STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER: Maple Springs of Wasilla		STREET ADDRESS, CITY, STATE, ZIP CODE: 3265 E Meridian Loop, Wasilla, AK 99654	

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 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)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Based on record review, observations, and interviews, the facility failed to implement fall prevention interventions for 1 resident (#49), out of 16 sampled residents. Specifically, a staff failed to ensure the resident correctly applied non-skid socks as outlined in the care plan. This failed practice placed the resident at risk for a fall and/or injuries.Findings:Resident #49 Record review on 6/29/25-7/3/25 revealed, Resident #49 was admitted to the facility with diagnoses that included traumatic ischemia of muscle related to a fall (decrease in the blood supply to a muscle due to a traumatic injury), Parkinson's disease without dyskinesia (degenerative brain condition that affects muscle control and movement), and lumbosacral radiculopathy (pain in the lower back and hip that radiates down the back of the thigh into a leg caused by compressed nerve roots). Review of Resident #49's, Care Plan Report, initiated on 2/11/25, revealed: . [Resident #49] has an ADL [activities of daily living] self-care performance deficit. Interventions. DRESSING: The resident requires limited assistance by (1) staff to dress.Position.CNA [Certified Nursing Assistant].Review of Resident #49's Care Plan Report, initiated 2/11/25, revealed: . [Resident #49] is High risk for falls r/t [related to] previous fall.Ensure that [Resident #49] is wearing appropriate footwear non-skid socks when ambulating or mobilizing in w/c [wheelchair]. CNA. LPN [Licensed Practical Nurse]. RN [Registered Nurse]. Review of Resident #49's, Minimum Data Set (MDS- a federally required nursing assessment), OBRA Quarterly Assessment, dated 5/20/25, revealed: .Mobility. Walk 10 feet.Independent. Walk 50 feet with two turns. Independent.An observation on 6/29/25 at 9:10 AM, revealed Resident #49 was noted to be wearing his/her yellow non-skid socks inside out. During this observation, the resident stated, the yellow socks were a little loose. He/she then got up from his/her bed, walked to the shelves and then proceeded to show the grey unopened non-skid socks on his/her shelf. He/she stated, that one fits a little better.An observation on 6/30/25 at 10:36 AM, revealed Resident #49 was noted to be wearing his/her yellow non-skid socks inside out. During this observation, CNA #1 knocked on the door, walked into the room, and asked the resident if he/she needed anything. The resident declined, and CNA #1 stated, Oh, your socks are inside out, and proceeded to leave the room without fixing Resident #49's socks. During an interview on 6/30/25 at 10:50 AM, when asked if he/she knew the purpose of the bottom white markings (tread grips) of the non-skid socks, and Resident #49 stated, no.An observation on 7/1/25 at 9:36 AM, Resident #49 was noted to be wearing his/her yellow non-skid socks inside out. During this observation, the resident got up from his/her chair and walked to his/her bed area to grab a personal item.During an interview on 7/2/25 at 9:51 AM, CNA #2 stated if a resident was found to not be utilizing the fall prevention measures such as using the call-light, using non-skid socks, or wearing proper footwear, he/she would attempt education and/or assist to help correct. When asked what he/she would do if he/she had found a resident with non-skid socks that are worn inside-out, CNA #2 stated that he/she would attempt to correct them so that the grippers are on the bottom of the feet, if the resident allowed, and notify the floor nurse if the resident declined.During an interview on 7/3/25 at 9:39 AM, CNA #3 stated he/she was trained to utilize the care plan when getting to know the residents and how to care for them. He/she further stated, the care plan contained resident-centered interventions, and staff were trained to follow these interventions that were planned to help mitigate the risk for falls.During an interview on 7/3/25 at 12:20 PM, Nursing Supervisor (NS) #2 stated CNA staff were expected to follow the resident's care plan, and if there were interventions that were not working for the resident, they were to notify the nurses on the floor and/or the NS on duty, which could lead to a revision of the care plan, if necessary.Review of the facility's policy Assessing Falls and Their Causes, revised on 7/2024, revealed: .Falls are a leading cause of morbidity