STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025020	A. BUILDING _____ B. WING _____	03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DENALI CENTER	1510 19TH AVENUE FAIRBANKS, AK 99701

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F 000	INITIAL COMMENTS . The following deficiencies were noted during an unannounced standard Medicare/Medicaid recertification survey conducted March 3-8, 2019. The sample included 19 sampled residents and 3 closed records. March 6, 2019 at 2.51 pm the facility was notified of an Immediate Jeopardy (IJ) at CFR483.60 (d) (3) Food Prepared in a Form Designed to Meet Individual Needs. The facility submitted a plan to remove the IJ to the health and safety of the resident on 3/6/1t 4:19 pm. The State survey team verified the mitigation of the risk while onsite. 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 000		
F 550 SS=E	. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		4/22/19

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

Electronically Signed | 04/01/2019

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F 550	Continued From page 1 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: . Based on record review, observations, and interviews the facility failed to ensure: 1) 4 sampled residents (#s 9; 14; 16 and 21) and 2) 3 non sampled residents (#s 24; 56; and 70), out of 31 residents observed eating, were assisted with	F 550	This plan of correction is respectfully submitted as evidence of allege compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is affirmation that correction to the cited have been or will be made and that the	

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F 550	Continued From page 2 dining in a dignified manner. This failed practice placed residents at risk for a poor quality of life from decreased self-esteem. Findings: Dining Dignity (Willow Unit) Resident #21 Record review on 2/4-8/19 revealed Resident #21 was admitted to the facility with diagnoses that included dementia; stroke; anxiety; and post-traumatic stress disorder. Random observations of meal times on 3/4/19, 3/6/19 and 3/7/19 throughout the survey revealed nursing staff Stood over the Resident #21 while providing supplement shakes from a cup with a bendable straw. The staff was above the Resident's eye level. Review of the most recent MDS assessment, a quarterly assessment dated 12/20/18, revealed the Resident had a BIMS (Brief Interview for Mental Status- a test used to get a quick snapshot of cognitive functioning) of 00 and was fully dependent on staff for eating. Dining Dignity (Fireweed Court) Observation on 3/5/19 at 12:00 to 12:20 pm, revealed Certified Nursing Assistant (CAN) #5 standing at a dining table in the dining room assisting two Residents (#s 14 and 24) with their meals. Additionally, Resident #9, seated at a nearby table. All three Residents needed monitoring and assistance with eating. CNA #5, assisted all three Residents, and went from one Resident to another frequently to assist them with their meal.	F 550	facility is in compliance by the date or dates indicated. F550 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * We identified a knowledge deficit for staff regarding meal service with dignity for residents #9, 14, 16, 21, 24, 56, 70, and 31. Immediate verbal education provided at Weekly Education and Learning Development (WELD) meetings on each wing during the week of 3/24/19 - 3/29/19. Education included the need to sit down at the elders level during meal times, engaging with each elder during meal times, the appropriate use of the clothing protectors (including removing them at the end of meal service), utilizing napkins and washrags to clean elders faces. * Corrective actions were completed by 3/29/19 2) How other residents having the potential to be affected by the same deficient practice will be identified? * The facility acknowledges that any resident receiving assistance during meal times can be affected by this deficient practice. Residents requiring assitance during meal times are identified from the CNA worksheets. The information is translated from the MDS and care plan in the Electronic Medical Record (EMR).	

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F 550	Continued From page 3 During the observation in the dining room on 3/5/19, CNA #3 arrived at 12:07 pm to assist Resident #70, seated at another table. Shortly thereafter, Resident #56 arrived. The CNA stood between the two Residents as he/she fed or assisted them throughout the meal. During an interview on 3/6/19 at 12:05 pm, CNA #5 stated he/she stood while feeding the Resident's because he/she was short. The CNA also stated, he/she was supposed to sit while assisting the Residents. During an interview on 3/6/19 at 1:30 pm, CNA #3 stated he/she should not stand while assisting the Residents with their eating. Resident #9 Record review on 3/4-8/19 revealed Resident #9 had diagnoses that included iron deficiency anemia, visual loss and bilateral (both sides) hearing loss. Review of the most recent MDS (Minimum Data Set) assessment, a quarterly assessment, dated 2/28/19, revealed the Resident was needed limited assistance with eating. Resident #14 Record review on 3/4-8/19 revealed Resident #14 had diagnoses that included anoxic brain damage (brain injury caused by lack of oxygen) and aphasia (a defect or loss of the power of expression by speech, writing, or signs, or of comprehending spoken or written language, due to injury or disease of the brain centers).	F 550	3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * Education will be provided to all CNA staff regarding the expectations of providing meals with dignity. Education will include review of the policy DC120, Denali Center Abuse and Neglect, specifically, each resident must be provided individualized care with dignity and respect. Each CNA will be required to view a video on Dining and Dignity. The policy and the video will be included in new hire orientation. * The expectations for dining with dignity will be communicated in a practice alert, at staff meetings, and at a skills fair. * Corrective action will be completed by 4/22/19 and will be ongoing. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice does not recur? * We will develop an audit tool to be completed to assess the compliance with dining with dignity. Audits will be completed weekly for 4 weeks and monthly until the end of the year. * The Quality team including the Administrator, DON, Quality Nurse, and Medical Director will monitor the audits on a monthly basis for six months or until the audits are at 100% for consecutive months. * Corrective action will be completed by 4/22/19 and will be ongoing.	

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F 550	Continued From page 4 Review of the most recent MDS assessment, an annual assessment, dated 2/21/19, revealed the Resident was needed supervision and oversight, encouragement and/or cueing with eating. Resident #24 Record review on 3/4-8/19 revealed Resident #24 had diagnosis that included Alzheimer's disease and dementia. Review of the most recent MDS assessment, an annual assessment, dated 12/27/18 revealed the Resident needed limited assistance with eating. Resident #56 Record review on 3/4-8/19 revealed Resident #56 had diagnosis that included Alzheimer's disease and dementia. Review of the most recent MDS (Minimum Data Set) assessment, a quarterly assessment, dated 1/31/19, revealed the Resident needed limited assistance with eating. Resident #70 Record review on 3/4-8/19 revealed Resident #70 had diagnoses that included multiple sclerosis, dysphagia and quadriplegia. Review of the most recent MDS (Minimum Data Set) assessment, a quarterly assessment dated 2/13/19, revealed the Resident needed extensive assistance with eating. Dining Dignity (clothing protectors):	F 550		

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Resident #14

During an observation on 3/5/19 at 11:55 am, revealed CNA #5 assisted Resident #14 with the meal. During the Meal the CAN wiped food Resident's face off clothing protector the Resident was wearing around his/her neck.

Resident #16

During an observation on 3/6/19 at 8:08 am, revealed Resident #16 seated at the dining table with soiled clothing protector. At 10:25 am revealed, the Resident had finished the meal, and continued to wear the soiled clothing protector around his/her neck.

During an interview on 3/6/19 at 12:00 pm, when asked how Residents were assisted with hygiene when dining, CNA #5 stated it was okay to use either a napkin or the Resident's clothing protector to wipe his/her face.

Review on 3/8/19 at 2:30 pm, of the facility's policy and procedure "CNA Expectations and Standards of Care" dated 12/27/18, revealed "CNA Expectations: 1. All CNAs will treat residents with respect ..."

During an interview on 3/7/19 at 4:45 pm, the Director of Nursing (DON) stated CNA staff should sit down while assisting Residents with eating their meal and should not use the Resident's clothing protector to wash their face.

Review on 3/8/19 at 2:30 pm, of the facility's policy and procedure "CNA Expectations and Standards of Care" dated 12/27/18, revealed

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F 550	Continued From page 6 "CNA Expectations: 1. All CNAs will treat residents with respect ..." Review on 3/8/19 at 2:30 pm, of the facility's policy and procedure "Resident Rights and Responsibilities" dated 11/16/17, revealed "Denali Center will make every effort to assist each resident in exercising his/her rights and to ensure residents are always treated with respect, kindness, and dignity." .	F 550		
F 577 SS=F	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying	F 577		4/22/19

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F 577	Continued From page 7 information about complainants or residents. This REQUIREMENT is not met as evidenced by: . Based on observation, record review and interview the facility failed to post a notice that the preceding 3 years of survey reports and plans of correction for any surveys, including complaint and certification surveys, was available to individuals upon their request. This failed practice resulted in the rights of all residents (based on a census of 77), family members and legal representatives being denied access to survey reports regarding the facility. Findings: Observations on 3/4/19 at 1:00 pm, revealed a folder with the State Survey results was attached to the window of the social workers office which faced the common area for accessibility by residents, family members and legal representatives. Further observation revealed no posting of a notice stating availability of the preceding 3 years of all surveys, including certification and complaint surveys was available for individuals to review upon request. Record review on 3/4/19 at 1:05 pm of the contents of the survey folder revealed a copy of the most recent recertification survey report was inside the folder. There were no other survey reports in the folder. During an interview on 3/7/19 at 5:30 pm, the Director of Nursing confirmed there was no posting regarding availability of the preceding 3 years of surveys.	F 577	F577 1) What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice? * The facility posts the most recent annual survey. The post is readily accessible to residents, family members, and legal representatives. Any other surveys, certifications, and complaint investigations made respecting the facility during the 3 previous years, and any plan of correction is available upon request. A sign has been placed outside the Social Worker office with directions for obtaining the aforementioned results. * Corrections was completed 3/23/19 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recoginizes that all residents residing at Denali Center could be affected by the deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * Education will be provided to residents at resident council and during care conferences for the next three months to ensure all elders and family are aware of the process to access surveys, certifications, and complaint	

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F 577	Continued From page 8 Record review on 3/8/19 at 2:30 pm, of the facility's policy and procedure "Resident Rights and Responsibilities" dated 11/16/17, revealed "Facility survey results are posted and accessible to residents, families, and representatives." The policy and procedure did not address availability of the 3 preceding years of surveys.	F 577	investigations. 4) How the corrective action(s) will monitored and evaluated for effectiveness to ensure the deficient practice does not recur? * Once signage has been put into place and education is provided, no monitoring will be required. * The responsible party is the Administrator and is verified by the Administrative Assistant to the Administrator.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		4/22/19

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F 584	Continued From page 9 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: . Based on observation, interview, and policy review the facility failed to ensure a clean, homelike environment was provided for 14 (#s 10; 16; 17; 18; 21; 23; 24; 31; 49; 50; 57; 62; 63; and 64) out of 77 residents. Specifically, the facility failed to ensure the Willow Unit (dementia-care unit) was free from foul odors. This failed practice denied the residents a clean and homelike environment. Findings: Random observations of Willow Unit from 3/4-7/19 revealed a strong urine odor noted around the common area and corridors during 4 out of the 5 days observed. The odor was noted both during the morning and evening times during these observations. During an interview on 3/6/19 Housekeeper #1 stated the Willow Unit often smells of urine but	F 584	F584 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * An immediate conversation occurred with the surveyor and the Director of Nursing, who then immediately notified housekeeping. The carpets were cleaned/shampooed in the main common area on Willow and the halls. The odor was not noticeable on the last day of the survey. * The corrective action occurred immediately, 3/7/19. 2) How other residents having the potential to be affected by the same deficient practice will be identified?	

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F 584	Continued From page 10 wasn't able to locate the source of the odor during the interview. During an interview on 3/7/19, the Director of Nursing (DON) stated a dementia resident on the Willow Unit was known to have urinate on the carpet. The DON stated the smell of urine is still present in the Willow Unit. Review of the facility's policy "Resident Rights and Responsibilities," dated 11/16/17, revealed "Residents have the right to expect the Denali Center staff to provide ...An environment that contributes to a positive self-image and preservation of dignity. A safe, clean, and comfortable environment." .	F 584	* Denali Center recognizes that all residents residing at Denali Center could be affected by the deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * A multidisciplinary review of the issue is scheduled the first week of April. The team that includes Denali Center administration, Environmental Services, and Facilities is investigating potential replacement flooring and furniture wtih non-permeable options. If unable to replace the current flooring and furniture with the current budget, Denali Center will include the replacement in the budget for 2020. * In the interim the team will identify other cleaning products and cleaning schedules to eliminate the urine odors from the Willow environment. Rounding of the team will occur weekly until the issue is resolved. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * The Director of Nursing will meet with Facilities and Housekeeping on a regular basis to round all of Denali Center to assess for offensive odors. The rounding and audits will be presented at the Quality meeting for the remainder of the year. * Red Team inspects Denali Center on a regular basis: The Red Team will notify	

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F 584	Continued From page 11	F 584	DON of inspection results so that repairs can be addressed in a timely manner, including correcting odors. * The Admministrator is responsible for the completion and maintenance of this correction. * Completion of corrective action will be 4/22/19.	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(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. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(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	F 585		4/22/19

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F 585	Continued From page 12	F 585		

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

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F 585	Continued From page 13 provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: . Based on observation, record review, and interview, the facility failed to provide prompt responses to residents/family who filed grievances. This deficiency had to potential to affect 77 residents of the facility and/or their families. This failed practice denied residents and their families and/or interested parties their right to participate in improving their experience, care, and to receive a timely resolution of their grievances. Findings: During an observation on 3/4/19 at 2:00 pm the	F 585	F585 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * The facility grievance procedure is posted and will be revised to contain the key elements identified by the surveyors findings. The DON met with the resident's identified in the finding to ensure they understand the process, and any ongoing	

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F 585	Continued From page 14 facility has several boxes in common areas where grievances can be filed. Record review on 3/6/19 at 4:00 pm of the grievance log book revealed: A grievance submitted on 1/21/19 had no documentation on whether the issue had been resolved. A grievance submitted on 1/16/19 was marked as waiting for response, there was no documentation of response to the Resident. A grievance submitted 12/26/18 did not have documentation the individual received a response. A resident submitted a grievance on 8/1/18, a box was checked that was labeled "awaiting response", no documentation of follow up or response to the resident. A resident submitted a grievance on 8/3/18, there was a written note that a response was not provided. A resident submitted a grievance on 8/20/18, letter not provided until 9/27/18. A resident submitted a grievance on 7/20/18, the response letter was dated 8/16/18. A grievance submitted on 6/6/18 revealed the response letter was not sent until 7/18/18. A grievance was submitted on 5/22/18, the response letter was not provided until 6/8/18. A grievance was submitted on 5/3/18, the response letter was not sent until 5/17/18. A grievance was submitted on 5/3/18, the response letter was not sent until 5/16/18. A grievance was submitted 4/2/18 by family member, there was no documentation present that a response had been sent to the family member. "A grievance was submitted on 4/4/18, the	F 585	concerns related to previous grievances. * The Customer Concern form will be revised to reflect the definition and categorization of a complaint or a grievance. If meeting the definition of grievance, form will reflect date received, action, summary statement of grievance, steps taken to investigate, summary of pertinent findings or conclusion, statement regarding grievance was confirmed or not confirmed, corrective actions taken, and date written decision was issued. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents residing at Denali Center could be affected by the deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * The Denali Center administration, which includes the grievance officer is meeting with the Foundation Health Patient Experience representative, who completes Foundation Health grievance investigations to align with a consistent process across the organization. * The team will ensure the grievance process is timely as defined by our policy, has clear resolution and a formal response has been completed. * The Grievance policy will be updated to reflect the regulatory language of a timely response. * Education will be provided to the	

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F 585	Continued From page 15 response letter was not sent until 4/27/18 A grievance submitted on 4/16/18 revealed no documented response to the resident. A grievance was submitted on 4/30/18, the response letter was not provided until 5/17/18. During an interview on 3/6/19 at 1:15 pm, Residents (#'s 28, 44, 66, and 176) present at the Resident Council meeting voiced concerns regarding receiving a timely response to grievances they had submitted. Residents' stated that sometimes they did not receive responses at all. During an interview on 3/6/19 at 4:37 pm the Director of Nursing (DON) stated she had not followed up grievances with letters. Completion is not likely to occur within the 5 day time period outlined in the policy. Record review on 3/6/19 at 5:00 pm of the facility policy entitled "Denali Center: Grievance Process" in section III, subsections (H) and (I), the policy revealed, "Upon received of a concern, an investigation of the allegations will be conducted by the appropriate department manager and the Case Manager, and a written report of findings submitted to the administration within five (5) working days of the facility's receipt of the concern and entered into Verge ...The resident and/or person filing the concern will be informed of the findings of the investigation and the corrective actions taken to address the issue ...A written or oral response to the concern will be provided to the resident and/or representative within ten (10) working days of the receipt of the report by the facility ..."	F 585	interdisciplinary leadership regarding the new policy and time constraints. * Education on the grievance process including an algorithm will be emailed out to Denali Center employees; this will be completed through WELD meetings, staff meetings, and the skills fair. Staff will complete the review of the policy and process on the Denali Center learning module for proof of completion. 4) How the corrective action(s) will be montiored and evaluated for effictiveness to ensure the deficient practice will not recur? * Once the Customer Concern form and the Grievance policy have been revised, the DON will report to the quality team completion of the grievance process within the defined time. * The responsible party is the DON. * Completion of the plan of correction will be 4/22/19.	

