STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025025	A. Building B. Wing	12/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centennial Post Acute	9100 Centennial Drive Anchorage, AK 99504

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Based on record review and interview, the facility failed to ensure the Notice of Medicare Non-Coverage (NOMNC - an official notice, issued by Medicare-certified healthcare facilities to inform beneficiaries when their coverage will end, with appeal right information) was provided to and signed by the resident's legally authorized Power of Attorney (POA) for 1 Resident (#113), out of 2 discharged residents reviewed. The resident had a documented POA with authority over insurance and government benefit decisions. The facility obtained the resident's signature on the NOMNC but failed to include the POA's signature, did not document review of the notice with the POA, and did not ensure the POA was informed of appeal rights prior to discharge. This failure denied the POA the opportunity to exercise Medicare appeal rights, resulting in the loss of a protected procedural right .Findings:Resident #113Record review on 12/14-24/25 revealed Resident #113 was admitted to the facility with diagnoses that included dementia, without behavioral disturbance (cognitive decline affecting memory, thinking, and problem solving which did not include agitation or aggression), fracture of the right femur (thigh bone), infection following the surgical procedure to fix the femur, and muscle weakness. Resident #113 also had diagnoses with depression and anxiety.Further review Resident #113 had a Power of Attorney (POA) legal document, dated 9/3/25, and this document indicated the POA had the power to decide about insurance transactions, benefits from government programs, and all other matters.Resident #113's POA was documented as Resident #113's agent in his/her medical record. Review of Resident #113's NOMNC form, Form CMS-10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953, revealed: . Medicare A stay for Skilled Nursing Facility Services Will End: 11/5/25. Further review revealed that despite having documented dementia, the facility had Resident #113 signed this form on 11/3/25, however the resident did not sign with his/her legal name (last name was not correct). Resident #113's POA did not sign this NOMNC form.During an interview on 12/16/25 at 1:00 PM, the Director of Social Services (DSS) and the Social Services Coordinator (SSC) stated that the Social Services department at the facility would issue a NOMNC within 48 hours of a resident's last covered day. This NOMNC would be reviewed with a resident (if they were their own decision maker,) or with the family, POA, or guardian (if applicable). When asked how this was completed for a resident with a POA, the DSS and SSC stated they would have the POA come into the facility, if they were local, review the form to include the appeal rights, and have them sign it. If they were not local, they would conduct the review over the phone. The DSS and SSC stated if a resident had a POA, the resident would not sign the form.During an interview on 12/17/25 at 11:24 AM, Resident #113's POA stated the facility did not provide the NOMNC paperwork to him/her prior to the resident's discharge. The POA was not aware of appeal rights and would have considered this option as he/she felt the resident's discharge was not appropriate.During an interview on 12/17/25 at 12:03 PM, the DSS acknowledged that Resident #113's signature was on the NOMNC, dated 11/3/25, and not the POA. The DSS stated that the SSC had told her that the NOMNC was provided to the POA, but this was not documented.Review of the Centennial Post Acute. Notice of Medicare Non-Coverage document, dated 11/3/25, revealed: Your Right to Appeal This Decision. You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal. If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish. How to Ask for an Immediate Appeal. You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services. Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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	025025	A. Building B. Wing	12/24/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure that residents were discharged in a manner that protected health, safety, and psychosocial well-being, as required. The facility failed to develop and implement an effective discharge planning process for 2 residents (#'s 112 and 113) out of 2 residents reviewed for discharge, resulting in an unsafe and inappropriate discharges.Specifically, the facility failed to:1. Identify and address each resident's post-discharge care needs;2. Ensure required services, referrals, and equipment were arranged prior to discharge;3. Assess and confirm caregiver availability, capacity, and training;4. Involve resident representatives in discharge planning and decision-making;5. Incorporate PASRR (Pre-admission Screening and Resident Review - (a federally mandated pre-admission screening to ensure individuals placed in a long-term care facility had appropriate services) Level II findings and required specialized services;6. Reassess and resolve changes in condition prior to discharge; and7. Ensure discharge destinations met the residents' health and safety needs.These failures resulted in residents being discharged to unsafe environments without adequate support, services, or coordination, causing actual physical compromise and psychosocial harm, and placing residents at continued risk for injury, decline, and loss of dignity:This failed practice resulted in the discharge of Resident #112 to a known unsafe and inaccessible home environment without