and mortality among the elderly in nursing homes. Residents must be assessed. for potential risk of falls. Relevant risk factors must be addressed properly. Review of the facility's policy Fall Risk Assessment, revised on 3/2024, revealed: .The nursing staff. will seek to identify and document resident risk factors for falls and establish a resident-centered fall prevention plan based on relevant assessment information. The staff will seek to identify environmental factors that may contribute to falling. The staff and attending physician will collaborate and identify and address modifiable risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. Review of the facility's policy Care Plans, Comprehensive Person-Centered, last revised on 1/2025, revealed: . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to

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	025038	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Springs of Wasilla	3265 E Meridian Loop Wasilla, AK 99654

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. .Based on record review, observation, and interview, the facility failed to administer a medication through the route ordered for 1 resident (#34), out of 16 sampled residents. This failed practice created a medication error and placed the resident at risk of adverse reactions.Findings:Resident #34Record review on 6/29/25-7/3/25 revealed Resident #34 was admitted to the facility with diagnoses that included intracranial (brain) injury, gastrostomy (a surgical procedure where a feeding tube called a percutaneous endoscopic gastrostomy, or PEG tube, is inserted through the abdominal wall to provide direct access into the stomach), and post-traumatic seizures.Review of Resident #34's eMAR (electronic medication administration record) revealed: .levETIRAcetam [an anti-seizure medication] Oral Solution 100 MG [milligram]/ML [milliliter] . Give 10 ml via PEG-Tube two times a day for seizure .-Start Date- .05/19/2025 0900 [9:00 AM] .An observation on 6/30/25 at 2:37 PM, revealed Licensed Nurse (LN) #1 prepared Levetiracetam oral solution in a medication cup. LN #1 asked the resident if he/she was ready for medications to which the resident nodded his/her head. LN #1 raised Resident #34's head of bed and then gave the resident the medication cup. The resident took the medication by mouth and requested water after.During an interview on 6/30/25 at 2:38 PM, LN #1 explained that although the order specified administration of the medication via PEG tube, the resident had been taking all intake, including medications, by mouth. LN #1 further stated that the resident had undergone a swallow study, which supported Resident #34's transition from PEG-tube feedings to oral intake. However, the PEG-tube remained in place pending a reassessment for removal. During an interview on 7/1/25 at 11:25 AM, LN #2 stated the Charge Nurse (CN) would notify the floor nurses if there were changes to the physician's order for a resident and it would be recorded in electronic health record system. He/she further added, orders could be placed or changed by the floor nurse, if necessary, after communicating with the provider.During an interview on 7/2/25 at 10:55 AM, the Director of Nursing (DON) stated Resident #34's orders to change the route for the PO [by mouth] trial (monitored attempt to give a patient food, fluids, or medication by mouth to evaluate their ability to safely swallow and tolerate oral intake) should have been completed when the resident came back from his/her appointment and after the recommendations were received and noted by the Charge Nurse. Review of the facility's policy Administering Medications, last revised 1/2025, revealed: .Policy Statement .Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medications, right dosage, right time and right method (route) of administration before giving the medication .Review of Lippincott Nursing Procedures, Safe Medication Practices, published in 2023, revealed: .To promote a culture of safety and to prevent medication errors, nurses must . adhere to the five rights of medication administration: .administer the medication by the right route .