devise a plan to correct all deficiencies found.  
3) Policy number 302.287.1, "Admissions to the Long Term Care Unit from the Medical/Surgical Unit and Direct Admits," will be modified to define the process, the charge nurse will use to ensure that these deficiencies are not present in the orders of new residents, prior to their transfer to this facility.  
4) Staff will receive inservicing regarding
**F 514 Continued From page 40**

During an interview on 5/18/17 at 10:08 am, Pharmacist #1 and #2 both stated there should have been an order for the administration of saline through the IV access once per shift. In addition, Pharmacist #1 and #2 stated the MAR should reflect the order to ensure documentation of the saline administration was in a resident's chart.

Review of the facility provided IV access guidelines, undated, revealed a peripheral IV should be flushed every eight hours with 10 milliliters normal saline.

### Pain Medication Order

Record review of Resident #5's MAR, dated 5/2017, revealed the following order: Hydrocodone-acetaminophen (Norco - narcotic pain medication) 5-325 mg per tablet, 1-2 tablets every four hours as needed for moderate to severe pain. Further review revealed the nurses had been administering the Norco prior to wound dressing changes.

During an interview on 5/17/17 at 12:57 pm, the Medical Director stated an order should be written to specify the use of Norco prior to wound dressing changes to reflect a more accurate portrayal of the Resident's medical record and care and ensure the Resident is receiving the appropriate pre-treatment pain medication.

During an interview on 5/18/17 at 8:15 am the Charge Nurse (CN) confirmed the nurses had been providing the Norco prior to wound dressing changes each day.

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<td>these findings and the Plan for Correction. 5) This inservicing will be done during the next staff meeting and / or via electronic means. Meeting minutes and / or e-mail receipts will serve as verification of completion.</td>
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<td>To Prevent Recurrence</td>
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<td>The policy, &quot;Comprehensive Quality Management program will be modified to include the process, by which resident medical records will be monitored for the deficiencies, identified at F-514, as well as other deficiencies.</td>
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**Statement of Deficiencies and Plan of Correction**

- **Provider/Supplier/CLIA Identification Number:** 025010
- **Multiple Construction:**
  - A. Building ____________
  - B. Wing _____________
- **Date Survey Completed:** 05/19/2017

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

**Street Address, City, State, Zip Code:**

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Ketchikan, AK 99901
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**NAME OF PROVIDER OR SUPPLIER**

KETCHIKAN MED CTR NEW HORIZONS TRANSITIONAL CARE

**ADDRESS**

3100 TONGASS AVENUE
KETCHIKAN, AK 99901

**DATE SURVEY COMPLETED**

05/19/2017

**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

05/19/2017