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F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: . Based on record review, observation, and interview the facility failed to ensure three residents (#s 18; 21; and 31) out of 19 sampled residents were free from potentially abusive and/or neglectful behavior by facility staff. This failed practice placed at risk for psychological harm and/or physical harm and a less than optimal environment to ensure they maintain highest practical well-being. Findings: Resident #18 Record review on 3/4-8/19 revealed Resident #18 was admitted to the facility with diagnoses that included Alzheimer's disease and dementia.	F 600	F600 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Denali Center takes an accusation of abuse and neglect very seriously and monitors residents with needs and behaviors that might lead to conflict or neglect. Denali Center completed the investigation of abuse and neglect. The staff accused of the verbal abuse was placed on immediate administrative leave. An investigation was completed. Formal Coaching was issued to CNAs involved in	4/22/19

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F 600	Continued From page 17 Review of the most recent MDS (Minimum Data Set - a federally required assessment) assessment, a quarterly assessment, dated 12/13/19, revealed the Resident had episodes of feeling or appearing down, depressed, or hopeless, as well as, being short-tempered and easily annoyed. The Resident was dependent on staff for activities of daily living. Further review of the MDS assessment revealed the Resident had severe cognitive impairment. Review from 3/6-8/19 of Resident #18's care plan, last revised on 2/26/19, revealed a problem of activity pursuits related to a diagnosis of dementia. Behaviors included intermittently crying out and wailing throughout the day. Approaches included monitoring attendance and level of participation in activities, refocusing Resident's thoughts, enjoys music, enjoys activities brought in by family, pet visits, and staff were to show understanding if crying out. Additional review of the care plan revealed a problem of cognitive decline with difficulty communicating needs verbally with words as a result of dementia. Approaches included providing conversation during cares and provide explanations of care being provided. Observation on 3/6/19 from 8:00 am to 9:30 am revealed Resident #18 was yelling out with no interaction from staff. Observation at 9:37 am revealed Certified Nursing Assistant (CNA #7) approached Resident #18 grabbed the back of the wheelchair device and abruptly spun the Resident to the left and then to right in an attempt to relocate him/her. During this observation the	F 600	the incident on professionalism in the workplace; not to swear in the workplace, as well as what to do in a situation when hit by a resident. * Denali Center leadership met with each employee and provided counseling for abuse and neglect and advised each CNA that cursing during cares or in the presence of elders is not acceptable. They were also advised to communicate with compassion and kindness at all times specifically when moving residents or providing cares. The organization immediately provided compassion fatigue training during the WELD meeting on Willow on 3/7/19. We are researching additional abuse and neglect training specifically in relation to dementia and long-term care. We do not find that the interaction can be verified or if it occurred, we find that there was not willful intent to cause harm towards the resident and therefore, by definition, is not verbal abuse. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents residing at Denali Center could be affected by the alleged deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * As per Denali Center policy; Each resident has the right to be free	

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F 600	Continued From page 18 CNA did not verbally address the Resident or come into line of sight allowing the Resident the opportunity to visualize the staff. The abrupt jerking of the wheelchair startled Resident #18. Additional observation on 3/6/19 at 9:42 am revealed CNA #7 approached Resident #18, who was now resting with eyes closed, and stated he/she was going to "jack down" the Resident. This resulted in Resident #18 becoming startled and yelling out again. The CNA did not approach the Resident or explain what he/she was doing before abruptly pumping the chair to a lower position. Resident #21 Record review on 3/4-8/19 revealed Resident #21 was admitted to the facility with diagnoses that included dementia; stroke; anxiety; and post-traumatic stress disorder. Review of the most recent MDS assessment, a quarterly assessment, dated 12/20/18, revealed the Resident was coded as having episodes of feeling or appearing down, depressed or hopeless; poor appetite; and being short-tempered or easily annoyed. Further review revealed the Resident had severe cognitive impairment was fully and received a mechanically altered therapeutic diet. Review from 3/6-8/19 of Resident #21's care plan, latest revision date of 2/15/19, revealed a problem of severely impaired decision making abilities. Approaches included to greet the Resident by name and give self-introductions often and interpret needs through body language.	F 600	from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals (483.13) reference F223, 224, 225,22. Abuse and neglect education is included in initial and annual competencies. Staff involved in the alleged incident completed the training as evidenced in our SABA training module. * Additional training on abuse and neglect were assigned in the organizations learning module to all direct care staff. We are researching additional abuse and neglect training specifically in relation to dementia and long-term care. * Abuse and neglect education is included in initial and annual competencies, this is ongoing. * Willow Run is a special care neighborhood designed for residents with various kinds and stages of dementia. Denali Center recognizes that a therapeutic environment would be one that provides comfort, safety, and daily involvement in meaningful activities. We are developing an activation position that will allow creative reassignment of workloads to allow participation in resident programs to maximize involvement and decrease boredom and loneliness. Staff will receive additional training in dementia care and approaches to minimize behavior problems and promote dignity and feelings of success while meeting	

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Further review of Resident #21's care plan revealed a problem of self-care deficient related to dementia and stroke. Approaches included heaving dependence on staff for activities of daily living. The care plan also identified the problem of nutritional status impairment. Approaches included assistance required for eating and drinking; promote socialization and comfort at mealtime.

During an observation on 3/6/19 at 9:25 am CNA #7 was assisting Resident # 21 with a drink in the common area. The liquid trickled down the resident's face during consumption, at which point CNA #7 stated out loud "[swearword]", and abruptly attempted to clean Resident's face with clothing protector.

Continuous observation of the lunch meal on 3/7/19 from 11:37 am - 12:15 am revealed food arrived to the Willow Unit and was placed on steam table by kitchen staff at 11:37 am. Resident # 21 was sitting in his/her recliner in dining room, while others are eating around him/her. Continuous observation of Resident #21 at 12:15 revealed the Resident still had not been provided assistance in eating.

Resident #31

Record review on 3/4-8/19 revealed Resident #31 was admitted to the facility with diagnoses that included dementia and Parkinson's disease.

Review of the most recent MDS assessment, a quarterly assessment dated 1/30/19, revealed the Resident was coded as mildly depressed with episodes of feeling or appearing down, depressed or hopeless; feeling tired or having

care needs.

* The designated activation staff person will provide cares for fewer residents, and will take on the additional responsibility of creating opportunities for resident engagement.

* Specific duties:

Post daily schedule on the Willow dry erase board seven days a week

Communicate information about the activities to staff and residents

Make sure supplies are available

Create opportunities for residents to feel welcomed, needed and useful.

Document successes, suggestions, supply needs, etc. daily in log book.

* We are developing compassion fatigue education and support for staff working with difficult, challenging elders to improve the identification of early warning signs to intervene prior to negative interactions by staff.

4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur?

* The DON will provide rounding to measure engagement and a therapeutic environment as evidenced by:

* Improve the quality of life for residents and staff, through engagement and satisfaction surveys.

* Reduced falls

* Reduced agitation

* Reduced turn-over

* The monthly audits and results will be reported to the Quality Committee monthly through the end of the year.

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F 600	Continued From page 20 little energy; trouble concentrating on things; being short-tempered or easily annoyed. Further review revealed the Resident was coded as having a BIMS of 5 (indicated the resident had severe cognitive impairment); behaviors; resistant to cares; requiring extensive assistance for toilet use. Review from 3/6-8/19 of Resident #31's care plan, latest revision date of 3/6/19, revealed a problem of self-care deficient due to dementia; impaired cognitive and decision making due to dementia; anxiety; and abusive behaviors. Approaches included to approach Resident in a calm manner and if Resident becomes combative during cares to provide him/her a few minutes to compose himself/herself. Further review of the care plan revealed a problem of resident risk for falls or injury related to Parkinson's disease. An approach included two person assist in bathroom. During an observation on 3/6/19 at 8:09 am the call light activated in Resident #31's room. CNA #8 entered the Resident's room and assisted the Resident out of bed. The Resident was wearing an adult undergarment, which sagged with the weight of urine and feces. The CNA assisted Resident #31 into the bathroom and attempted to clean feces off the Resident. The CNA called for assistance, using a portable radio device, after Resident #31 became agitated and began to strike out. CNA #7 entered the bathroom to assist with the Resident's care. After the surveyor stepped out and waited outside the partially opened bathroom door he/she heard, Resident #31 yelling and cursing during care. A moment of quiet ensued and female voice stated, "[Swearword]!" The same female voice then stated, "You're such an [swearword]." Both CNAs	F 600	* DON is responsible for the completion and maintenance of the correction. * Completion of corrective action will be 4/22/19 and ongoing.	

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(#s 7 and 8) exited the room, and ambulated Resident #31 to the common area.

The surveyors reported the incident to the Director of Nursing, on 3/6/19. The DON stated he/she would initiate an investigation.

Review of the facility policy "Resident Rights and Responsibilities," dated 11/16/17 revealed the facility will make every effort to assist each resident in exercising his/her rights and to ensure residents are always treated with respect, kindness, and dignity.

Review of the facility policy "Denali Center Abuse and Neglect," dated 10/3/18 defined verbal abuse as the use of oral or gestured language that willfully includes the use of disparaging and derogatory terms to residents or within their hearing distance, regardless of their age, ability to comprehend, or disability. The policy also defines mental abuse to include humiliation. Further review of the policy revealed the facility will identify and prevent resident abuse by identifying residents with a history of aggressive behaviors and formulating a well-developed care plan. Each staff member providing care has the knowledge of the individual residents' care needs. Further, supervisory staff are able to identify and prevent inappropriate staff behaviors, such as using derogatory language.
During an interview on 3/6/19 the Director of Nursing stated the reported incident by the State survey team was unacceptable and needed to be investigated immediately.

Review of the facility policy "Resident Rights and Responsibilities," dated 11/16/17 revealed the facility will make every effort to assist each

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F 600	Continued From page 22 resident in exercising his/her rights and to ensure residents are always treated with respect, kindness, and dignity. Review of the facility policy "Denali Center Abuse and Neglect," dated 10/3/18 defined verbal abuse as the use of oral or gestured language that willfully includes the use of disparaging and derogatory terms to residents or within their hearing distance, regardless of their age, ability to comprehend, or disability. The policy also defines mental abuse to include humiliation. Further review of the policy revealed the facility will identify and prevent resident abuse by identifying residents with a history of aggressive behaviors and formulating a well-developed care plan. Each staff member providing care has the knowledge of the individual residents' care needs. Further, supervisory staff are able to identify and prevent inappropriate staff behaviors, such as using derogatory language.	F 600		
F 641 SS=D	. Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: . Based on record review, interview and observation the facility failed to ensure the Minimum Data Set (MDS-a Federally required assessment) assessment accurately reflected the status of pressure injuries for 1 resident (#49) out	F 641	F641 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	4/22/19

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F 641	Continued From page 23 of 19 sampled residents. This failed practice placed the resident at risk for not receiving care and services to maintain his/her highest practical well-being. Findings: Record review from 3/4-8/19 revealed Resident #49 was admitted to the facility with diagnoses that included anemia, high blood pressure, Alzheimer's disease, dementia, chronic kidney disease, and weight loss Review from 3/6-8/19 of Resident #49's care plan, last revised 1/15/19, revealed a problem for potential skin breakdown related to dry itchy skin dated 9/9/14. In addition, a second left toe abrasion, dated 5/4/18. The care plan did not contain any information related to pressure injuries or prevention of pressure injuries to feet. The care plan also identified the Resident was legally blind and crawled on the floor for mobility. Left Foot Wound: Record review from 3/7-8/19 of the Resident #49's medical record revealed documentation under "Skin Condition / Wound Progression:" 12/28/18 - Wound Care Registered Nurse (WCRN) #1 noted area to be a stage 3 pressure injury measuring 1.3 cm x 1.5 cm x 0.1 cm. Specifically, "Wound is on the top of the [left] great toe, and has evolved to a Stage 3 pressure injury ...deterioration noted in site" Review of nurses notes dated , 1/18-24/19 - wound still present and nursing staff provided wound dressing changes Right 2nd Toe Wound:	F 641	* MDS and care plan were corrected to reflect the diagnosis and interventions of the documented Stage 3 pressure ulcers. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents residing at Denali Center could be affected by the alleged deficient practice. 3) What measures will be put into place or what systmeic changes will be made to ensure that the deficient practice does not recur? * Denali Center shares wound care services with Fairbanks Memorial Hospital. There is a disconnect with the process of assessment of causative factors and classification of wounds. * A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue as defined by The National Pressure Ulcer Advisory Panel (NPUAP), https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ para. 4.	

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F 641	Continued From page 24 Record review from 3/7-8/19 of the Resident #49's medical record revealed documentation under "Skin Condition / Wound Progression: 12/28/18 - WCRN #1 noted area to be a stage 3 pressure injury measuring 0.5 cm x 0.8 cm x 0.8 cm. Specifically, " ...deterioration noted in site ...Wound has developed into a Stage 3 pressure injury ...." The Wound Care Nurse stated the finding should have provided relief of pressure. The wound was described as granulation and slough tissue Review of nurses notes dated 1/18-24/19 - wound still present and nursing staff provided wound dressing changes. Review of the MDS assessment, dated 1/24/19, revealed the Resident had an active diagnosis of Stage 3 pressure ulcer under Section I8000 - Additional active diagnosis. Review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2018, revealed "Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period." Further review revealed the MDS Determination of Pressure Ulcer Risk under Section M0100(A) was not marked. Review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated	F 641	* Denali Center is researching a wound and skin care consultant to provide an assessment of the skin and wound care program in the organization. The DON and Quality specialist will be working with the consultant to address the disconnect with the WOCN. We have replaced our long term care MDS coordinator. The MDS Coordinator will be completing classes on accurate MDS completion. Denali Center is researching best practice for consistent wound measurement. The Pressure Ulcer Scale for Healing (PUSH Tool) was developed by the National Pressure Ulcer Advisory Panel (NPUAP) as a quick, reliable tool to monitor the change in pressure ulcer status over time. The tool is based on (1) an analysis of research literature to identify the critical parameters commonly used to monitor pressure ulcer healing and (2) a statistical analysis (i.e. principal component analysis) of existing research data bases on pressure ulcer monitoring and (3) a national retrospective validation study. (NPUAP, https://www.npuap.org/resources/educational-and-clinical-resources/push-tool/push-tool-information-and-registration-form/ para. 1). * A Casper Report was created to identify all residents currently triggering for a pressure ulcer. The tool will be used to compare the MDS findings to the documentation and the care plan. * Denali Center is creating a bimonthly meeting with the DON, Quality Specialist, MDS coordinator, and the neighborhood	

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F 641	Continued From page 25 10/2018, revealed "Check A if resident has a Stage 1 or greater pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/ device. Review descriptions of pressure ulcers/injuries and information obtained during physical examination and medical record review." Review of the MDS Section M0150 - Risk for Pressure Ulcers revealed the MDS coded the Resident to not have been at risk for pressure ulcers. Review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2018, revealed, under section M0150: Risk for Pressure Ulcers/Injuries, "If the medical record reveals that the resident currently has a pressure ulcer/injury, a scar over a bony prominence, or a non-removable dressing or device, the resident is at risk for worsening or new pressure ulcers/injuries." Review of the MDS Section M0210 - Unhealed Pressure Ulcer(s) revealed the MDS coded the Resident as not having having one or more unhealed pressure ulcer(s) at Stage 1 or higher. Review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2018, revealed, under the section M0210: Unhealed Pressure Ulcer(s), "Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period." During an interview on 3/7/19 at 10:50 am WCRN #2 stated the Resident sustained a stage 3 pressure injuries to toes on both feet and the wounds were currently open but healing since	F 641	Nurse Manager to review MDS CAAS and care planning for each resident during their assessment period. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * The DON or Quality Manager will complete audit to ensure MDS and care plans reflect current quality findings, including pressure injuries. We will complete 4 audits monthly for 6 months or until 100% accuracy is attained for three consecutive months. * Results will be reported to the Quality Committee monthly through the end of the year. * DON is responsible for the completion and maintenance of the correction. * Initiation of corrective action will be 4/22/19 and ongoing.	