adequate caregiver support, without required services in place, and without safe access into the residence. As a result, the resident experienced distress and emotional harm, required fire department assistance to enter the home, he/she fell after discharge, lacked necessary wound care and nursing services, and relied on unplanned third parties for essential care. The resident's ability to maintain safety, dignity, and highest practicable physical and psychosocial well-being was compromised.This failed practice resulted in the discharge of Resident #113 despite unresolved acute behavioral changes, cognitive impairment, documented need for nursing facility level care, and required specialized mental health services identified through PASRR Level II. The discharge occurred without required referrals, without representative involvement, and without addressing a documented change of condition on the day of discharge. As a result, the resident experienced distress, confusion, and loss of security, and required the POA (Power of Attorney) to assume unplanned caregiving responsibilities to prevent harm.This citation utilizes the reasonable person concept for determination of psychosocial harm. A reasonable person in the position of either resident would experience fear, distress, and loss of dignity when discharged under these circumstances. These outcomes constitute actual psychosocial harm .Findings:During an interview on 12/16/25 at 1:00 PM, the Director of Social Services (DSS) and Social Service Coordinator (SSC) stated currently, the facility had no documented set of standards for their discharge planning process. The DSS stated that there were expectations, however they were only verbalized throughout the social service department (SSD).When asked to explain the standards used, the DSS and SSC stated that the SSD would have a care conference with new admissions, about two or three days from admission. This first care conference would be to identify needs of the admission and discharge goals when ready.Then, the SSD would have another care conference about two weeks prior to discharge. The DSS stated that, currently, these were the only care conferences conducted, however this was self-identified as a need to improve upon, and it was a goal to initiate more care conferences throughout a resident's admission in the future. When asked to describe how the facility prepared for a discharge, the DSS and SSC stated during the care conference prior to discharge, the facility would identify where the resident would discharge to, and which services would be needed upon discharge. Examples of needs and services that would be reviewed included, but not limited to:1. Durable medical equipment (DME - wheelchair, walker, hospital bed, or other equipment);2. PCA (Personal Care Assistant) services (where a certified nursing assistant, or CNA, would help in the house with ADLs, activities of daily living such as bathing);3. Primary Care Provider (PCP) follow-up (the goal would be to have a 2-week follow-up appointment made prior to leaving the facility);4. Home health services;5. Physical Therapy (PT), Occupational Therapy (OT), and/or Speech Therapy (SP);6. Wound Care;7. Skilled Nursing (where a Licensed Nurse, or LN, would come to the house for assistance); and/or8. Meals on Wheels.The DSS and SSC further stated the care conference would include the resident and resident representatives or family (if applicable), and referrals would be coordinated after the care conference for the identified discharge needs. The expectation would be to have the referrals ordered, by sending a fax to each referral, two to three days before the resident left the facility. For DME, it was the

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	025025	A. Building B. Wing	12/24/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

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	025025	A. Building B. Wing	12/24/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to comply with PASRR Pre-admission Screening and Resident Review - requirements by not incorporating the PASRR Level II determination into the resident's assessment, care planning, and discharge planning for 1 Resident (#113), out of one resident reviewed for PASRR documentation. The PASRR Level II evaluation identified the need for continued nursing facility services and required specialized mental health services. The facility did not ensure the Level II report was available at admission, did not initiate specialized services during the stay, did not revise the care plan to reflect PASRR findings, and discharged the resident without addressing PASRR-identified needs or following recommended discharge options. This failure resulted in an untreated and escalating behavioral symptoms, increased psychotropic medication use, and discharge without appropriate mental health supports, constituting psychosocial harm by reasonable person concept .Findings:Record review on 12/14-24/25 revealed Resident #113 was admitted to the facility on [DATE] with diagnoses that included dementia without behavioral disturbance (cognitive decline affecting memory, thinking, and problem solving which did not include agitation or aggression), fracture of the right femur (thigh bone), infection to surgical site to fix the femur, metabolic encephalopathy (a brain disorder caused by a chemical imbalance from an underlying illness leading to impaired brain function, confusion, memory issues, and personality changes), and muscle weakness.Further review revealed Resident #113 also had diagnoses of depression and anxiety.Review of Resident #113's PASRR Level 1, which was in the resident's medical record and dated 9/4/25, revealed