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F 641	Continued From page 26 November 2018. Observation with WCRN #2 and Licensed Nurse (LN) #2 on 3/7/19 at 11:00 am revealed the left foot pressure injury measured 0.6 cm X 0.7 cm, depth 0.1. WCRN #2 stated wound was still healing. Observation of the right 2nd toe wound revealed it measured 0.2 cm x 0.3 x 0.1 cm and was still healing per WCRN #2. . During an interview on 3/7/19 at 11:00 am LN #2 reviewed Resident #49's care plan and stated the care plan did not contain information pertaining to the toe wounds nor provide any prevention measures to aid to prevent further decline of the wounds.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		4/22/19

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F 656	Continued From page 27 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: . Based on record review, observation and interview, the facility failed to develop and/or implement comprehensive care plans for 5 residents (#s 18; 21; 28; 31; and 49) out of 19 sampled residents. Specifically the facility failed to 1) implement the care plan for pain management for 1 resident; 2) implement activities on care plans for 4 residents; 3) implement care planned interventions for mechanically altered diet for 1 resident; 4) implement communication and language interventions on the care plan for 2 residents; and 5) develop a care plan to include risk of pressure ulcers and management of pressure related	F 656	F656 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Counseling and education were provided to the CNA involved with the interaction of resident #18, 21, and 49. Activities care plans were provided to the Willow team at WELD and included a review of the Activation care model proposed. * Resident #28 is no longer with the organization.	

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F 656	Continued From page 28 wounds for 1 resident. These failed practices placed residents at risk for decreased functional ability and less than optimal quality of life. Findings: Resident #18 Record review on 3/4-8/19 revealed Resident #18 had diagnoses that included Alzheimer's disease and dementia. Record review of the most recent MDS (Minimum Data Set- a Federally required assessment) assessment, a quarterly assessment dated 12/13/19, revealed the Resident had episodes of feeling or appearing down, depressed, or hopeless, as well as, being short-tempered and easily annoyed. The Resident required heavy dependence on staff for activities of daily living. Further review of the MDS assessment revealed the Resident was coded as having a BIMS (Brief Interview for Mental Status) of 00 (indicated the resident had severe cognitive impairment). Review from 3/6-8/19 of Resident #18's care plan, last revised 2/26/19, revealed a problem of activity pursuits altered related to a diagnosis of dementia. Behaviors indicating the alteration included intermittently crying out and wailing throughout the day. Approaches included monitoring attendance and level of participation in activities and refocusing Resident's thoughts. Resident preferences were documented as music, activities brought in by family, pet visits. Interventions for staff were to show understanding if crying out. Additional review of the care plan revealed a problem of cognitive decline with difficulty	F 656	* Resident #31, care plan updated to reflect risk of aspiration due to dysphagia diet. Education was provided to Willow staff regarding diets and care planning of diets. Eduation was provided for defintion of altered diets. * Resident #49 care plan was updated to reflect wound care for stage three pressure ulcer. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents residing at Denali Center could be affected by the deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * Denali Center is creating a bimonthly meeting with the DON, Quality Supervisor, MDS coordinator,neighorbood Nurse Manager, Activity Coordinator, and Dietician to review MDS CAAS and care planning for each resident during their assessment period. Additionally, care plans will be printed for updates at bedside for changes in condition. They will be maintained in the Nurse Manager office or Nurse medication room. * Willow Run is a special care neighborhood designed for residents with various kinds and stages of dementia. Denali Center recognizes that a therapeutic environment would be one that provides comfort, safety, and daily involvement in meaningful activities. We	

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F 656	Continued From page 29 communicating needs verbally as a result of dementia. Approaches included to provide conversation during cares and provide explanations of care being provided. Observation on 3/6/19 from 8:00 am to 9:30 am on the unit revealed Resident #18 was yelling out with no interaction from staff. Observation at 9:37 am revealed #7 approached Resident #18 and grasped the back of the wheelchair device and spun the Resident to the left and then to right in an attempt to relocate him/her. During this observation the CNA did not verbally address the Resident or come into line of sight allowing the Resident the opportunity to visualize the staff prior to moving the wheel chair. The Resident had a startled expression on his/her face. Additional observation on 3/6/19 at 9:42 am revealed Certified Nursing Assistant (CNA) #7 approached Resident #18, who was now resting with eyes closed, stated he/she was going to "jack down" the resident. The Resident suddenly awoke and began yelling out. The CNA did not approach the Resident or explain what he/she was doing before suddenly pumping the chair to a lower position. Resident #21 Record review on 3/4-8/19 revealed Resident #21 had diagnoses that included dementia; stroke; anxiety; and post-traumatic stress disorder. Review of the most recent MDS assessment, a quarterly assessment dated 12/20/18, revealed the Resident was coded as having episodes of feeling or appearing down, depressed or hopeless; poor appetite; and being	F 656	are developing an activation position that will allow creative reassignment of workloads to allow participation in resident programs to maximize involvement and decrease boredom and lonliness. Staff will receive additional training in dementia care and approaches to minimize behavior problems and promote dignity and feelings of success while meeting care needs. * The designated activation staff person will provide cares for fewer residents, and will take on the additional responsibility of creating opportunities for resident engagement. * Specific duties: * Post daily schedule on the dry erase board seven days a week. * Comunicate information about the activities to staff and residents. * Make sure supplies are available. * Create opportunities for residents to feel welcomed, needed and useful. * Document successes, suggestions, supply needs, etc. daily in log book. * Review and update care plans with collaboration of Resident Care Coordinator. * We are developing compassion fatigue education and support for staff working with difficult, challenging elders to improve the identification of early warning signs to intervene prior to negative interactions by staff. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur?	

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F 656	Continued From page 30 short-tempered or easily annoyed. Further review revealed the Resident was coded as having a BIMS of 00 (indicated the resident had severe cognitive impairment). Review from 3/6-8/19 of Resident #21's care plan, revision date of 2/15/19, revealed a problem of activity pursuits altered. Approaches included talking to the Resident about interest, taking Resident to religious activities, moving the Resident to a quiet area and comforting with touch when Resident is upset. Preferences included enjoying Native foods. Observations from 3/4-8/19 revealed an activities calendar in Resident #21's room that documented the staff were to help the Resident go to activities of interest such as church on Sundays and Fridays, Native culture on Mondays and music on Saturday. Random observations from 3/4-8/19 revealed Resident #21 was placed in common area with no interaction from staff during the day time. In addition, the Resident was not observed to have attended any religious or native based activities during the survey. Record review of Resident #21's activities participation documentation, dated 12/8/18 to 3/8/19, revealed the Resident was provided activities 28 out of 90 days. Review of the 28 days where activities were provided, 1 out of the 28 activities were religious/spiritual based. Further review revealed the Resident was not provided activities since 2/25/19. During a continuous observation on the unit from 8:45 am - 9:25 am revealed Resident #21 was in	F 656	* Director of Nursing/designee will randomly audit care plans ensure appropriate interventions are initiated. * Comprehensive care plans will be randomly audited for accuracy weekly x4 then montly x2. * Results of audit will be forwarded to Quality Assurance Performance Improvement Committee for evaluations and need for further action. * Reference F600 for skin program Plan of Correction * Reference F804 for meal service Plan of Correction	

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the common area punching and kicking his/her chair while yelling out curse words. Multiple healthcare staff (nurse, nurse aids and unit manager) passed the Resident during this observation without any interaction to mitigate the Resident's behaviors.

During an interview on 3/8/19 at 11:00 am the Transitional Counselor (TC) stated Resident #21 should be taken to religious activities throughout the week but made it difficult to meet activity needs due to staffing and acuity of Willow Unit's residents. TC further stated that Resident #21 did not attend any religious activities the week of the survey. In addition, the TC stated the Resident should not have exhibited behaviors for 40 minutes without intervention from staff.

Resident #28

Record review on 3/4-8/19 revealed Resident #28 had diagnoses that included rheumatoid arthritis (RA), chronic pain and muscle spasm.

Review of the most recent MDS assessment, a quarterly assessment dated 01/02/19, revealed the Resident was coded as having moderate, almost constant pain.

Review of the comprehensive care plan revealed the Resident was care planned for "Pain Alert ...Resident with complaints of paint d/t [due to] diagnosis of RA... Approach ...Nursing to use pain scale and document effectiveness of medications Q [every] shift and prn [as needed]"

Review of the electronic medication administration record (eMAR) for the week ending 2/28/19 and 3/7/19 revealed the Resident

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was taking acetaminophen (Tylenol) as needed for pain, baclofen 4x a day for muscle spasm and Lidoderm (lidocaine for numbing pain) patch for RA.

Review of Resident #28's clinical "Progress Notes by Resident" for the period 2/20/19 to 3/8/19 revealed 2 progress notes related to pain were documented. A note on 3/7/19 at 11:26 am and 3/7/19 at 11:39 am. No other progress notes related to pain were documented, for the 2 week time period.

During an interview on 3/8/19 at 9:40 am, the RN Manager (RNM) #1 stated the nursing staff should be conducting pain assessments every shift per the care plan and confirmed this was not being done consistently.

Review on 3/8/19 of the facility's policy and procedure "Pain- Management" dated 4/19/18, revealed "The resident's level of comfort will be reassessed and documented in EMR [electronic medical record]: a. Each shift b. Each time vital signs are taken ..."

Resident #31

Record review on 3/4-8/19 revealed Resident #31 had diagnoses that included dementia and Parkinson's disease.

Review of the most recent MDS assessment, a quarterly assessment dated 1/30/19, revealed the Resident was coded as mildly depressed with episodes of feeling or appearing down, depressed or hopeless; feeling tired or having little energy; trouble concentrating on things; being short-tempered or easily annoyed. Further

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review revealed the Resident was coded as having a BIMS of 5 (indicated the resident had severe cognitive impairment). In addition, the Resident was coded as receiving a mechanical altered therapeutic diet; requiring supervision of meals with encouragement and/cueing

Food:

Review from 3/6-8/19 of Resident #31's care plan, last revised 3/6/19, revealed a problem of being at risk for nutritional deficiency less than body requirements with approaches to monitor intake and dietary needs, provide soft food that were chopped/diced. Further review of the Resident's care plan revealed no problem, intervention or goals related to dysphagia, aspiration precautions or risk.

Review of the Resident #31's lunch diet card, dated 3/6/19, revealed the Resident was to have received diced mandarin oranges, diced paprika pork, diced linguine, and diced carrots.

During the lunch observation on 3/6/19 at 12:00 pm CNA #6 plated vegetable serving, meat serving and a serving of linguine noodles (characterized by long, flat strands). The CNA chopped the vegetables and meat into pieces ranging from ½" x ½" to 1" x 1" and left the linguine noodles whole.

Further observation on 3/6/19 at 12:08 pm CNA #3 took the prepared lunch plate from the Willow Unit dining area to the common area located at the other end of the unit. At 12:11 pm CNA #3 placed the plate in front of Resident #31 and uncovered the dish with the whole linguine noodles. At this time, the Surveyor stopped the

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CNA and inquired about the Resident's diet order. The CNA stated the Resident doesn't usually get served noodles. When asked if the noodles were to be chopped like the other food items, the CNA stated the noodles should not have been served whole and should have been chopped or pureed.

During an interview on 3/6/19 at 12:12 pm CNA #6 stated the linguine noodles should have been chopped per diet order.

Activities:

Review from 3/6-8/19 of Resident #31's care plan, latest revision date of 3/6/19, revealed a problem of activity pursuits altered. Approaches included talking to the Resident about topics he/she enjoyed throughout life, being outdoors, read and enjoyed music.

Random observations from 3/4-8/19, on the unit, revealed Resident #31 often became agitated and wandered. The staff did not engage Resident in discussion of his/her life passions, offer any distraction activity related to reading or music, and walks off the unit.

Record review of Resident #31's activities participation documentation, dated 12/8/18 to 3/8/19 revealed the Resident was provided activities 24 out of 90 days. Additional review on 3/8/19 revealed the Resident has not had a documented activity since 2/20/19.

During an interview on 3/8/19 at 11:10 am TC stated Resident #31 seemed to respond well to taking walks off the unit and talking about his/her life passions. The TC further stated due to many residents having behaviors, staff may not be

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available to cater to all activity needs for each resident.

Resident #49

Record review on 3/4-8/19 revealed Resident #49 was admitted to the facility with diagnoses that included dementia, depression, and Alzheimer's disease. The Resident was coded as being blind.

Review of the most recent MDS assessment, a quarterly assessment dated 1/24/19, revealed the Resident was coded as requiring extensive assistance with activities of daily living. Further review revealed the Resident was coded as having a BIMS of 00 (indicated the resident had severe cognitive impairment).

Activities:

Review from 3/6-8/19 of Resident #49's care plan, latest revision date of 1/15/19, revealed a problem of activity pursuits altered. Approaches included invite to cultural events, talking about past hobbies, invite to community events, and enjoys playing guitar located in Resident's closet. Additional review of the care plan revealed a problem of self-care deficit related to dementia.

Random observations on the unit from 3/4-8/19 revealed Resident #49 often sat in common area and needed assistance to attend and perform activities due to his/her severe vision deficit. During these observations, Resident #49 was not offered to attend Native culture group during survey per activity calendar for March 2019. Random observations of community events during the survey revealed the Resident did not attend any of the activities from 3/4-8/19. The

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Resident was not offered his/her guitar during the survey observations.

Record review of Resident #49's activities participation documentation, dated 12/8/18 to 3/8/19 revealed the Resident was provided activities 20 out of 90 days.

During an interview on 3/8/19 at 1:00 pm CNA #9 stated Resident #49 likes to hold a baby doll and listen to music. The Resident seemed happy when doing these activities. When asked how the CNAs know what activities work for residents, the CNA stated he/she would ask the unit nurse because the CNAs do not have access to care plans.

During an interview on 3/8/19 at 1:05 pm CNA #11 stated when a CNA works on Willow Unit it seems to be a "fly by the seat of your pants" since he/she was not a consistent CNA that worked on the dementia unit.

During an interview on 3/8/19 at 10:48 am Activities Coordinator (AC) stated the facility had no formal activities program specific to the dementia unit. The AC further stated the activities department was to produce a quarterly progress note for all residents. When asked about care planned activities, the AC stated each resident's care plan should have a section on activities and should be followed by staff.

During an interview on 3/8/19 at 11:01 am, when asked about care planning for activities the TC stated that care planning and written guidelines would have been most helpful for cares of Willow residents. In addition, the TC stated he/she would like to be part of the care conferences but does

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not attend them currently.

Approach:

Review from 3/6-8/19 of Resident #49's care plan, latest revision date of 1/15/19, revealed a problem of self-care deficit related to dementia. Approaches included staff were to speak to resident before touching him. The care plan also identified a problem of impaired cognitive abilities related to dementia.

During an observation on 3/6/19 at 9:38 am revealed CNA #7 grasped Resident #49's hand and placed a piece of bread in his/her hand. No introduction or conversation was provided to the Resident prior to the CNA grabbing his/her hand. The Resident appeared to be startled by the CNA's actions.