the resident had diagnoses of delirium, encephalopathy, anxiety, and depression. Further review revealed: . Based on the information reviewed. the following determination is made. If admission. for this individual is approved, all services as identified by PASRR Level II evaluation must be provided. to meet the individual's nursing and disability-specific needs. Level II PASRR evaluation needed. Date referred for Level II evaluation: 9/5/25. Date Level II report received: 9/18/25.Further review of Resident #113's medical record revealed no PASRR Level II report was present.During an interview on 12/17/25 at 12:03 PM, when asked to provide Resident #113's PASRR Level II report, the Director of Social Services (DSS) stated Resident #113's PASRR Level II report was not in the resident's medical record and was retrieved on 12/17/25 from the facility's PASRR Coordinator. The DSS stated this Level II report was not available during Resident #113's admission or reviewed during discharge planning.Review of Resident #113's Behavioral Health Level II Pre-admission Screening and Resident Review (PASRR) Assessment, dated 9/18/25, revealed: . Summary Narrative of Functional Assessment. [Resident's POA] stated [Resident #113] would need help performing all ADLs [Activities of Daily Living]. Per PASRR Level I request, [Resident #113] experiences challenges with practical skills, including occupational skills, safety, schedule/routines, mobility, travel, and transportation. experiences challenges with completion of tasks, needs assistance to complete tasks, lack persistence, and has difficulty concentrating. demonstrates socially inappropriate behaviors, including challenges with independent living. Self-monitoring of health status. [Resident #113] would need help with self-monitoring of [his/her] health status. Self-administering of medical treatment. [Resident #113] would need help tracking [his/her] appointments, making [his/her] appointments, as well as tracking, obtaining, and remembering to take [his/her] medication. Self-monitoring of nutritional status. [Resident #113] would need help with self-monitoring of [his/her] nutritional status. [Resident #113] wants to cook [his/her] own food but [his/her] cooking 'was becoming a safety concern'. Determination. Nursing facility services. are needed. Mental Illness. Individual has mental illness. Specialized services. are needed. [Resident #113] would benefit from continuing to receive medication management following discharge from Providence Alaska Medical Center. Further review revealed: Additional PASRR Determination Information. A level II evaluation was completed. on 9/18/25. The evaluator found that [Resident #113] would benefit from nursing facility services and required specialized services (SS) for mental health needs. If the LTC [long-term care] facility chooses to admit [Resident #113], but finds they can no longer safely meet [his/her] care needs, please consider the options listed below: The LTC facility can pursue placement at an ALH [assisted living home] that offers more mental health supports (may obtain list from the Division of Behavioral Health)[;] The LTC facility can issue a formal 30-day discharge notice to the client, stating they cannot safely meet the client's care needs. If this occurs, a copy of the discharge notice should be submitted to SDS [Senior and Disabilities Services] in Harmony [an electronic data base][;] The LTC facility can send the client to the emergency room for

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	025025	A. Building B. Wing	12/24/2025

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Centennial Post Acute	9100 Centennial Drive Anchorage, AK 99504

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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	025025	A. Building B. Wing	12/24/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to ensure comprehensive, person-centered care plans were developed and implemented to address identified needs for 2 residents (#'s 27 and 111) out of 2 residents reviewed for comprehensive care plans. Specifically, the facility failed to develop and implement dementia-related care plan interventions for Resident #27 and failed to develop and implement fall-risk-specific care plan interventions for Resident #111. These failed practices placed Resident #27 at risk for unmet cognitive and behavioral needs and placed Resident #111 at risk of injury Findings: Resident #27Record review on 12/14-24/25 revealed Resident #27 was admitted to the facility with diagnoses that included unspecified dementia, unspecified severity, with other behavioral disturbance (cognitive decline of unclear cause and severity, accompanied by behavioral symptoms), and mild cognitive impairment of uncertain or unknown etiology.Review of Resident #27's MDS (Minimum Data Set- a federally required assessment) Comprehensive Assessment, dated 10/24/25, revealed, under Section I-Active Diagnosis, Resident #27 was not coded for dementia. Review of the MDS's Section V - Care Area Assessment (CAA) Summary revealed the care area of cognitive loss/dementia had not been triggered and had not been addressed in the resident's care plan. Review of Resident #27's physician orders revealed: [Order Date 12/11/25 at 12:51 PM] RisperiDONE [atypical antipsychotic medication used to treat psychosis, mood disorders, and behavioral symptoms by helping balance neurotransmitters in the brain] Oral Tablet 1 MG (Risperidone) Give 2 mg by mouth at bedtime for Hallucinations F03.91: Unspecified dementia, unspecified severity, with behavioral disturbance.Review of the [Provider] Progress Note, dated 10/21/25, revealed: Chief Complaint: New