During an observation on 3/7/19 at 11:00 am revealed Licensed Nurse (LN) #2 and Wound Care Registered Nurse (WCRN) #1 performed a dressing change on the Resident's feet. During cares the Resident verbally expressed pain and frequently pulled back from staff. LN #2 apologized to the Resident but did not provide an explanation to the Resident prior to providing the dressing changes.

Pressure Injuries:

Review from 3/6-8/19 of Resident #49's care plan, latest revision date of 1/15/19, revealed a problem for potential skin breakdown related to dry itchy skin dated 9/9/14. In addition, a second problem was identified as left second toe abrasion dated 5/4/18. The care plan did not contain any information related to pressure

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F 656	Continued From page 38 injuries or prevention of pressure injuries to feet. Record review of "Wound Care Notes/Photo," dated 8/14/18, revealed trauma wound to 4th toe with bruising and abrasions observed. Record review of "Wound Care Notes/Photo," dated 12/10/18, revealed left great toe with full thickness lesion, trauma, friction with potential cause of pressure. Further review revealed right 2nd toe with full thickness lesion. "Both wound started as abrasion from crawling, bony deformities, very thin skin over joints, age, friction, and pressure from [him/her] pulling up on [his/her] socks." Record review of "Wound Care Notes/Photo," dated 12/28/18, revealed the wounds on the right 2nd toe and left great toe were identified as stage 3 pressure injuries. Record review of "Wound Care Notes/Photo," dated 1/8/19, revealed the wounds were observed to have granulating tissue. During an interview on 3/7/19 at 10:50 am WCRN #1 stated the Resident did sustained a pressure injury to toes on both feet and the wounds were currently open but healing. During an interview on 3/7/19 at 11:00 am LN #2 reviewed Resident #49's care plan and stated the care plan did not contain information pertaining to the toe wounds nor provide any prevention measures to aid in prevent further decline of wounds.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		4/22/19

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F 657	Continued From page 39 §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. (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, interview, and observation the facility failed to ensure that resident care plans were updated in a timely manner after significant change, change of condition or after the most recent MDS (Minimum Data Set- a federally required assessment) for 6 residents (#s 5; 9; 14; 15; 28 and 36) out of 19 sampled residents. This failed practice placed	F 657	F657 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Care plans were updated to reflect current resident status. * Order obtained for Physical Therapy	

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F 657	Continued From page 40 the residents at risk for less than the highest practicable mental, physical, and psychosocial well-being. Findings: Resident #5- Activities and Behavioral Health Record review on 3/4-8/19 revealed Resident #5 had diagnoses that included multiple sclerosis, schizophrenia, and chronic pain. During an interview on 3/6/19 at 10:00 am, Social Worker (SW) #1 stated that Resident #5 had been at the facility for a very long time. SW #1 stated that Resident #5 is non-verbal and that he/she was aware that Resident #5 was admitted with a diagnosis of schizophrenia. Review of Resident #5's care plan, last updated 12/31/18, revealed there had been no update to the activities approaches since 12/1/17. The care plan had no behavioral health problem, goals for behavioral health goals, or non-pharmaceutical interventions. During an interview on 3/8/19 at 8:53 am, Registered Nurse Manager (RNM) #3 stated that staff have difficulty knowing how to interact with Resident #5 unless he/she showed obvious signs of distress. They did not know how to interact with the Resident when he was non-distressed. During an interview on 3/8/19 at 9:43 am, SW#1 stated that Resident #5's team was unsure, due to the diagnosis of multiple sclerosis and schizophrenia, if Resident #5 was able to engage in shared reality. Review of Resident #5's most recent "Interdisciplinary Care Conference", dated	F 657	to evaluate resident #15 for restorative care. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents may be affected by the deficient practice. * All care plans will be reviewed for up to date problems, goals and approaches. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * MDS coordinators will complete checklist of items for each MDS thus assuring updated goals/approaches for each resident. * Physcial Therapy immediately changed the process when recommending restorative therapy. If a resident has reached a plateau with physical therapy and could benefit from restorative therapy, a physical therapist will complete a physician's order requesting discontinuation of physical therapy and request restorative therapy services within the same order. * Completion of corrective action will be 4/22/19 and ongoing. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * Quality Supervisor will complete audit to ensure care plan	

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F 657	Continued From page 41 1/12/19 revealed "no significant issues [with Resident #5], not troubled by A/H [audio hallucinations]." Resident #9 - Nutrition Record review on 3/4-8/19 revealed Resident #9 had diagnoses that included iron deficiency anemia, visual loss and bilateral (both sides) hearing loss. Review on 3/7/19 of the Resident's "Physicians Order Sheet" revealed a dietary order dated 1/18/19, " ...Special Instructions: Regular, Soft W/ [with] ground meats ..." Review of Resident #9's comprehensive care plan, last updated 1/3/19, revealed under the category "Nutritional Status" the "Problem ...decreased food intake due to blindness and utilizing finger foods only". The "Goal" was "...increase food and fluid intake" ..." The care plan did not identify that the Resident was to receive a regular soft diet with ground meats. During an interview on 3/8/19 at 11:30 am, RN Manager (RNM) #1 stated the Resident's care plan should identify that he/she was on a soft diet with ground meats. Resident #14 - Sling Record review on 3/4-8/19 revealed Resident #14 had diagnoses that included anoxic brain damage (brain injury caused by lack of oxygen) and bed confinement status. Review on 3/4-8/19 of Resident #14's most recent MDS assessment, a quarterly assessment	F 657	goals/approaches are in compliance. * Audits to be completed 4/month until reach 100% compliance and report to QAA. * Responsible party is the Quality Supervisor.	

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dated 2/21/19, revealed the Resident was coded total dependency with transferring.

Review of Resident #14's comprehensive care plan for the "Category *ADLs [activities of daily living] / Bathing /Transfers/Safety/Falls ...Approach ...Mechanical lift for all transfers. Use large green sling."

Observation on 3/5/19 at 3:48 pm, revealed Resident #14 being transferred with a sling lift. The sling was purple/blue in color.

During an interview on 3/7/19 at 4:00 pm, CNA #6 stated the sling for the type of lift the Resident used, was a purple/blue colored sling.

During an interview on 3/7/19 at 4:00 pm, RN Manager (RNM) #1 confirmed the comprehensive care plan was incorrect.

Resident #15-Rehab and Restorative

Record review on 3/4-8/19 of Resident #15's electronic medical record (EMR) revealed that Resident #14 was admitted to the facility post hip fracture with diagnoses that included respiratory failure secondary to pneumonia and diastolic dysfunction (heart rhythm abnormalities).

During an interview on 3/6/19 at 3:19 am, Resident #15 stated that he/she had been in physical therapy (PT) but was told that Medicare did not cover any additional visits so it would no longer be provided. Resident #15 further stated that he/she would like to continue so that he/she could maintain the ability to walk.

Record review on 3/7/19 at 3:00 pm of Resident

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#15's Interdisciplinary Care Conference (ICC), dated 12/7/18, revealed that Resident #14 had been receiving PT "1-2x 5x daily M-F [Monday through Friday] per PT POC [Plan of Care] for bed mobility, transfers, and gait. Rehab is coming to a close on 12/14/18." The Nursing section of the ICC revealed that Resident #15 " ...continues to fatigue easily [with] activity and spends most of the day in w/chair [wheelchair]." Under the Follow Up section of the ICC, documentation revealed "Rehab plans to d/c [discontinue] svcs [services] 12/14- need to set up nursing POC [Plan of Care] that promotes self-care."

Record review on 3/7/19 at 7:00 pm of Resident #15's Therapy Note History, dated 12/21/18, revealed, "Explained to pt [patient] that she is being discharged from PT and will be transferred to Restorative care to continued HEP [home exercise program] and other exercises to maintain her current strength and functional mobility."

Record review on 3/7/19 at 7:15 PM of Resident #15's Care Plan, start date of 10/10/18, with the most recent entry dated 1/8/19, revealed no updated plan for restorative care.

During an interview on 3/8/19 at 10:56 am, RNM #1 stated that the Resident had been transferred from another unit and that restorative should have started immediately after physical therapy was discontinued. He/she stated he/she was unsure why Resident #15 did not have a plan for restorative therapy since the discontinuation of physical therapy on 12/21/18.

Resident #28 - Pressure Injury

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Record review on 3/4-8/19 revealed Resident #28 had diagnoses that included rheumatoid arthritis (RA), chronic pain, and stage 3 pressure ulcer (a full-thickness loss of skin).

Review of the most recent MDS assessment, a quarterly assessment dated 01/02/19, revealed the Resident was coded as having 1, Stage 3 pressure ulcer.

Review of the physicians note dated 10/5/18 revealed "The patient [Resident] does have a dressing on [his/her] left foot ...due to pressure ulcer which was described as mild erythema (redness of the skin).

Review of Resident #28's "Wound Care Consultation" from the facility's Wound Care RN, dated 12/27/18, revealed "Recommend shoes that truly accommodate the form of [his/her] feet and provide protection along with appropriate dressings and pressure relief at all time including from weight of covers in bed."

Review of Resident #28's comprehensive care plan revealed the care plan did not identify a stage 3 pressure ulcer. The care plan was last updated on 8/15/18 for the "Problem ...Resident a/r [at risk] for impaired skin integrity r/t [related to] diagnosis of Rheumatoid Arthritis". "Approaches" did not address any interventions for the pressure ulcer or the recommendations identified by the Wound Care RN.

During an interview on 3/8/19 at 11:30 am, RNM #1 stated the pressure injury should be on the comprehensive care plan and confirmed it was

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not.

Resident #36 - Pacemaker

Record review on 3/4-8/19 revealed Resident #36 had diagnoses that included cerebrovascular disease (damage to the blood vessels in the brain), atrial fibrillation (an abnormal heart rhythm originating in the atria) and had a cardiac pacemaker.

Review of Resident #36's comprehensive care plan revealed under the category "Cardiac Condition" the "Problem ...Start Date: 06/16/14 ...Has a pacemaker in upper left chest wll [wall], telephone transmitters are in room, black and gray cases".

Record review of two "Pacemaker/ICD Follow-up" notes from the cardiologist revealed the Resident visited the heart center on 4/16/18 and 11/26/18. The heart center advised follow-up in 6 months.

During an interview on 3/7/19 at 10:20 am, RNM #1 stated the Resident no longer had a telephone transmitter for the pacemaker in his/her room. The RNM stated the Resident followed up with the cardiologist annually.

Resident #36 - Anticoagulant

Record review on 3/4-8/19 of Resident #36's most recent MDS assessment, a quarterly assessment dated 1/10/19, revealed the Resident was coded as taking an anticoagulant medication.

Review of Resident #36's comprehensive care

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plan revealed under the category "Cardiac Condition" the "Problem ...Start Date: 06/16/14 ...Approach ...Cardiac meds as per MD orders ..." The care plan did not identify what cardiac medications the Resident was prescribed and what approaches would be used for an anticoagulant.

Review of the "Physicians Order Sheet" dated 2/1/19, revealed an anticoagulant medication "ELIQUIS (Apixaban), tablet, 2.5 mg: Administer 2.5 mgs By Mouth 2 times per day ...For paroxysmal A-FIB [irregular heart rhythm] ..."

Review of the Resident's "PHARMACY CONCERNS AND MD ORDERS", dated 2/6/19, for the "January Chart Review" revealed "...Of note, resident is on a low dose of apixaban follow history of GI bleed -Currently at apixaban ...Does the benefit of this still outweigh the risks?"

During an interview on 3/7/19 at 10:25 am, RNM #1 stated the care plan should identify an anticoagulant medication and approaches for monitoring.

Review on 3/14/19 of the manufacturer insert for "Eliquis" (apixaban) obtained from the website https://www.eliquis.bmscustomerconnect.com, revealed "ELIQUIS can cause bleeding, which can be serious, and rarely may lead to death ...you may bruise more easily and it may take longer than usual for any bleeding to stop."

Review of the facility's policy and procedure entitled "Multidisciplinary Care Review and Care Plan Process", last approved on 12/19/17, revealed the purpose of the policy was to ensure care plans were updated on an ongoing bases

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F 657	Continued From page 47 and under section B. Care Planning, "A Plan of Care will include: a) Focus of problems b) Long-term and short-term goals which are measurable, including therapy goals." and that care plan reviews are performed monthly during monthly assessment and as needed.	F 657		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: . Based on record review, observation and interview the facility failed to provide meaningful and individualized activities that supported the physical, mental and psychosocial well-being of 4 residents (#s 18; 21; 31; and 49) out of 14 residents on the dementia unit. This failed practice placed these residents at risk for social isolation, depression and less than optimal quality of life. Findings: Resident #18 Record review on 3/4-8/19 revealed Resident #18 was admitted to the facility with diagnoses that included Alzheimer's disease and dementia.	F 679	F679 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Educate all staff about care plans. Discuss at Weekly Education and Learning Discussion (WELD) activity needs for each resident and where activity care plan can be found. * Improve activities/engagement documentation by teaching all staff LifeLoop, the activities web based data collector. * Implement, educate and utilize	4/22/19

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F 679	Continued From page 48 Review of the most recent MDS (Minimum Data Set - a federally required assessment) assessment, a quarterly assessment dated 12/13/19, revealed the Resident had episodes of feeling or appearing down, depressed, or hopeless, as well as, being short-tempered and easily annoyed. The Resident required heavy dependence on staff for activities of daily living. Further review of the MDS assessment revealed the Resident was coded as having a BIMS (Brief Interview for Mental Status) of 00 (indicated the resident had severe cognitive impairment). Review from 3/6-8/19 of Resident #18's care plan, last revised on 2/26/19, revealed a problem of activity pursuits altered related to a diagnosis of dementia as evidence by intermittently crying out and wailing out throughout the day. Approaches included monitoring attendance and the level of participation in activities, refocusing the Resident's thoughts. The Resident was documented to enjoy music, activities brought in by family, pet visits, and interventions for staff were to show understanding if crying out. Random observations from 3/4-8/19 revealed Resident #18 often seated in the common area not facing the TV. Further observation revealed the TV was on 4 of the 5 days with low volume, as a result the TV was unable to be heard in the common area each day. Music was played at low volume via a radio/speaker device 1 of 5 days observed. During the random observations, Resident #18 was observed to be yelling out randomly and was restless. Minimal interaction by staff was observed during the verbal outburst of the Resident. Specifically, observation on 3/6/19 from 8:00 am to 9:30 am revealed Resident #18	F 679	Person Centered Engagement Opportunities listed in Willow closets. * Implement 1:1 engagement visits for those residents identified needing additional engagement. * Create, implement, maintain and audit a Willow Activity/Engagement Calendar. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents residing at Denali Center could be affected by the deficient practice. 3) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * Educate all staff about care plans. * Hard copy care plans will be available on the neighborhoods for bedside staff review. The CNA worksheets will contain activities specifice likes and dislikes of each individual resident. * Improve activities/engagement documentation by teaching staff Lifeloop, the activities web based data collector. * Implement, educate, and utilize Person Centered Engagement Opportunities listed in Willow closets. * Implement 1:1 engagement visits for those residents identified needing additional assistance with engagement. * Create, implement, maintain and audit a Willow Activity/Engagement Calendar.	