admit.History of Presenting Illness: .pmh [primary medical history sig [significant] for dementia.Past Medical History: dementia.Review of the [Provider] Progress Note, dated 10/28/25, revealed: History of Presenting Illness: . sig for dementia. cognitive impairment: tests done in hospital M-ACE [Mini-Addenbrooke's Cognitive Examination]: 21/30 [suggests mild cognitive impairment] .MoCA [Montreal Cognitive Assessment] 18/22 [suggests mild cognitive impairment]. noted to have been rx'ed [prescribed] risperdal for dementia with behavioral disturbance.Review of Resident #27's care plan, last reviewed 10/24/25, revealed: Resident requires antipsychotic medication related to hallucinations as evidenced by auditory hallucinations. Further review revealed no care planning for dementia.During an interview on 12/17/25 at 10:13 AM, Resident Care Manager (RCM) #2 and RCM #3 stated Resident #27's diagnosis of dementia was added to the electronic health record (EHR) but not added to the MDS as it was not identified on admission. RCM #3 further stated Resident #27's diagnosis of dementia will be added to the next quarterly MDS.Review of the facility's Dementia-Clinical Protocol policy, revised 11/2018, revealed: Assessment and Recognition.5. The staff and physician will review the current physical, functional, and psychosocial status of individuals with dementia, and will summarize the individual's condition, related complications, and functional abilities and impairments.Treatment/Management.1. For the individual with confirmed dementia, the IDT [Interdisciplinary Team] will identify a resident-centered care plan to maximize remaining function and quality of life.5. The IDT will Identify and document the residence condition and level of support needed during care planning and review changing needs as they arise. A. Resident needs will be communicated to direct care staff through care plan conferences, during change of shift communications and through written documentation (nurses' notes and documentation tools) .Monitoring and Follow-Up.2. The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors. Resident #111Record review on 12/14-24/25 revealed Resident #111 was admitted to the facility on [DATE] with diagnoses that included radiculopathy (compression or irritation of a spinal nerve root) and spinal stenosis (spaces within the spine narrow, placing pressure on the spinal cord or nerves) followed by a lumbosacral spinal fusion (surgical procedure that joins two or more vertebrae in the lower spine to stabilize the spine, reduce pain, and correct spinal instability or deformity).Review of Resident #111's Morse fall assessment [a standardized assessment tool used to evaluate a patient's risk of falling based on factors such as history of falls, mobility, mental status, and use of assistive devices], dated 8/14/25 at 1:50 PM, revealed: Description: Admission. Category: Moderate Risk of Falling.Gait.Impaired-difficulty rising from chair, uses chair arms to get up, bounces to rise-keeps head down when walking, watches the ground - grasps furniture, person or aid when ambulating

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	025025	A. Building B. Wing	12/24/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. .Based on record review, interview, and observation, the facility failed to ensure treatment and care was provided, based on physician orders and comprehensive person-centered care plans, for 2 residents (#23 and #27), out of 20 sampled residents. This failed practice had the potential to diminish overall health and wellbeing, placing Resident #23 at risk for unrecognized blood pressure instability related to antihypertensive therapy and Resident #27 at risk for impaired skin integrity due to failure to implement ordered offloading and pressure reduction measures Findings: Resident #23Record Review on 12/14-24/25 revealed Resident #23 was admitted to the facility with diagnoses that included hypertension (elevated blood pressure), heart failure (condition in which the heart pumps ineffectively) and history of transient ischemic attack (stroke).Review of Resident #23's electronic health record (EHR) revealed a physician's order, dated 6/18/25: .Vital signs daily. Further review revealed an order for blood pressure medication, dated 9/12/25: .Coreg Oral Tablet 6.25 MG (Carvedilol). Give 1 tablet by mouth two times a day for HTN (hypertension - elevated blood pressure). Review of Resident #23's Care Plan Report, last reviewed 10/8/25, revealed: .Goal. Will exhibit a therapeutic effect related to the use of the medication. Interventions/Tasks. Vital signs as ordered.Review of Resident #23's vital signs flowsheets dated 6/18/25-12/14/25 revealed only two documented vital sign assessments (9/1/25 and 9/11/25), with no documentation of daily vital signs for the remaining 177 days.During an interview with the facility's acting Director of Nursing (DON) on 12/17/25 at 9:30 AM, the DON confirmed that the facility should have been checking vital signs daily on Resident #23.Review of the facility policy Vital Sign Monitoring, last revised 3/2025, revealed: .It is the policy of this facility to monitor the resident's vital signs. Vital signs will be monitored for residents receiving medications including but not limited to anti-hypertensives and psychotropics. Vital signs, to include temperature, blood pressure, pulse and respirations are done no less often than monthly, unless physician's orders or the plan of care specifies differently. Resident #27Record Review from 12/14-24/25 revealed Resident #27 was admitted to the facility with diagnoses that included weakness, mild cognitive impairment of uncertain or unknown etiology and