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F 679	Continued From page 49 was yelling out with no interaction from staff. Record review of Resident #18's activities participation documentation, dated 12/21/18 to 3/8/19 revealed the Resident was provided activities 22 out of 77 days. Resident #21 Record review on 3/4-8/19 revealed Resident #21 had diagnoses that included dementia; stroke; anxiety; and post-traumatic stress disorder. Review of the most recent MDS assessment, a quarterly assessment dated 12/20/18, revealed the Resident was coded as having episodes of feeling or appearing down, depressed or hopeless; poor appetite; and being short-tempered or easily annoyed. Further review revealed the Resident was coded as having a BIMS of 00 (indicated the resident had severe cognitive impairment). Review from 3/6-8/19 of Resident #21's care plan, latest revision date of 2/15/19, revealed a problem of activity pursuits altered. Approaches included talking to the Resident about interest, taking Resident to religious activities, moving Resident to quiet area and comfort with touch when Resident is upset. Resident preferences included enjoying Native foods. Observations from 3/4-8/19 of an activities calendar in Resident #21's room that stated the staff were to help the Resident go to activities of interest such as church on Sundays and Fridays; Native culture on Mondays and music on Saturday.	F 679	* Identify facility wide residents with low participation/involvement and implement reassessment and care planning for those residents by 4/22/19. * Patient Services Manager is responsible for completion and maintenance of the correction. * Willow Run residents will have monthly progress notes reflecting their level of participation in meaningful activities/engagement, and quarterly progress notes for long-term care residents. * Implement 1:1 engagement visits for those residents identified need additional assistance with engagement. * Completed by 4/22/2019 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * Improve activities/engagement documentation by teaching all staff LifeLoop, the activities web based data collector. * Weekly audits on documentation numbering 6 residents per neighborhood for 3 months. 6 randon audits monthly after. * Implement 1:1 engagement visits for those residents identified as needing additional engagement. Initial, quarterly, and annual assessments will identify needed 1:1 visits. Progress notes will reflect engagement outcomes. * Create, implement, maintain and audit a Willow Activity/Engagement Calendar. Monthly audits of Willow	

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F 679	Continued From page 50 Random observations from 3/4-8/19 revealed Resident #21 was placed in common area with no interaction from staff during the day time. In addition, the Resident was not observed to have attended any religious or Native based activities during the survey. Record review of Resident #31's activities participation documentation, dated 12/8/18 to 3/8/19 revealed the Resident was provided activities 28 out of 90 days. Review of the 28 days where activities were provided, 1 out of the 28 activities were religious/spiritual based. Further review revealed the Resident was not provided activities since 2/25/19. During a continuous observation from 8:45 am - 9:25 am revealed Resident #21 was in the common area punching and kicking his/her chair while yelling out curse words. Multiple healthcare staff (nurse, nurse aids and unit manager) passed the Resident during this observation without any interaction to mitigate the Resident's behaviors. During an interview on 3/8/19 at 11:00 am the Transitional Counselor (TC) #1 stated Resident #21 should be taken to religious activities throughout the week but made it difficult to meet activity needs due to staffing and acuity of Willow Unit's residents. TC further stated that Resident #21 did not attend any religious activities the week of the survey. In addition, the TC stated the Resident should not have exhibited behaviors for 40 minutes without intervention from staff. Resident #31 Record review on 3/4-8/19 revealed Resident #31	F 679	activities will be done by Social Services. * All residents found to have low participation will be identified and reassessed by 4/22/2019.	

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was admitted to the facility with a diagnoses that included dementia and Parkinson's disease.

Review of the most recent MDS assessment, a quarterly assessment dated 1/30/19, revealed the Resident was coded as mildly depressed with episodes of feeling or appearing down, depressed or hopeless; feeling tired or having little energy; trouble concentrating on things; being short-tempered or easily annoyed. Further review revealed the Resident was coded as having a BIMS of 5 (indicated the resident had severe cognitive impairment)..

Review from 3/6-8/19 of Resident #31's care plan, last revised on 3/6/19, revealed a problem of activity pursuits altered. Approaches included talking to the Resident about topics he/she enjoyed throughout life, being outdoors, reading and music.

Random observations from 3/4-8/19 revealed Resident #31 often became agitated and wandered. The staff did not engage Resident in discussion of his/her life passions, offer any distraction activity related to reading or music, and walks off the unit.

Record review of Resident #31's activities participation documentation, dated 12/8/18 to 3/8/19 revealed the Resident was provided activities 24 out of 90 days. Additional review on 3/8/19 revealed the Resident has not had a documented activity since 2/20/19.

During an interview on 3/8/19 at 11:10 am TC #1 stated Resident #31 seemed to respond well to taking walks off the unit and talking about his/her life passions. The TC further stated due to many

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residents having behaviors, staff may not be available to cater to all activity needs for each resident.

Resident #49

Record review on 2/4-8/19 revealed Resident #49 was admitted to the facility with a diagnoses that included dementia, depression, and Alzheimer's disease.

Review of the most recent MDS assessment, a quarterly assessment dated 1/24/19, revealed the Resident was coded as requiring extensive assistance with activities of daily living. Further review revealed the Resident was coded as having a BIMS of 00 (indicated the resident had severe cognitive impairment).

Review from 3/6-8/19 of Resident #49's care plan, latest revision date of 1/15/19, revealed a problem of activity pursuits altered. Approaches included invite to cultural events, talking about past hobbies, invite to community events, and enjoys playing guitar (located in Resident's closet).

Random observations from 3/4-8/19 revealed Resident #49 often sat in common area. During these observations, Resident #49 was not offered to attend Native culture group during survey. Low volume music was only played 1 of 5 days observed. Random observations of community events during the survey revealed the Resident did not attend any of the activities from 3/4-8/19. The Resident was not offered his/her guitar during the survey observations.

Record review of Resident #49's activities

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participation documentation, dated 12/8/18 to 3/8/19 revealed the Resident was provided activities 20 out of 90 days.

During an interview on 3/8/19 at 1:00 pm Certified Nursing Assistant (CNA(#9 stated Resident #49 likes to hold a baby doll and listen to music. Resident #49 seemed happy doing these activities, and that's how CNA knows that these activities work for the Resident. When asked they knew what activities work for residents, the CNA stated he/she would ask the unit nurse because the CNAs do not have access to care plans.

During an interview on 3/8/19 at 1:05 pm CNA #11 stated he/she was unaware of individualized activity care plans in each resident's room. The CNA further stated when a CNA works on Willow Unit it seems to be a "fly by the seat of your pants" since he/she was not a consistent CNA that worked on the dementia unit.

During an interview on 3/8/19 at 1:10 pm CNA #12 stated Residents can participate in facility wide activities, posted on the monthly calendar and white board dry erase calendar in each unit. The CNA further stated he/she could contact the activities director for additional activities that could have been added to the calendar for spontaneous activities.

During an interview on 3/8/19 at 10:48 am Activities Coordinator (AC) stated the facility had no formal activities program specific to the dementia unit. The AC further stated the activities department was to produce a quarterly progress note for all residents. When asked about care planned activities, the AC stated each resident's care plan should have a section on activities and

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should be followed by staff.

During an interview on 3/8/19 at 11:01 am the TC and AC both stated that the TV and music should have been at a volume that allowed residents the opportunity to hear. The TC further stated that the current number of Willow Unit staffing compared to the acuity of behaviors and resident needs could have contributed to the lack of activities being performed and/or offered. The TC stated it was the goal of the facility to offer activities when a resident is agitated or displaying behavior issues.

When asked about care planning for activities the TC stated that care planning and written guidelines would have been most helpful for cares of Willow residents. In addition, the TC stated he/she would like to be part of the care conferences but does not attend them currently.

Review of the facility policy "Willow Run Programming," dated 12/20/17 revealed "The residents of Willow Run Special Care Unit will enjoy activities provided both on and off the unit, which will provide their interest and abilities ...CNA/Activity staff will write the group programs for the day on the white board and determine any specific needs related to off the neighborhood group activities ...Residents will receive individualized care as indicated on their care plans ...Engagement activities will be provided daily by staff for residents as indicated by care plans ...The Activities Department will write a monthly progress note to reflect participation ..."

Review of the facility policy "Activities," dated 11/17/19 revealed "The facility must provide ...preferences of each resident, an ongoing

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F 679	Continued From page 55 program to support residents in their choice of activities ...designed to meet the interest of and support the physical, mental and psychosocial well-being of each resident ...Denali Center will provide adequate staff with appropriate training and experience to meet the varied needs and multiple interest of each resident.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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: . Based on record review, interview and observation the facility failed to ensure one resident (#49), out of 5 resident reviewed for pressure injuries, received timely care and services to prevent and treat avoidable pressure injuries. This failed practice resulted in resident #49 acquiring two stage 3 pressure injuries resulting in actual harm to the resident. Findings: Record review from 3/4-8/19 revealed Resident #49 had diagnoses that included anemia, high	F 686	F686 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Care plan was corrected to reflect the diagnosis and interventions of the documented Stage 3 pressure ulcers.	4/22/19

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F 686	Continued From page 56 blood pressure, Alzheimer's disease, dementia, chronic kidney disease, and weight loss Review from 3/6-8/19 of Resident #49's care plan, last revised 1/15/19, revealed a problem for potential skin breakdown related to dry itchy skin dated 9/9/14. In addition, a second problem was identified as left second toe abrasion dated 5/4/18. The care plan did not contain any information related to pressure injuries or prevention of pressure injuries to feet. The care plan further revealed the Resident was legally blind and prefers to be mobile by crawling. Review of the Minimum Data Set (MDS - a federally required assessment) assessment, dated 1/24/19, revealed the Resident had an active diagnosis of Stage 3 pressure ulcer. Further review revealed the MDS coded the Resident as not at risk for pressure ulcers and he/she did not have any unhealed/active pressure ulcers. Record review of "Wound Care Notes/Photo," dated 12/10/18, revealed left great toe with full thickness lesion, trauma, friction with a potential cause of pressure. Further review revealed right 2nd toe with full thickness lesion. "Both wounds started as abrasions from crawling, bony deformities, very thin skin over joints, age, friction, and pressure from [him/her] pulling up on [his/her] socks." Record review of "Wound Care Notes/Photo," dated 12/28/18, revealed the wounds on the right 2nd toe and left great toe were identified as stage 3 pressure injuries. Record review of "Wound Care Notes/Photo,"	F 686	2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents residing at Denali Center could be affected by the alleged deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * Denali Center shares wound care services with Fairbanks Memorial Hospital. The service is provided by Wound Care Nurses that serve as needed for wound assessment. There is a disconnect with the process of assessment of causative factors and classification of wounds. * A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissure for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue as defined by the National Pressure Ulcer Advisory Panel (NPUAP), https://npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/para.4. * Denali Center is researching a	

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F 686	Continued From page 57 dated 1/8/19, revealed the wounds were observed to have granulating tissue. Left Foot Wound: Record review from 3/7-8/19 of the Resident #49's medical record revealed documentation under "Skin Condition / Wound Progression": 10/6/18 - new wound noted on the left foot as an abrasion measuring 0.5 cm x 0.2 cm 10/8/18 - cause of wound accredited to friction caused by the Resident crawling around 10/12/18 - new wound found on 2nd toe, described as the whole toe being red with open wound and black scab, as well as "does not look good. painful to touch" 10/15/18 - left 2nd toe continued to be red, painful to touch with open area with pus drainage 10/21/18 - no change in site or condition documented 11/8/18 - area noted to have faint odor, documented as having punched out appearance 11/15-21/18 - area noted to have yellow drainage 11/26/18 - area noted to have no improvement per two licensed nurses, consult wound care for assessment and recommendations 11/28/18 - wound care nurse was not able to view the wounds (2 days post consult request) 11/30/18 - floor nurses attempted to contact	F 686	wound and skin care consultant to provide an assessment of the skin and wound care program in the organization. The DON and Quality specialist will be working with the consultant to address the disconnect with the WOCN. * Education is developing a skills fair and education to bedside staff includes Braden Scale, risk, care planning, and pressure injury prevention strategies based on risk. * The skin process and education will include; * Risk Assessment and Prevention * NEWLY IDENTIFIED SKIN INJURY * Or NONHEALING/WORSENING WOUND * Person finding skin injury/alerts nurse, safeguards resident, prevents further injury, primary nurse assesses injury/wound, stabilizes, alerts RCC/Charge, RCC/Charge lead Skin Huddle to identify cause, type of injury, or woud change, and determine if injury/wound change was avoidable based on assessment of skin/wound, recommends specific actions to prevent recurrence and promote healing, and documents them on the Skin Huddle form. Skin Huddle form is used to guide Care Plan changes, and is routed to RCC/Charge, and DON for review. * If new wounds identified, RN will initiate a Wound Measurement Flow Sheet, measure and date each wound identified. We are investigating best practices from NPUAP, PUSH scores. * Denali Center is creating a bimonthly skin meeting with the DON, Quality	

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F 686	Continued From page 58 wound care nurse for consult 12/8/18 - area noted to be the size of a "quarter" with yellow-tan draining with specks of green, wound care nurse consulted for verification of treatment. Resident complained of his/her feet hurting. "Cradle or tray table over bed to keep blankets from creating pressure to feet. If possible leave socks to decrease pressure" 12/10/18 (2 weeks post initial consult request)- Wound Care Registered Nurse (WCRN) #1 documented the wound was a full thickness lesion approximately 1.2 cm in diameter that initiated as an abrasion from crawling on the floor but exacerbated by boney deformity, friction from crawling and potential pressure from socks that the Resident pulls up snug and slippers that his/her food can slide in to 12/12/18 - area documented at no longer having a scab, dry and appeared to be painful to Resident 12/20/18 - area noted to have thick consistent drainage 12/28/18 - WCRN #1 noted area to be a stage 3 pressure injury measuring 1.3 cm x 1.5 cm x 0.1 cm. Specifically, "Wound is on the top of the [left] great toe, and has evolved to a Stage 3 pressure injury ...deterioration noted in site" 1/2/19 - no change in site condition documented 1/8/19 (11 days since last wound care nurse assessment)- WCRN #1 noted wound improvement	F 686	Specialist, MDS coordinator, WCON and the neighborhood Nurse Manager to review skin injuries including pressure ulcers, healing, treatments, trending, and care planning for active wounds. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * The DON or Quality Manager will complete audit to ensure wound healing and care plans reflect current quality findings, and accuracy of documentation. We will complete 4 audits monthly for 6 months or until 100% accuracy is attained for three consecutive months. * Results will be reported to the Quality Committee monthly through the end of the year. * DON is responsible for the completion and maintenance of correction. * Initiation of corrective action will be 4/22/19 and ongoing.	

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F 686	Continued From page 59	F 686		

Right 2nd Toe Wound:

Record review from 3/7-8/19 of the Resident #49's medical record revealed documentation under "Skin Condition / Wound Progression:

10/17/18 - new wound identified to the right 2nd toe, documented as "not present on admission."

10/18/18 - area described as slight sloughing with white center and red tissue surrounding area

10/23/18 - area described as having white center with no change noted

10/31/18 - area noted to have dried blood and drainage to bandage

11/4/18 - area noted to have dried blood on drainage with wound described as tan with "red-tinged"

11/8/18 - area noted to have faint odor, Resident experienced discomfort, punched out appearance

11/15-21/18 - area noted to have yellow drainage

11/26/18 - area noted to have no improvement noted per two licensed nurses, consult wound care for assessment and recommendations

11/28/18 - wound care nurse was not able to view the wounds (2 days post consult request)

11/30/18 - floor nursing attempted to contact wound care nurse for consult, no change in wound

12/8/18 - area noted to be the size of a dime with

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yellow-tan draining with specks of green, wound care nurse consulted for verification of treatment. "Cradle or tray table over bed to keep blankets from creating pressure to feet. If possible leave socks to decrease pressure."

12/10/18 (2 weeks post initial consult request) - WCRN #1 documented the top of the right 2nd toe was a full thickness lesion approximately 0.7 cm in diameter that initiated as an abrasion from crawling on the floor but exacerbated by boney deformity, friction from crawling and potential pressure from socks that the Resident pulls up snug and slippers that his/her food can slide into. The wound was described as granulation and slough tissue

12/11/18 - new "skin tear" noted to right 2nd toe

12/12/18 - Resident documented as appearing the site was painful and guarded area

12/16/18 - area noted to be larger in size, approximately 2 cm

12/28/18 - WCRN #1 noted area to be a stage 3 pressure injury measuring 0.5 cm x 0.8 cm x 0.8 cm. Specifically, " ...deterioration noted in site ...Wound has developed into a Stage 3 pressure injury ...." The Wound Care Nurse stated finding should that he/she would wear would could have provided relief of pressure. The wound was described as granulation and slough tissue

1/2/19 - no change in site condition documented

1/8/19 (11 days since last wound care nurse assessment) - WCRN #1 stated Resident still not wearing shoes. Improvement noted

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Review of the facility provided document "Guidelines for Staging of Pressure Injuries" from the national Pressure Ulcer Advisory Panel (NPUAP), dated 4/2016 revealed "Stage 3 Full-Thickness loss of skin ...granulation tissue ...are often present. Slough and or eschar may be visible"

Record review of Resident #49's physician's order, dated 1/15/19, revealed a podiatry consult for both feet to determine possible cause of feet injuries

Review of the podiatry consult, dated 2/5/19, revealed the podiatrist believed the " ...ulcerations are results of abrasion and pressure ..."