osteoarthritis.An observation on 12/14/25 at 10:00 AM, revealed Resident #27 was laying supine (on back) in bed, with both heels of his/her feet on the mattress. Further observation revealed his/her feet and heels were covered by non-skid socks.Review of Resident #27's EHR revealed two wound care orders:1.Left heel (vascular). leave open to air. Start Date. 11/9/2025,2.offloading boots to LLE (left lower extremity). Start Date. 11/3/2025.Review of Resident #27's Care Plan Report, last reviewed 10/24/25, revealed: .Focus. Skin: Resident is at risk for skin breakdown related to immobility, and central cord syndrome, and malnutrition. Goal. Will prevent or delay skin breakdown to the extent possible given risk factors. Interventions. Keep skin clean and dry to the extent possible. Further review revealed no interventions to keep Resident #27's left heel open to air or for the use of offloading boots.During an interview on 12/14/25 at 1:00 PM, when asked if Resident #27 should have been wearing heel boots, Licensed Nurse (LN) #12 agreed that there was an order to have heel boots in place.Review of the facility provided policy Care Plans, Comprehensive Person-Centered, last revised 3/2022, revealed: .The comprehensive, person-centered care plan. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. reflects currently recognized standards of practice for problem areas and conditions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025025	A. Building B. Wing	12/24/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	025025	A. Building B. Wing	12/24/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to ensure necessary treatment and services, consistent with professional standards of practice, were provided for the treatment of pressure ulcers. Specifically, the facility failed to ensure a resident with a facility acquired pressure ulcer received appropriate treatment interventions, to include timely higher level of care, for 1 Resident (#110), out of 3 residents with pressure ulcers reviewed. These failed practices contributed to Resident #110 being hospitalized with sepsis and passed away from this complication Findings:Resident #110Record review on 12/14-24/25 revealed Resident #110 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease and type 2 diabetes. Resident #110 required routine dialysis.Resident #110 was admitted to the facility for physical therapy (PT), occupational therapy (OT), and dialysis assistance.Resident #110's dialysis was converted to hemodialysis (filtration of the blood using a machine with a special filter called a dialyzer, acting like an artificial kidney. A port in the arm called a fistula, a connection between an artery and vein in the arm, was used during dialysis to filter waste products and excess fluid from the body) while at the facility. The facility transported the resident to a dialysis center every Monday, Wednesday, and Friday for treatment. Resident #110's skin assessment on admission, dated 3/10/25, revealed there was redness to his/her sacrum (central position of the hips directly below spine, at area above buttocks crease) that was blanchable (turns white when pressure applied, and returns to original color after pressure released which indicated good circulation), however had no wounds to his/her sacral area upon admission.Further record review revealed Resident #110 had a fall in the facility on 4/8/25 which caused a fracture of the right femur (thigh bone) at the neck, or top, of the bone. According to the notes, this required hospitalization and surgical repair. Review of Resident #110's Admission/re-admission Summary Note, dated 4/14/25, revealed: This resident is readmitted this afternoon following hip repair surgery. [His/her] ADL [activities of daily living] had declined since [his/her] discharge to the hospital, returning [he/she] has difficulty standing and transferring well as bed mobility and dressing.Review of Resident #110's nursing SBAR (situation, background, assessment, and recommendation) note, which was completed by nurses when a change in condition occurred with residents, dated 5/6/25, revealed: New pressure injury to the [left] [iliac] crest [the left hip bone's upper, outer edge]. Stage II [a shallow wound involving partial skin loss] . Further review revealed the wound measured 2.2 centimeters (cm) long by 1.5 cm wide by 0.1 cm deep. Further review revealed Provider #1 ordered for the facility's SNF (skilled nursing facility) wound care team assess the resident on 5/7/25.Review of Resident #110's first SNF Wound Care note was dated 5/14/25 (7 days after the order was written) and completed by Wound Care Physician Assistant (PA) #5. Review of this note revealed Resident #110 now had two diabetic wounds:1) A right sacral area (right side of lower back, to the right of the upper buttock crease) measuring 3. 0 cm long by 1.0 cm wide by 0.2 cm deep. This wound was described as an open diabetic wound (a slow-healing open sore or lesion, that develops in people with diabetes due to nerve damage and poor circulation) that was not infected; and2) A left sacral area (left side of lower back, to the left of the upper buttock crease) measuring 2.0 cm long by 0.5 cm wide by 0.2 cm deep. This wound was described as an open diabetic wound that was not infected.Further review revealed: . Please change dressing after shower/bed bath/soilage to avoid leaving on wet/moist dressings. Change positions often to keep pressure off the wound, and spread body weight evenly with cushions, mattresses, pillows, foam wedges, or other pressure-relieving devices. Complicating factors include the patient's limited mobility status, nutritional status, and underlying medical conditions as noted