During an interview on 3/7/19 at 10:50 am WCRN #2 stated the Resident sustained a pressure injury to toes on both feet and the wounds were currently open but healing. Additionally, WCRN #2 stated that if a Resident had an active wound that required a wound nurse consult then the wound care nurse should have visited them weekly.

Observation with WCRN #2 and LN #2 on 3/7/19 at 11:00 am revealed the left foot pressure injury measured 0.6 cm X 0.7cm, depth 0.1. WCRN #2 stated wound was still healing. Observation of the right 2nd toe wound revealed it measured 0.2 cm x 0.3 x 0.1 cm and was still healing per WCRN #2.

During an interview on 3/7/19 at 11:00 am LN #2 reviewed Resident #49's care plan and stated the care plan did not contain information pertaining to the toe wounds nor provide any prevention

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F 686	Continued From page 62 measures to aid in prevent further decline of the wounds. During an interview on 3/7/19 at 12:45 pm WCRN #1 and WCRN #2 stated the wounds could have possibly been avoided if the wound care process was more efficient. When asked about the time line of the wound care, WCRN #1 stated wound care was consulted in November 2018. An attempt was made on 11/28/18 but had not seen the Resident until 12/10/18. WCRN #1 stated the large gap in time should not have occurred and the Resident should have been seen sooner. Additionally, once the Resident was seen by a wound care nurse on 12/10/18 there was an 18 day gap before the wound care nurse assessed the Resident again. WCRN #1 stated the Resident should have been assessed sooner. Review of the facility's policy "Skin Integrity: Prevention and Early Intervention for Skin Breakdown," dated 7/13/17, revealed "[Residents] identified at risk for skin breakdown have prevention measures implemented and appropriately documented" Pressure Injuries are staged by wound are specialist, physician or physical therapy. The policy identified populations at risk for developing pressure injuries as individuals that are elderly, have impaired mobility, neurological disease, history of weight change and depression. .	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		4/22/19

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F 688	Continued From page 63 resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: . Based on interview and record review, the facility failed to implement measures to increase/prevent decrease physical mobility for 1 resident (#15), out of 2 residents reviewed for rehabilitation and restorative needs. This failed practice placed residents at risk for not receiving their optimal physical, mental, and psychosocial functioning. Findings: Record review on 3/4-8/19 of Resident #15's electronic medical record (EMR) revealed that Resident #15 was admitted to the facility post hip fracture with diagnoses that included respiratory failure secondary to pneumonia and diastolic dysfunction (heart rhythm abnormalities). During an interview on 3/6/19 at 8:19 am, Resident #15 stated that he/she had been in physical therapy (PT) but was told that Medicare did not cover any additional visits so it would no	F 688	F688 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Order obtained from physician for physical therapy evaluation in restorative therapy program. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents residing at Denali Center could be affected by the deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	

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F 688	Continued From page 64 longer be provided. Resident #14 further stated that he/she would like to continue so that he/she could maintain the ability to walk. Record review on 3/7/19 at 3:00 pm of Resident #15's Interdisciplinary Care Conference (ICC) dated 12/7/18 revealed that Resident #15 had been receiving PT "1-2x 5x daily M-F [Monday through Friday] per PT POC [Plan of Care] for bed mobility, transfers, and gait. Rehab is coming to a close on 12/14/18." The Nursing section of the ICC revealed that Resident #15 "...continues to fatigue easily [with] activity and spends most of the day in w/chair [wheelchair]." Under the Follow Up section of the ICC, documentation revealed "Rehab plans to d/c [discontinue] svcs [services] 12/14- need to set up nursing POC [Plan of Care] that promotes self-care." Record review on 3/7/19 at 7:00 pm of Resident #15's Therapy Note History dated 12/21/18 revealed,"Explained to pt [patient] that [he/she] is being discharged from PT and will be transferred to Restorative care to continued HEP [home exercise program] and other exercises to maintain [his/her] current strength and functional mobility." Record review on 3/7/19 at 7:15 pm of Resident #15's Care Plan, start date of 10/10/18, with the most recent entry dated 1/8/19, revealed no updated plan for restorative care. During an interview on 3/8/19 at 8:47 am, Registered Nurse Manager #3 (RNM) stated that physical therapy was discontinued because Resident #15 had "plateaued".. During an interview on 3/8/19 at 9:29 am, Social	F 688	* Physical Therapy immediately changed the process when recommending restorative therapy. If residents have reached a plateau with physical therapy and could benefit from restorative therapy, the physical therapist will complete a physician's order requesting discontinuation of physical therapy and request restorative therapy services within the same order. * Completion of corrective action will be 3/28/19 and ongoing. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * Quality Supervisor will audit physical therapy orders vs discharges from facility, 4/month. Report to QAA. * Responsible person is the Quality Supervisor.	

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F 688	Continued From page 65 Worker (SW) #1 that the facility's obligation for physical therapy was "to take them as far as they can". SW #1 stated that Resident #15 was being assessed for restorative and there was no process in place to in place for residents to be re-evaluated on a regular schedule. He/she further stated that residents could be missed over time. During an interview on 3/8/19 at 10:56 am, RNM #1 stated that the Resident had been transferred from another unit and that restorative should have started immediately after physical therapy was discontinued. He/she stated he/she was unsure why Resident #15 did not have a plan for restorative therapy since the discontinuation of physical therapy 12/21/18. Record review from 3/4-8/19 of the facility's policy and procedure entitled "Multidisciplinary Care Review and Care Plan Process", last approved on 12/19/17 under section B. Care Planning, revealed "A Plan of Care will include: b. Long-term and short-term goals which are measurable, including therapy goals; d. Rehabilitation potential is developed from admission form and will be noted on plan of care and physician order form." .	F 688		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the	F 730		4/22/19

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F 730	Continued From page 66 requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: . Based on personnel record review, interview and policy review, the facility failed to ensure 1 certified nursing assistant (CNA #5) had completed 12 hours of annual training that included dementia training. The failed practice to ensure the CNA had 12 hours of training, based on their annual evaluation, placed all Residents at risk (based on a census of 77) for harm and less than optimal care. Findings: Personnel record review on 3/8/19 at 12:15 pm, revealed CNA #5 was hired on 6/12/17. Review of CNA #5's annual training, revealed the CNA did not have documentation of 12 hours of annual training that included dementia training. During an interview on 3/8/19 at 12:30 pm, the RN Clinical Educator (RN CE) stated that CNA did not meet the 12 hours of training, including dementia training. The RN CE stated the facility was in the process of fixing the dementia training program. Review on 3/4-8/19 of the "Denali Center Facility Assessment 2019" revealed " ...Required in-service training for nurse aides. In-service training included: 12 hours of Dementia training per year. Includes resident abuse prevention training. Addresses areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff. For nurse aides providing services to individuals	F 730	F730 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Denali Center will be re-initiating LTC nursing skills fair annually - date set for 4/17/19 to address learning needs. * SABA mandatory LTC modules will be added to the Denali Center staff as applicalbe for abuse, neglect, dementia, skin, pressure ulcer prevention and dining with dignity/dementia. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recoginizes that all residents at Denali Center could be affected by the deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * Based upon staff feedback need for electronic centralized access for LTC educational resources and LTC specific evidence based best practices. This was developed, implemented and provided staff education for new Denali Center LTC Educational Resources available under Foundation Health Partners internet services. Completed at March Nursing Staff Meeting.	

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F 730	Continued From page 67 with cognitive impairments, also address the care of the cognitively impaired ..." Review on 3/8/19 of the facility's policy and procedure "In Service Training Programs" dated 10/3/18, revealed "All personnel are encouraged to attend regularly scheduled in-service training classes." .	F 730	* Completed meeting with Foundation Health Partners central education department to outline methods to electronically track the Denali Center employees 12 hour education through the training venues provided. * All in-services, WELDS, nursing staff meetings, Skill Fairs, SABA mandatory, policy review, will be tracked electronically through the current Foundation Health Partners systems and Denali Center has implemented the electronic roster to be able to have Foundation Health Partners directly download edcuation provided at Denali Center and employees attendance recorded onto their Foundation Health Partners transcripts. * Paper roster will only be utilized when the elecronic system is down as a backup method, not the primary method of tracking Denali Center education. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * Standardized education tracking tool will be implemented for the RCCs and bedside staff to track at mid-year check for number of training hours completed and will be required to have an action plan with RCC to address how remaining outstanding training hours will be accomplished through the educational offerings available by annual evaluation. * These are records that can be provided as proof of training completed: * Foundation Health Partners education transcript	

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F 730	Continued From page 68	F 730	* SABA transcript * Completion of annual Foundation Health Partners and Denali Center Nursing Skills Fair. * Certificates for education completed outside of the FHP education system.	
F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: . Based on record review, observations and interviews the facility failed to ensure 4 residents (#s 18; 21; 49; and 57) out of 14 residents that resided on the dementia unit received dementia care in accordance with individualized plans of care. Specifically, the facility failed to ensure residents were treated in a dignified manner as it related to having a diagnosis of dementia and/or address dementia-related behavioral needs. These failed practices placed the residents at risk for an inability to receive care to maintain the highest practicable physical, mental and psychosocial well-being. Findings: Resident #18 Record review on 3/4-8/19 revealed Resident #18 had diagnoses that included Alzheimer's disease and dementia.	F 744	F744 1) What corrective aciton(s) will be accomplished for those residents found to have been affected by the deficient practice? * Counseling and education were provided to the CNA involved with the interaction of resident #18, 21, 49, and 57. Activities care plans were provided to the Willow team at WELD and included a review of the Activation care model proposed. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents residing at Denali Center could be affected by the deficient practice.	4/22/19

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F 744	Continued From page 69 Review of the most recent MDS (Minimum Data Set - a federally required assessment) assessment, a quarterly assessment dated 12/13/19, revealed the Resident had episodes of feeling or appearing down, depressed, or hopeless, as well as, being short-tempered and easily annoyed. The Resident required heavy dependence on staff for activities of daily living. Further review of the MDS assessment revealed the Resident was coded as having a BIMS (Brief Interview for Mental Status) of 00 (indicated the resident had severe cognitive impairment). Review from 3/6-8/19 of Resident #18's care plan, last revised on 2/26/19, revealed a problem of activity pursuits altered related to a diagnosis of dementia as evidence by intermittently crying out and wailing out throughout the day. Approaches included monitor attendance and level of participation in activities, refocus Resident's thoughts, enjoys music, enjoys activities brought in by family, pet visits, and staff were to show understanding if crying out. Additional review of the care plan revealed a problem of cognitive decline with difficulty communicating needs verbally with words as a result of dementia. Approaches included to provide conversation during cares and provide explanations of care being provided. Random observations from 3/4-8/19 revealed Resident #18 was observed to be yelling out randomly and became very agitated. Minimal interaction by staff was observed during Resident #18's multiple verbal outburst. Observation on 3/6/19 from 8:00 am to 9:30 am revealed Resident #18 was yelling out with no	F 744	3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * Willow Run is a special care neighborhood designed for residents with various kinds and stages of dementia. Denali Center recognizes that a therapeutic environment would be one that provides comfort, safety, and daily involvement in meaningful activities. We are developing an activation position that will allow creative reassignment of workloads to allow participation in resident programs to maximize involvement and decrease boredom and loneliness. Staff will receive additional training in dementia care and approaches to minimize behavior problems and promote dignity and feelings of success while meeting care needs. * The designated activation staff person will provide cares for fewer residents, and will take on the additional responsibility of creating opportunities for resident engagement. * Specific duties: * Post daily schedule on the dry erase board seven days a week. * Communciate information about the activities to staff and residents. * Make sure supplies are available. * Create opportunities for residents to feel welcomed, needed, and useful. * Document successes, suggestions, supply needs, etc. daily in log book. * Review and update care plans with collaboration of Resident Care Coordinator.	

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F 744	Continued From page 70 interaction from staff. Observation at 9:37 am revealed Certified Nursing Assistant (CNA) #7 approached Resident #18 grabbed the back of the wheelchair device and abruptly spun the Resident to the left and then to right in an attempt to relocate him/her. During this observation, the CNA did not verbally address the Resident or come into line of sight allowing the Resident the opportunity to visualize the staff. The abrupt turning of the wheelchair startled Resident #18. Additional observation on 3/6/19 at 9:42 am revealed CNA#7 approached Resident #18, who was now resting with eyes closed, and stated he/she was going to "jack down" the resident. This resulted in Resident #18 becoming startled and yelling out again. The CNA did not first approach the Resident or explain what he/she was doing before abruptly pumping the chair to a lower position. Resident #21 Record review on 3/4-8/19 revealed Resident #21 had diagnoses that included dementia; stroke; anxiety; and post-traumatic stress disorder. Review of the most recent MDS assessment, a quarterly assessment dated 12/20/18, revealed the Resident was coded as having episodes of feeling or appearing down, depressed or hopeless; poor appetite; and being short-tempered or easily annoyed. Further review revealed the Resident was coded as having a BIMS of 00 (indicated the resident had severe cognitive impairment); fully dependent on staff in eating; and received a mechanically altered therapeutic diet.	F 744	* We are developing compassion fatigue education and support for staff working with difficult, challenging elders to improve the identification of early warning signs to intervene prior to negative interactions by staff. 4) How the corrective action(s) will be monitored and evaluated for effictiveness to ensure the deficient practice will not recur? * Director of Nursing/designee will randomly audit activities documentation and the components of the activation care model including 4 CNAs on days and evenings, scheduled daily activities on the dementia neighborhood, and respectful staff interactions as evidenced by speaking prior to interactions to ensure appropriate interventions are initiated. The audits will be weekly for 4 weeks, and monthly for the remainder of the year. * Results of audit will be forwarded to Quality Assurance Performance Improvement Committee for evaluations and need for further action.	

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Review from 3/6-8/19 of Resident #21's care plan, last revised on 2/15/19, revealed a problem of activity pursuits altered. Approaches included talking to the Resident about interest, take Resident to religious activities, move to quite area and comfort with touch when Resident is upset, and enjoys native foods. Additional care plan review revealed the problem of severely impaired decision making abilities. Approaches included to greet the Resident by name and give self-introductions often and interpret needs through body language.

Further review of Resident #21's care plan revealed a problem of self-care deficient related to dementia and stroke. Approaches included heaving dependence on staff for activities of daily living. The care plan also identified the problem of nutritional status impairment. Approaches included assistance required for eating and drinking; promote socialization and comfort at mealtime.

Random observations from 3/4-8/19 revealed Resident #21 was placed in common area with no interaction from staff during the day time. In addition, the Resident was not observed to have attended any religious or Native based activities during the survey.

During an observation on 3/6/19 at 9:25 am CNA #7 was assisting Resident # 21 with a drink in the common area. The liquid trickled down the resident's face during consumption, at which point CNA #7 stated out loud "[swearword]", and abruptly attempted to clean Resident's face with clothing protector.
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Continuous observation of the lunch meal on 3/7/19 from 11:37 am - 12:15 am revealed food arrived to the Willow Unit and was placed on steam table by kitchen staff at 11:37 am. Resident # 21 was sitting in his/her recliner in dining room, while others are eating around him/her. Continuous observation of Resident #21 at 12:15 revealed the Resident still had not been provided assistance in eating.

During a continuous observation from 8:45 am - 9:25 am revealed Resident #21 was in the common area punching and kicking his/her chair while yelling out curse words. Multiple healthcare staff (nurse, nurse aids and unit manager) passed the Resident during this observation without any interaction to mitigate the Resident's behaviors.