and reviewed in Past Medical History.In addition, the SNF Wound Care note stated: Overall treatment goals include a decrease in wound size, preventing infection/inflammation, maceration, excessive drainage, malodor, and discomfort/pain for continued day-to-day activities of daily living. If the patient has any complications, please contact me or the office. I will be visiting this patient as needed every week until all wounds heal or are otherwise specified. This documentation for goals of treatment was the same on every SNF Wound Care note reviewed, 5/14/25 through 8/11/25, throughout the resident's admission.Review of Resident #110's provider/nursing progress notes, dated 5/6-14/25, revealed no documentation of the right sacral wound.Review of Resident #110's Treatment Administration Record (TAR), dated 5/2025, revealed a standing order was placed by nursing on 5/6/25: Left iliac crest Stage 2 pressure injury: Cleanse with normal saline/wound cleanser, pat dry, skin prep peri wound [a wipe or spray protective barrier on intact skin around a wound], apply [nickel] depth pluro gel

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	025025	A. Building B. Wing	12/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centennial Post Acute	9100 Centennial Drive Anchorage, AK 99504

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to ensure a resident on wander guard elopement precautions received adequate supervision for 1 Resident (#90), out of 2 residents reviewed for wander guard supervision. This failed practice contributed to the resident's ability to leave the facility in a cab, become stranded at a local store, and returned to the facility by entering a stranger's privately owned vehicle, placing him/her at risk for abuse, exploitation, and/or death .Findings:Record review on 12/14-24/25 revealed Resident #90 was admitted to the facility on [DATE] with diagnoses that included a displaced fracture of medial wall of left acetabulum (a fracture in the socket part of the left hip joint where the bone fragments are moved out of their normal alignment), chronic kidney disease, schizophrenia (a mental disorder that disrupts how a person thinks, feels, and behaves, causing them to lose touch with reality), and anxiety.Further review revealed Resident #90 left the faciity on [DATE] by calling a cab around 3:00 PM. Facility personnel became aware that the resident was not in the facility around 5:30 PM (2 1/2 hours after the resident left). Once aware, facility personnel began to search the facility, notify leadership, and were about to call the police when the resident was returned to the facility by a man and woman who found the resident at [NAME] (a local grocery store six miles away from the facility).Elopement EvaluationReview of Resident #90's Elopement Risk Evaluation, dated 9/17/25, revealed: . Mental status. Is the resident cognitively impaired with poor decision making skills (i.e., poor decision cues, intermittent confusion, inattention, and disorganized thinking)?. Yes. Is the resident an elopement risk? . Yes.Further review revealed Resident #90 scored 15 on this evaluation, which indicated he/she was a high risk to wander.Review of Resident #90's physician orders, revealed an order dated 9/17/25: Wander guard [a discreet wearable tag that triggers an alarm at doors providing staff alerts that a resident has left through a door]: check placement every shift.Review of Resident #90's provider note, dated 9/23/25, revealed: . cannot make [his/her] own decisions. Elopement BehaviorsReview of Resident #90's progress notes, dated 9/28/25 through 11/15/25, revealed the following wander guard monitoring and elopement-type behaviors:- 9/17/25: . earlier part of the shift [he/she] wants to go home and smoke outside.- 9/28/25: . frequently asks for someone to take [him/her] shopping at Walmart.- 10/2/25: . [he/she] is fixated on leaving to go shopping today and is working on staff to call [him/her] a cab.- 10/13/25: . wander guard functioning well on Left wrist.- 10/19/25: [he/she] wishes to go to Walmart. Cab service ordered by another resident[,] refuses due to not being handicap ready. [Resident #90] transfers on [his/her] own.- 10/31/25: . Wander guard is intact on [his/her] wheelchair.During an interview on 12/16/26 at 4:10 PM, Licensed Nurse (LN) #3 stated he/she was the nurse working Resident #90's court on 11/15/25. LN #3 stated that Resident #90 had left through the front door of the facility that day, and the wander guard alarm did go off when he/she exited. LN #3 and others on the court questioned each other if that was an alarm, however LN #3 stated they did not respond to the alarm. LN #3 stated that apparently no one was at the front desk at that time, so the resident was able to leave. LN #3 stated he/she didn't realize Resident #90 was not on the unit when he/she attempted to deliver Resident #90's afternoon medications and meal. This was when a search started and leadership was notified. LN #3 stated he/she was about to call the police when Resident #90 was returned to the facility by a couple who happened to be at the store. LN #3 stated Resident #90 had told the staff that he/she went to see a friend at the store, however this friend left him/her at the store when the line he/she was in took too long, and the resident couldn't get back to the facility. Review of Resident #90's care plan, initiated on 9/18/25, revealed: . FOCUS: Elopement: Resident is at risk for elopement/exit seeking/wandering related to wanders aimlessly. GOAL: Resident's safety will not be endangered related to behaviors. Will have reduced episodes of exit-seeking behaviors. Will not leave the facility without a responsible person. Will