During an interview on 3/8/19 at 11:00 am the Transitional Counselor (TC) stated Resident #21 should be taken to religious activities throughout the week but made it difficult to meet activity needs due to staffing and acuity of Willow Unit's residents. TC further stated that Resident #21 did not attend any religious activities the week of the survey. In addition, the TC stated the Resident should not have exhibited behaviors for 40 minutes without intervention from staff.

Resident #49

Record review on 3/4-8/19 revealed Resident #49 was admitted to the facility with diagnoses that included dementia, poor vision and hearing, depression, and Alzheimer's disease.

Review of the most recent MDS assessment, a quarterly assessment dated 1/24/19, revealed the

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Resident was coded as requiring extensive assistance with activities of daily living. Further review revealed the Resident was coded as having a BIMS of 00 (indicated the resident had severe cognitive impairment).

Review from 3/6-8/19 of Resident #49's care plan, last revised 1/15/19, revealed a problem of activity pursuits altered. Approaches included invite to cultural events, talking about past hobbies, invite to community events, and enjoys playing guitar located in Resident's closet. Additional review of the care plan revealed a problem of self-care deficit related to dementia. Approaches included staff were to speak to resident before touching him. The care plan also identified a problem of impaired cognitive abilities related to dementia.

Random observations from 3/4-8/19 revealed Resident #49 often sat in common area. During these observations, Resident #49 was not offered to attend native culture group during survey per activity calendar for March 2019. Low volume music was only played 1 of 5 days observed. Random observations of community events during the survey revealed the Resident did not attend any of the activities from 3/4-8/19. The Resident was not offered his/her guitar during the survey observations.

An observation on 3/6/19 at 9:38 am revealed CNA #7 grabbed Resident #49's hand and placed a piece of bread in his/her hand. No introduction or conversation was provided to the Resident prior to the CNA grabbing his/her hand. The Resident appeared to be startled by the CNA's actions.

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During an observation on 3/7/19 at 11:00 am revealed LN #2 and Wound Care Registered Nurse (WCRN) #2 performed a dressing change on the Resident's feet. During cares the Resident verbally expressed pain and frequently pulled back from staff. LN #2 apologized to the Resident but did not provide an explanation for being touched prior to or during cares.

During an interview on 3/8/19 at 1:00 pm CNA #9 stated he/she had to ask the unit nurse how to care for Resident #49 because the CNAs did not have access to care plans.

Resident # 57

Record review on 3/4-8/19 revealed Resident #57 had a diagnosis of dementia.

Review of the most recent MDS assessment, a quarterly assessment dated 1/31/19, revealed the Resident was coded as having moderate depression with episodes of having little interest or pleasure in doing things; feeling or appearing down, depressed or hopeless; indications he/she feels bad about himself/herself; stating life isn't worth living; and being short-tempered, easily annoyed. In addition, the Resident was coded as physical and verbal behaviors directed toward others and required extensive assistance with activities of daily living. Further review revealed the Resident was coded as having a BIMS of 4 (indicated the resident had severe cognitive impairment).

Review from 3/6-8/19 of Resident #57's care plan, latest revision date of 3/6/19, revealed a problem of crying, tearfulness; agitation; depression; and anxiety. Approaches included to

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provide one on one attention and reassurance.

Observation on 3/4/19 at 1:24 pm revealed Resident #57 yelling that he/she was going crazy. A staff member on the unit was writing on a document across the room at the time of observation. The staff member stated "you are fine' without looking up at Resident or approaching him/her to provide direct one on one attention.

Random observations from 3/5-8/19 revealed the Resident cried out often about not wanting to live, asking staff to kill him/her and that he/she was going to die. Staff frequently failed to address Resident's outburst.

Dementia Care Follow-Up:

During an interview on 3/7/19 at 3:00 pm the Director of Nursing stated the facility had challenges with staffing since last year.

During an interview on 3/8/19 at 10:48 am Activities Coordinator (AC) stated the facility had no formal activities program specific to the dementia unit. The AC further stated the activities department was to produce a quarterly progress note for all residents. When asked about care planned activities, the AC stated each resident's care plan should have a section on activities and should be followed by staff.

During an interview on 3/8/19 at 11:01 am Transition Counselor (TC) stated that care planning and written guidelines would have been most helpful for the dementia care of Willow residents. In addition, the TC stated he/she would like to be part of the care conferences but does

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not attend them currently.

During the same interview the TC stated that the current number of Willow Unit staffing compared to the acuity of behaviors and resident needs could have contributed to the lack of activities being performed and/or offered. The TC stated it was the goal of the facility to offer activities when a resident is agitated or displaying behavior issues.

During an interview on 3/8/19 at 1:05 pm Certified Nursing Assistant (CNA) #11 stated he/she was unaware of individualized activity care plans in each resident's room. The CNA further stated when a CNA works on Willow Unit it seems to be a "fly by the seat of your pants" since he/she was not a consistent CNA that worked on the dementia unit.

Review of the facility policy "Resident Rights and Responsibilities," dated 11/16/17 revealed the facility will make every effort to assist each resident in exercising his/her rights and to ensure residents are always treated with respect, kindness, and dignity.

Review of the facility policy "Activities," dated 11/17/19 revealed "The facility must provide ...preferences of each resident, an ongoing program to support residents in their choice of activities ...designed to meet the interest of and support the physical, mental and psychosocial well-being of each resident ...Denali Center will provide adequate staff with appropriate training and experience to meet the varied needs and multiple interest of each resident.

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F 744	Continued From page 77	F 744		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of	F 791		4/22/19

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F 791	Continued From page 78 dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: . Based on record review, observation, and interview the facility failed to ensure 1 Resident (#14), out of 19 sampled, received routine dental care. This failed practice prevented Resident #14 from receiving timely and prescribed dental evaluation and care. Record review on 3/4-8/19 of the electronic medical record revealed Resident #14 had diagnoses that included anoxic brain damage (brain injury caused by lack of oxygen) and chronic adenoiditis (infection of the adenoid in the throat). Observation on 3/6/19 at 8:32 am, revealed Resident #14 had his/her own front teeth. The front teeth were chipped and discolored. Review of the physician orders dated 2/19/19 revealed an order for "Consult: Dental - Follow All Recommendations 1 time per day every Feb 15th during Day ...Last Seen 2/24/14 ...and "CHLORHEXIDINE GLUCONATE (PAROEX / PERIDEX) [used to treat gingivitis] mouthwash ...BY MOUTH 1 TIME PER DAY AT 10)), FOR part loss teeth ...". Review of the comprehensive care plan revealed "Dental Care ...Approach ...Dental exam yearly	F 791	F791 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Dental appointment obtained for resident. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents residing at Denali Center could be affected by the deficient pracitce. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * Ward clerks will have a list of the last dental appointment resident's received, they will be responsible for checking and making necessary appointments on a monthly basis. * Completion of correcitve action will be 4/22/19 and ongoing. 4) How the corrective action(s) will be monitored and evaluated for effectiveness	

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F 791	Continued From page 79 and prn [as needed] ..." During an interview on 3/7/19 at 10:03 am, when asked when the most recent dental appointment was, RN Manager (RNM) #1 stated the last dental exam for Resident #14 was in 2014. During an interview on 3/7/19 at 4:41 pm, Social Worker (SW) #2 stated the Resident was due for dental care every February 14th. SW #2 stated there was no reason why the Resident was not receiving dental care.	F 791	to ensure that the deficient practice will not recur? * Quality Supervisor will audit 4/month, report to QAA. * Responsible person is Quality Supervisor.	
F 802 SS=E	. Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by:	F 802		4/22/19

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F 802	Continued From page 80	F 802	F802	

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Based on observation, record review, and interview the facility failed to ensure staff serving residents on the Willow unit were provided with appropriate competencies and skills set to carry out functions of food service in conjunction with residents' individualized needs and plans of care. This failed practice placed 5 sampled residents (#s 18; 31; 49; 57; and 62) and 1 non-sampled resident (#64) out of 14 residents located on the Willow Unit (dementia care unit) at risk for undesired alterations in nutritional status. In addition the failed practice placed 1 resident (#31) at risk for aspiration associated with incorrect food service. Findings:

Observation of the Willow unit dinner service on 3/4/19 revealed Resident #s 18; 31; 57; 62; and 64 did not receive dinner food items as dictated on each residents' diet card.

Observation of the Willow unit lunch service on 3/6/19 revealed 18; 31; 49; and 64 did not receive lunch food items as dictated on each resident's diet card.

Review of the Resident #31's lunch diet card, dated 3/6/19, revealed the Resident was to have received diced mandarin oranges, diced paprika pork, diced linguine, and diced carrots.

During the lunch observation on 3/6/19 at 12:00 pm Certified Nursing Assistant (CNA) #6 plated a vegetable serving, a meat serving and a serving of linguine noodles (characterized by long, flat strands). The CNA chopped the vegetables and meat into pieces ranging from ½" x ½" to 1" x 1" and left the linguine noodles whole. The plate was then taken to Resident #31.

1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?
* Education was provided to the Willow CNAs to follow the meal ticket provided to fill plates from the steam table.

2) How other residents having the potential to be affected by the same deficient practice will be identified?
* Denali Center recognizes that all residents residing at Denali Center could be affected by the deficient practice.

3) What measures will be put into place or what systemic changes will be made to ensure that the deficient pracitce does not recur?
* Willow Run is a special care neighborhood designed for residents with various kinds and stages of dementia. Denali Center recognizes that Willow meal service is unique, in that the service is from the steam table and is family style. An interdisciplinary team met to review the meal service and menus provided to Denali Center residents. The team consisted of administration, food services, CNAs, and nursing.
* The team processed mapped out the current process from receiving an order for a diet to service to the resident on Willow. It was determined that trays would be filled in nutrition services and delivered to Willow. The steam table has

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F 802	Continued From page 81 During an interview on 3/6/19 at 12:08 pm when asked about Resident #31's diet order CNA #8 stated the Resident doesn't usually get served noodles. When asked if the noodles were to be chopped like the other food items, the CNA stated the noodles should not have been served whole and should have been chopped or pureed. During an interview on 3/6/19 at 12:12 pm CNA #6 stated the linguine noodles should have been chopped per diet order. During an interview on 3/6/19 at 12:35 pm the Speech Language Pathologist (SLP) stated the certified nursing assistants (CNAs) that serve food on Willow unit should follow the diet card as provided by the dietary department. During an interview on 3/6/18 at 1:15 pm the Dietitian stated the diet cards are made based on the residents' diet order and nutritional needs. During an interview on 3/6/19 at 2:45 pm CNA #6 stated he/she was not provided with any specific training on how to plate food for the residents on the Willow unit. The CNA further stated he/she was a "fill-in" CNA from another unit in the facility. Review of the facility's policy "Denali Center - Nutritional Care," dated 12/20/18, revealed the Registered Dietitian Nutritionist worked closely with Nutrition Service staff to ensure residents receive appropriate diet and supplements. Review of the facility's policy "Modification of Food Texture," dated 1/26/18, revealed expected outcome was to provide a diet that meets the food texture needs of the resident while ensuring	F 802	been removed. We are continuing to look at the process and we are researching a potential hybrid of family meal service to meet the home like and resident meal choice as well as the safety of the residents to receive diets ordered and altered diets. * We are developing compassion fatigue education and support for staff working with difficult, challenging elders to improve the identification of early warning signs to intervene prior to negative interactions by staff. 4) How the corrective action(s) will be montiored and evaluated for effectiveness to ensure the deficient practice will not recur? * Director of Nursing/designee will randomly audit meal times and compliance with the ordered diet and altered diets. The audits will be weekly for 4 weeks, and monthly for the remainder of the year. * Results of audit will be forwarded to Quality Assurance Performance Improvement Committee for evaluations and need for further action.	

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F 802	Continued From page 82 resident safety. .	F 802		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: . Based on record review, observation and interview the facility failed to ensure 5 sampled residents (#s 18; 31; 49; 57; and 62) and 1 non-sampled resident (#64)out of 14 residents	F 803	F803 1) What corrective action(s) will be accomplished for those residents found to	4/22/19

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F 803	Continued From page 83 located on the Willow Unit (dementia care unit) received meals in accordance with approved menus and met nutritional parameters established by the facility. This failed practiced placed these 6 residents at risk for altered nutritional intake and poor nutritional status. Findings: Resident #18 Record review on 3/4-8/19 revealed Resident #18 had a diagnosis of Alzheimer's disease. Review of the most recent MDS (Minimum Data Set - a federally required assessment, a quarterly assessment dated 12/13/19, revealed the Resident was coded as receiving a mechanical altered therapeutic diet and totally dependent on staff for eating. Further review of the MDS assessment revealed the Resident was coded as having a BIMS (Brief Interview for Mental Status)of 00 indicated the resident had severe cognitive impairment). Review from 3/6-8/19 of Resident #18's care plan, latest revision date of 2/26/19, revealed a problem of nutritional status impairment at risk for further decline - inadequate oral, food and fluid intake. Approaches included the need for assistance with eating, cueing while eating, and pudding at lunch. Identified goals included ensuring the Resident receives estimated nutritional needs. Review of the Resident #18's diet card, dated 3/4/19, revealed the Resident should have received: 1 pureed mandarin oranges 1/4 cup	F 803	have been affected by the deficient practice? * Education was provided to the Willow CNAs to follow the meal ticket provided, including the altered diet indicated on the orange color tickets, to fill plates from the steam table. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents residing at Denali Center could be affected by the deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * Willow Run is a special care neighborhood designed for residents with various kinds and stages of dementia. Denali Center recognizes that Willow meal service is unique, in that the service is from the steam table and is family style. An interdisciplinary team met to review the meal service and altered texture diets provided to Denali Center residents. The team consisted of administration, food services, CNAs, and nursing. * The team processed mapped out the current process from receiving an order for a diet to service to the resident on Willow. It was determined that altered diets would be prepared, trays would be filled in nutrition services, and delivered to Willow. The steam table has been removed. We are continuing to look at the process and we are researching a	

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F 803	Continued From page 84 1 banana pudding 1/4 c 1 skim milk 8 oz carton 1 smart balance 5gmPC 1 pureed pork fajita/shell 1/4 cup 1 pureed broccoli 1/4 cup 1 pureed can chicken noodle 4oz bowl 1 port gravy 2 oz ladle 1 soup in a cup 1 pork gravy 4 oz side bowl Note "pudding on trays"- diet dysphagia pureed During the dinner observation on 3/4/19 Resident #18 received a serving of meat, broccoli and mashed potatoes with gravy. Resident #18 consumed approximately 10% of meal. Review of Resident #18's diet card, dated 3/6/19, revealed the Resident should have received: 1 pureed mandarin oranges ¼ cup 1 banana pudding ¼ cup 1 apple juice 4 oz container 1 vanilla milkshake 8 oz cup 1 pureed paprika pork ¼ cup 1 pureed linguine 1/3 cup 1 pureed asparagus ¼ cup 1 pureed tortellini veg soup 4 oz bowl 1 pork gravy 2 oz ladle 1 soup in a cup 1 pork gravy 4 oz side bowl During the lunch observation on 3/6/19 Resident #18 received a serving of meat and vegetable, with larger serving of mashed potatoes with gravy, and one serving yogurt and pudding. Resident #31 Record review on 3/4-8/19 revealed Resident #31	F 803	potential hybrid of family meal service to meet the home like and resident meal choice as well as the safety of the residents to receive diets ordered and altered diets. The orange meal ticket must be verified by two staff; the staff preparing the tray in nutrition services and the staff providing the tray to the resident. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * Director of Nursing/designee will randomly audit meal times and compliance with the ordered diet and altered diets. The audits will be weekly for 4 weeks, and monthly for the remainder of the year. * Results of audit will be forwarded to Quality Assurance Performance Improvement Committee for evaluations and need for further action.	

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F 803	Continued From page 85	F 803		

had diagnoses that included dementia and Parkinson's disease.

Review of the most recent MDS assessment, a quarterly assessment dated 1/30/19, revealed the Resident was coded as receiving a mechanical altered therapeutic diet; requiring supervision of meals with encouragement and/cueing. Further review revealed the Resident was coded as having a BIMS of 5 (indicated the resident had severe cognitive impairment)..

Review from 3/6-8/19 of Resident #31's care plan, latest revision date of 3/6/19, revealed a problem of being at risk for nutritional deficiency with approaches to monitor intake and dietary needs. An identified goals was to ensure the Resident did not lose more than 5 pounds a month.

Review of the Resident #31's diet card, dated 3/4/19, revealed the Resident should have received:

1 diced strawberries 1/2 cup
1 Hi Kcal/PRO Vanilla Shake 8 oz cup
1 benecalorie 1.5 oz PC
1 High Kcal/PRO Choc Shake 8 oz Cup
2 butter pat
1 strawberry ice cream 4 oz container
1 whole milk 8 oz carton
1 diced port chop 3 oz
1 mashed potatoes 1/4 cup
1 diced broccoli 1/4 cup
1 white roll/marg. diced each
1 pork gravy 2 oz ladle
1 pork gravy 4oz side bowl

During the dinner observation on 3/4/19 Resident

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F 803	Continued From page 86	F 803		

#31 received mashed potatoes, a meat serving and a vegetable serving.

Review of the Resident #31's diet card, dated 3/6/19, revealed the Resident should have received:

2 diced mandarin oranges ¼ cup
1 apple juice 4 oz container
1 Hi Kcal/PRO Vanilla shake 8 oz cup
1 benecalorie 1.5 ox PC
1 high Kcal PRO Choc shake 8 oz cup
1 vanilla ice cream 4 oz container
1 2% milk 8 oz carton
4 butter pat
1 diced paprika pork 3 oz
1 diced linguine 1/3 cup
2 diced carrots ¼ cup
1 pork gravy 4 oz side bowl

During the lunch observation on 3/6/19 Resident #31 only received a serving of meat, vegetables and pasta.

Resident # 49

Record review on 3/4 -8/19 revealed Resident # 49 was admitted to the facility with diagnoses that included Alzheimer's disease and dementia.

Review of the most recent MDS assessment, a quarterly review dated 1/24/19, revealed the Resident was coded as requiring extensive assistance with eating. Further review revealed the Resident was coded as having a BIMS of 00 (indicated the resident had severe cognitive impairment).

Review of Resident #49's diet card, dated 3/6/19,

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F 803	Continued From page 87	F 803		

revealed the Resident should have received:

1 shredded iceberg lettuce 1 cup
1 mandarin oranges ½ cup
1 fat free ranch 1/5 oz pkg
1 apple juice 4 oz container
1 benecalorie 1.5 oz
1 paprika pork 3 oz
1 white rice 1/3 cup
1 asparagus tips ½ cup
1 coffee 6 oz mug
Noted: "Double Portions Low Carb Vegetables at L/D."

During the lunch observation on 3/6/19 Resident #49 received a whole grilled cheese and a whole pork serving. The Resident was not offered any other item of the main meal.

Resident # 57

Record review on 3/4-8/19 revealed Resident #57 was admitted to the facility with a diagnosis of dementia.

Review of the most recent MDS assessment, a quarterly assessment dated 1/31/19, revealed the Resident was coded as requiring supervision of meals with encouragement and/cueing. Further review revealed the Resident was coded as having a BIMS of 4 (indicated the resident had severe cognitive impairment).

Review from 3/6-8/19 of Resident #57's care plan, latest revision date of 3/6/19, revealed a problem of being at risk for nutritional imbalance resulting from consuming more than body requirements. Approaches included the Resident was to have normal portion sizes and follow the

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F 803	Continued From page 88	F 803		

dietitian's recommendations. Identified goals included the Resident would not gain more than 5 pounds a month.

Review of the Resident #57's diet card, dated 3/4/19, revealed the Resident should have received:

1 garbanzo bean salad 1/2 cup
1 mandarin oranges 1/2 cup
1 skim milk 8 oz carton
1 smart balance 5 gm
1 pace salsa 1.5 tbsp
1 pork fajita/shell 1 ea
1 broccoli 1/2 cup
Note- salad or relish plate with meals

During the dinner observation on 3/4/19 Resident #57 received double portions of fajitas.

Resident #62

Record review on 3/4-8/19 revealed Resident #62 was admitted to the facility with a diagnosis of dementia.

Record review of the most recent MDS assessment, a quarterly assessment dated 2/7/19, revealed the Resident was coded as having weight loss not on a physician prescribed diet; receives a mechanically altered therapeutic diet; requiring supervision of meals with encouragement and/cueing. Further review revealed the Resident was coded as having a BIMS of 3 (indicated the resident had severe cognitive impairment).

Record review from 3/4-8/19 of Resident #62's care plan, last revised 2/15/19, revealed a

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F 803	Continued From page 89	F 803		

problem of impaired nutritional status with risk for further decline. Approaches included the encouragement of eating at least 75% of meal, provide assistance with eating, and monitor weights weekly. The identified goal, dated 1/31/19, revealed the Resident was to exhibit no signs of malnutrition for next 90 days and not lose more than 3 pounds a month for the next 90 days.

Review of the Resident #62's diet card, dated 3/4/19, revealed the Resident should have received:

1 soft beet salad 1/2 cup
1 diced strawberries 1/2 cup
1 skim milk 8 oz carton
1 smart balance 5gmPC
1 Hi Kcal/PRO Vanilla Shake 8 oz cup
1 baked pork chop 3 oz
1 mashed potatoes 1/2 cup
1 broccoli 1/2 cup
1 wheat dinner roll each
Note "mashed potatoes/gravy daily....prefers only items. PUREED MEATS PLEASE"

During the dinner observation on 3/4/19 Resident #62 received a bowl with 3 scoops of mashed potatoes with gravy. No pureed meats were provided. The Resident consumed about 20% of meal. During the observation, the Resident would frequently get up from table and ambulate out of dining room.

Resident #64

Record review on 3/4-8/19 revealed Resident #64 had a diagnosis of Alzheimer's disease.

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F 803	Continued From page 90	F 803		

Review of the most recent MDS assessment, an annual assessment dated 2/7/19, revealed the Resident was coded as requiring supervision of meals with encouragement and/cueing and placed on a therapeutic diet. Further review revealed the Resident was coded as having a BIMS of 2 (indicated the resident had severe cognitive impairment).

Review of the Resident #64's diet card, dated 3/4/19, revealed the Resident was to have received:

1 garbanzo bean salad 1/4 cup
1 granny smith apple 1/2 cup sliced
1 smart balance 5gmPC
1 pace salsa 2 oz PC
1 pork fajita/WW shell 1 ea
1 broccoli 1/2 cup
1 lemon ginger herb tea 6 oz mug

During the dinner observation on 3/4/19 Resident #64 only received serving of meat, broccoli and mashed potatoes with gravy.

Review of Resident #64's diet card, dated 3/6/19, revealed the Resident was to have received:

1 shredded iceberg lettuce 1 cup
1 fat free ranch 1.5 oz pkg
1 banana half
1 paprika pork 3 oz
1 white rice 1/3 cup
1 asparagus tips ½ cup
1 lemon ginger herb tea 6 oz mug

During the lunch observation on 3/6/19 Resident #64 received serving of salad and cottage cheese, with larger serving of jello.

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F 803	Continued From page 91 During an interview on 3/6/19 at 12:35 pm the Speech Language Pathologist stated certified nursing assistants (CNAs)that served food on Willow Unit, from a steam table, should follow the diet card as provided by the dietary department. During an interview on 3/6/18 at 1:15 pm the Dietitian stated the diet cards are made based on the residents' diet order and nutritional needs. During an interview on 3/6/19 at 1:40 pm, the Culinary Supervisor stated foods not brought it the unit by dietary should be obtained from Willow Unit's kitchenette/dining area. During an interview on 3/6/19 at 1:45 pm Residential Care Manager #2 stated that not all items on the diet cards are available in the Willow Unit kitchenette/dining area. During an interview on 3/6/19 at 2:45 pm CNA #6 stated he/she was not provided with any specific training on how to plate food for the residents on the Willow Unit. The CNA further stated he/she was a "fill-in" CNA from another unit in the facility. Review of the facility's policy "Denali Center - Nutritional Care," dated 12/20/18, revealed the Registered Dietitian Nutritionist works closely with Nutrition Service staff to ensure residents receive appropriate diet and supplements.	F 803		
F 805 SS=J	. Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3)	F 805		4/22/19

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F 805	Continued From page 92 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: . Based on record review, observation, and interview the facility failed to ensure 1 resident (#31), out of 8 residents reviewed on modified texture diet, received food in a form designed to meet the resident's needs. Specifically, the facility provided food not concurrent with the resident's mechanically altered diet order. This failed practice placed the resident at risk for choking and/or aspiration (the inhalation of food partials or fluid into the lungs that can lead to pneumonia and/or death), which could lead to serious illness and/or death. This failed practice placed the health and safety of the resident in immediate jeopardy. The surveyor interceded in the care being provided and notified the facility of the deficient practice and the risk of serious harm to the resident on 3/6/19 at 2:51 pm. The facility submitted a plan to mitigate the risk of serious harm and/or death to facility residents on 3/6/19 at 4:19 pm. Findings: Resident #31 Record review on 2/4-8/19 revealed Resident #31 had diagnoses that included dementia and Parkinsons disease (neurological disease than can cqause muscle rigidity/difficulty swallowing/ tremors).	F 805	F805 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * In response to an alleged deficiency related to an ordered diet not followed in the Dementia Dining room the following procedure was placed immediately to ensure compliance with provider orders related to diet provided. * All mechanically altered diets required an orange meal slip. * Before serving the meal to the resident, verification of modified-texture diet and/or allergy required by a two staff, one is a Licensed Staff member or nutrition services. * Nutrition Services staff sign the Orange/Red Meal Ticket in the main cafe verifying they served the correct modified-texture diet according to the diet listed on the Orange/Red Meal Ticket. * A Licensed Staff member (LPN or RN) will then sign the Orange/Red Meal Ticket verifying the correct texture if not served by dining staff in the main cafe. If the meal served, is not the same as the diet order listed at the top of the Orange/Red Meal Ticket, the Licensed	

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F 805	Continued From page 93 Record review of the most recent MDS (Minimum Data Set- a Federally required assessment) assessment, a quarterly assessment dated 1/30/19, revealed the Resident was coded as receiving a mechanical altered therapeutic diet; requiring supervision of meals with encouragement and/cueing. Further review revealed the Resident was coded as having a BIMS (Brief Interview for Mental Status) of five (indicated the resident had severe cognitive impairment). Record review from 3/6-8/19 of Resident #31's care plan, latest revision date of 3/6/19, revealed a problem of being at risk for nutritional deficiency less than body requirements with approaches to monitor intake and dietary needs, provide soft food that were chopped/diced. Additional review of the Resident's care plan revealed no problem, intervention or goals related to dysphagia, aspiration precautions or risk. Review of the Resident #31's lunch diet card, dated 3/6/19, revealed the Resident was to have received diced mandarin oranges, diced paprika pork, diced linguine, and diced carrots. After dietary staff delivered the noon meal to the steam table on the Willow Run nursing unit, the certified nursing assistants (CNAs) plated the food and served it to the residents. During the lunch observation on 3/6/19 at 12:00 pm, CNA #6 plated a vegetable serving, meat serving and a serving of linguine noodles (characterized by long, flat strands). The CNA, chopped the vegetables and meat into pieces ranging from ½" x ½" to 1" x 1" and left the	F 805	Staff member will discard that meal and request a different meal consisitent with the diet ordered at the top of the Orange/Red Ticket. * A CNA or other staff member will not serve a modified-texture diet served on Willow to a resident unless the Orange/Red Ticket bears two signtures- one from the CNA and one from a Licensed Staff member. * The signed meal slips will then be presented to the respective RCC for oversight. * Failure to comply with the above policy will result in corrective measure. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents residing at Denali Center could be affected by the deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? * Willow Run is a special care neighborhood designed for residents with various kinds and stages of dementia. Denali Center recognizes that Willow meal service is unique, in that the service is from the steam table and is family style. An interdisciplinary team met to review the meal service and altered texture diets provided to Denali Center residents. The team consisted of administration, food services, CNAs, and nursing. * The team processed mapped out the	

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F 805	Continued From page 94 linguine noodles whole. At 12:08 pm, CNA #3 took the prepared lunch plate from the Willow Unit dining area to the common area located at the other end of the unit. At 12:11 pm, after he/she placed the plate in front of Resident #31 and uncovered the dish with the whole linguine noodles, the Surveyor stopped the CNA and inquired about the Resident's diet order. The CNA stated noodles were not usually served to the Resident. When asked if the noodles should be chopped like the other food items, the CNA stated the noodles should not have been served whole and should have been chopped or pureed. During an interview on 3/6/19 at 12:12 pm, CNA #6 stated the linguine noodles should have been chopped per diet order. Record review of Resident #31's medical record revealed a document entitled a "Speech Therapy Module," dated 3/1/18 by Speech Language Pathologist (SLP) #1. SLP #1 had evaluated the Resident for dysphagia (difficulty swallowing) and increased coughing while eating. The evaluation revealed the Resident presented with moderate to severe oral pharyngeal dysphagia with likely mild aspiration of liquids and difficulty with efficient chewing of solid foods. Further review revealed, "Given resident's advanced Parkinson's disease and dementia prognosis for improvement in swallowing function is poor and [his/her] aspiration risk is high... Recommend texture modification recommendations (soft foods - diced) and adherence to aspiration precautions... and caregiver training..." Further record review revealed a document	F 805	current process from receiving an order for a diet to service to the resident on Willow. It was determined that altered diets would be prepared, trays would be filled in nutrition services, and delivered to Willow. The steam table has been removed. We are continuing to look at the process and we are researching a potential hybrid of family meal service to meet the home like and resident meal choice as well as the safety of the residents to receive diets ordered and altered diets. The orange meal ticket must be verified by two staff; the staff preparing the tray in nutrition services and the staff providing the tray to the resident. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * Director of Nursing/designee will randomly audit meal times and compliance with the ordered diet and altered diets. The audits will be weekly for 4 weeks, and monthly for the remainder of the year. * Results of audit will be forwarded to Quality Assurance Performance Improvement Committee for evaluations and need for further action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025020	A. BUILDING _____ B. WING _____	03/08/2019

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F 805	Continued From page 95	F 805		

entitled "Nursing Concerns and MD [Doctor of Medicine] Orders," dated 3/1/18, that stated a diet texture modification was ordered to soft foods chopped/diced due to dysphagia and dementia as a result of recommendations following the clinical swallowing assessment completed by SLP #1.

During an interview on 3/6/19 at 12:35 pm, SLP #1 stated the CNAs that serve food on Willow Unit should follow the diet card as provided by the dietary department. During the interview it was revealed the Resident has history of weight loss, dementia and esophagitis (inflammation of the lining of the esophagus, the tube that connects the throat to the stomach), and Parkinson's which effect his/her swallowing. When presented with the observation from lunch meal the SLP stated the staff were not compliant with the diet order. The SLP stated the food should have been chopped into ¼" x ¼" pieces with sauce due to the Resident's diet order for chopped food.

During an interview on 3/6/18 at 1:15 pm, the Dietitian stated diet cards were based on the residents' diet order and nutritional needs.

During an interview on 3/6/19 at 2:45 pm, CNA #6 stated he/she was not provided with any specific training on how to plate food for the residents on the Willow Unit. The CNA further stated he/she was a "fill-in" CNA from another unit in the facility.

Review of the facility's policy "Denali Center - Nutritional Care," dated 12/20/18, revealed the Registered Dietitian Nutritionist works closely with Nutrition Service staff to ensure residents receive the appropriate diet.

Review of the facility's policy "Modification of

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F 805	Continued From page 96 Food Texture," dated 1/26/18, revealed the expected outcome was to provide a diet that meets the food texture needs of the resident while ensuring resident safety. Review of the facility provided document entitled "Mechanically Altered Food Appendix #4," undated, revealed dysphagia chopped foods should be cut into ¼" x ¼" x ¼" pieces and served moist. The document indicated Ditalini Pasta (characterized by small tubular shape approximately 0.19" x 0.18") could be use whole. Further review revealed the facility was to refer to current, prescribed therapeutic diet plan as a guide when planning the menu and alteration will be care planned. .	F 805		