not wander out of the facility. INTERVENTIONS: Administer medications as ordered. Allow wandering in safe areas within the facility. Approach in calm, non-threatening manner. Check exit, stairwell and door alarms on a routine schedule for operability. Check function of wander alarm per manufacturer recommendations. Check placement of wander alarm every shift. Document and notify physician if behavior interferes with daily functioning. Elopement risk assessment per facility policy. During an interview on 12/28/25 at 6:38 PM, when asked if the facility had made any changes to Resident #90's care plan after this elopement, LN #7 stated they added a goal for the resident to notify staff when he/she would like to go to the store.Review of Resident #90's revised care plan, dated 11/20/25, revealed the addition of this goal: resident will notify staff when [he/she] would like to go to the store. Further review

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to ensure continuity of rehabilitative services for 1 resident (#111) reviewed for rehabilitative services. Specifically, the facility failed to ensure physical therapy services were provided as ordered when the facility's physical therapist went on leave. This failed practice resulted in an interruption of ordered rehabilitative services and placed the resident at risk of negative impacts to their functional status and rehabilitation outcomes Findings:Record review on 12/14-24/25 revealed Resident #111 was admitted to the facility on [DATE] with diagnoses that included radiculopathy (compression or irritation of a spinal nerve root, leading to pain, numbness, tingling, or weakness that radiates along the path of the affected nerve), spinal stenosis (spaces within the spine narrow, placing pressure on the spinal cord or nerves and causing pain, numbness, or weakness) and lumbosacral spinal fusion (surgical procedure that joins two or more vertebrae in the lower spine to stabilize the spine, reduce pain, and correct spinal instability or deformity).During an interview on 12/17/25 at 4:20 PM, Resident Representative (RR) stated Resident #111 was not making progress while he/she was at the facility because he/she was not receiving physical therapy (PT). RR further stated the physical therapist went on leave.Review of the Minimum Data Set (MDS- a federally required assessment), admission Assessment, dated 8/21/25, revealed, under Section GG-Functional Abilities, Resident #111 was coded as requiring substantial/maximal assistance for toileting hygiene, shower/bathe self and upper body dressing and dependent -where a helper does all the effort and the resident does none of the effort for lower body dressing and putting on/taking off footwear. Further review revealed Resident #111 was coded as requiring substantial/maximal assistance for sitting on side of bed to lying flat on the bed, lying on the back to sitting on the side of the bed with no back support, getting on and off a toilet and getting in and out of a tub/shower and dependent - where a helper does all the effort and the resident does none of the effort to complete the activities of coming to a standing position from sitting in a chair, wheelchair, or on the side of the bed and transferring to and from a bed to a chair.Review of Resident #111's Medicare PT Evaluation & Plan of Treatment, dated 8/16/25, revealed: Plan of Treatment.Frequency: 5/time(s)/week Duration 4 week(s) Intensity: Daily.Review of Resident #111's Physical Therapy Treatment Encounter Note(s) revealed Resident #111 had PT sessions on 8/16/25, 8/18/25 and 8/19/25 and no PT services for 12 calendar days (8 business days) until 9/1/25, 9/3/25 and 9/4/25.Review of the physician's orders revealed: PT Clarification: Continue skilled PT 5x [5 times] a week for 4 weeks: PLAN OF CARE may include: gait training 97116, ther ex [therapeutic exercise] 97110, ther act [therapeutic activity] 97530, neuro re-ed [neuromuscular reeducation] 97112, group therapy 97150, sensory integration 97533, manual therapy 97140. TXDX [Treatment Diagnosis] . muscle weakness. LTG [Long Term Goals]: Able to negotiate 8 stairs to return to split level home of [family member], safely and with CGA [contact guard assistance]. THE THERAPY CLARIFICATION ORDER SERVES AS THE PHYSICIAN CERTIFICATION FOR THE THERAPY PLAN OF CARE. [Start Date] 8/16/25. [End Date] 9/12/25. Further review of the medical record revealed no modifications, discontinuation, or suspension of the physical therapy orders during the lapse in services. During an interview on 12/16/25 at 2:00 PM, the Director of Rehabilitation (DOR) stated the facility's physical therapist went on leave on 8/20/25. DOR stated that, during that time, PT services were not provided, and the facility was attempting to secure replacement PT coverage. The DOR further stated PT services resumed on 9/1/25 after a temporary physical therapist was obtained. When asked how the lapse in PT services was communicated to residents, the DOR stated it may have been discussed with residents during care conferences, however no documentation was available to verify this. The DOR stated PT services were routinely provided on weekdays and were not offered on weekends. The DOR further stated he believed the physician was notified of the lapse in services but was not aware of any corresponding physician order changes or care plan revisions during the period PT services were not provided.During an interview on 12/16/25 at 4:00 PM, the Regional Director of Clinical Nursing Services (RDCNS) stated that during the lapse in PT services, the facility did not update care plans or modify physician orders for residents receiving PT services. The RDCNS further stated the facility discussed plans to hold Interdisciplinary Team (IDT) conferences to notify residents of service interruptions in the future. The Regional DON stated these discussions occurred during morning rounds; however, there was no documentation available to confirm the discussion during morning rounds.Review of the Centennial Post Acute Facility Assessment, updated 11/25/25, revealed: We provide long-term care and short-term care to include rehab. 2. Services we utilize to

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review, interview, and observation, the facility failed to develop, implement, and maintain an effective Quality Assurance and Performance Improvement (QAPI) program that identified, analyzed, and corrected systemic quality deficiencies. The facility failed to use available data to identify trends, failed to prioritize high-risk issues, and failed to implement and sustain corrective actions.Specifically, the facility failed to identify and/or address ongoing patterns of deficient practice related to staffing, grievance process, clinical care, activities, medication management, therapy services, discharge planning, environmental conditions, and care planning. These issues were evident through internal reports, resident council concerns, medical record documentation, staffing data, and direct observation, yet were not recognized and/or effectively acted upon through the QAPI process.These failed practices placed all residents (based on a census of 97) at risk of receiving less than optimal care and poor quality of life Findings:During an interview on 12/18/25 at 4:34 PM, the Regional Director of Clinical Nursing Services (RDCNS) and the Administrator stated the QAPI committee collected data from different metrics. When asked to clarify what metrics were used, the RDCNS stated for clinical metrics that they look into were electronic health record, corporate dashboard, HR (human resources) reporting work day, maintenance through TELS (a maintenance software) that track and document activities, sanitation rounding in the kitchen, activities, resident council minutes, feedback from residents and staff. The RDCNS stated data from the metrics were brought into the QAPI meeting. The RDCNS stated the committee prioritized patient safety, resident and staff satisfaction, maintenance, activities, impacts quality of life such as high risk, adverse events. They also had a quick review of accidents and events, and post incident interventions. The RDCNS also stated the team would come up with a plan based on the prioritized data.When asked about their monitoring process, the RDCNS stated a sub-committee would be assigned to look into the root cause of the issue then a PIP (Performance Improvement Project) would be created. She explained that the PIP lead would report to the QAPI committee, then the QAPI committee would give their feedback if the plan would be updated or sustained. She further stated that currently the QAPI committee had Infection control and skin integrity PIP.Low Weekend Staffing Review of the Payroll Based Journal (PBJ) Staffing Data Report (a mandatory electronic staffing data submission system created by the Centers for Medicare & Medicaid Services [CMS]) for the fourth quarter (7/1/25 to 9/30/25) revealed: Excessively Low Weekend Staffing was triggered.Review of the facility provided Centennial Post Acute Facility Assessment, updated on 11/25/25, revealed: . The facility is struggling with securing FT [full time] staff for nurses and CNAs. The assessment indicated staffing should include: . 6 nurses on day/eve[[NAME]] shift and minimum of 3 on NOC/night shift.12-15 CNAs on day shift/eve shift and 9-12 on NOC/night shift. 2 restorative aides daily.Review of 12 randomly selected weekend staffing schedules for the fourth quarter (7/1/25-9/30/25) revealed staffing consistently fell below the facility assessment's established levels. Specifically:- On 8/9/25, 2 LNs were scheduled, the established minimum was 3.Dayshift, CNAs, the established minimum was 12:- On 7/5/25, 10 day shift CNAs were scheduled;- On 7/6/25, 11 day shift CNAs were scheduled;- On 7/12/25,11 day shift CNAs were scheduled; and- On 7/13/25, 9 day shift CNAs were scheduled.Nightshift, CNAs, the established minimum was 9:- On 7/5/25, 7 night shift CNAs were scheduled;- On 7/6/25, 8 night shift CNAs were scheduled;- On 7/13/25,6 night shift CNAs were scheduled; and- On 9/6/25, 7 night shift CNAs were scheduled.Restorative Aides (RAs) - established minimum was 2 daily:- On 7/5/25, 1 RA was scheduled;- On 7/6/25, 0 RAs were scheduled;- On 7/12/25,1 RA was scheduled;- On 7/13/25,1 RA was scheduled;- On 8/9/25,1 RA was scheduled;- On 8/10/25,1 RA was scheduled;- On 8/23/25,1 RA was scheduled;- On 8/24/25,1 RA was scheduled;- On 9/6/25, 1 RA was scheduled;- On 9/7/25, 1 RA was scheduled;- On 9/27/25, 0 RAs were scheduled; and- On 9/28/25, 1 RA was scheduled.Resident #48Record review on 12/14-24/25 revealed Resident #48 was admitted to the facility with diagnoses that included quadriplegia (paralysis of all four limbs). The resident fully relied on staff to dress and get the resident up and out of bed.During an interview and concurrent observation on 12/14/25 at 11:11 AM, Resident #48 stated that he/she had called for staff around 9:00 a.m. to assist with getting out of bed and was still waiting. The resident remained in bed with a Hoyer lift positioned beside the bed and the wheelchair near the doorway. The resident stated that he/she had requested to be out of bed by 9:30 a.m. and reported that long waits had been common since admission, expressing concern that the facility seemed very short-staffed. Staff assisted Resident #48 out of