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Based on record review, observation, and interview, the facility failed to ensure infection control procedures were properly implemented in the facility for 3 residents (#s 4, 54, and 58) out of 16 sampled residents. Specifically, the facility failed to: 1) ensure Certified Nurse Assistants (CNAs) used required personal protective equipment (PPE) while caring for residents (#'s 4 and 54) who were on enhanced barrier precautions (EBP-the use of gown and gloves during high-contact resident care activities); and 2) ensure a clean environment during Resident #58's wound care. These failed practices placed the residents at risk of infection which could have affected their overall health and wellbeing.Findings:Use of PPEResident #4Record review on 6/29/25-7/3/25 revealed Resident #4 was placed on EBP due to the presence of an indwelling catheter (a medical device that drains urine from the bladder leading to a drainage bag).An observation on 6/30/25 at 3:42 PM, revealed a sign posted on the door outside of Resident #4's room. The sign read: STOP Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and leaving the room. Providers And Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities . Device care or use .urinary catheter .An observation on 6/30/25 at 3:45 PM, LN #1 administered medications to Resident #4. Further observation revealed Certified Nursing Assistant (CNA) #1 knocked on the door, walked into the room, completed hand hygiene with the alcohol-based sanitizer, then put on a pair of gloves. Next, he/she walked over to the right side of the resident's bed and drained urine from the catheter bag. The CNA stated, there was 300 mL [milliliter] output, to LN #1. It was noted CNA #1 was not wearing a gown during the observation.During an interview on 6/30/25 at 3:50 PM, CNA #1 stated there were signs posted on the resident's door to help indicate to staff whether they need to follow precautions. He/she stated hand hygiene, wearing a gown and gloves were required when a catheter bag was being emptied due to them being on EBP. Resident #54Record review on 6/29/25-7/3/25 revealed Resident #54 was on EBP due to the use of an indwelling catheter.An observation on 7/2/25 at 11:17 AM, revealed a sign posted on the door outside of Resident #54's room. The sign read: STOP Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and leaving the room. Providers And Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities . Changing Linens . Providing Hygiene. Further observation revealed CNA #4 and Student #1 entered the resident's room. Both CNA #4 and Student #1 sanitized their hands with alcohol-based hand sanitizer, put on gloves, then gathered supplies for resident care. CNA #4 and Student #1 stood on each side of the bed. Both proceeded to remove Resident #54's blanket, pillows, soiled chucks (an absorbent pad used to protect the bedding). Next, they placed a clean fitted sheet onto the bed and inserted clean chucks under Resident #54's buttocks. Then, CNA #4 repositioned Resident #54 onto his/her left side after which Student #1 cleaned the resident's back using wet wipes. Afterwards, Student #1 placed a wedge pillow under Resident #54's legs. CNA #4 changed his/her gloves without performing hand hygiene. CNA #4 and Student #1 assisted Resident #54 with repositioning in bed and placed a clean blanket over the resident's legs. CNA #4 gathered all soiled sheets and chucks and placed them under the bathroom sink. Afterwards, CNA #4 and Student #1 removed their gloves and performed hand hygiene. It was noted both CNA #4 and Student #1 were not wearing gowns for the duration of the task.During an interview on 7/2/25 at 2:13 AM, the Infection Preventionist (IP) stated staff were expected to follow the EBP recommendations posted on the residents' door during resident cares.During an interview on 7/3/25 at 10:10 AM, the Director of Nursing (DON) was asked if all staff were trained on EBP, the DON stated: Yes. Review of the facility's policy, Enhanced Barrier Precautions, adopted 3/27/24, revealed: .[EBP] .Purpose: To reduce transmission of multidrug resistant organisms (MDROs) .Policy: Care staff will wear gowns and gloves during high contact activities.when caring for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.Clean wound care environmentAn observation on 7/2/25 at 10:41 AM, revealed LN #3 performed hand hygiene, and put on a gown and gloves. Afterwards, without cleaning the surface, and without putting down a clean surface barrier, LN #3 placed wound dressing supply packages, an opened syringe with saline, and gloves on the windowsill. Then, LN #3 continued wound care for Resident #58. During an interview on 7/3/25 at 10:02 AM, when asked what the standard practice should be when preparing supplies for wound care, the DON stated the LNs could use a bedside table or use a part of the bed. She further stated if the LN preferred to use a bedside table, the LN should clean the bedside table before placing the wound care supplies on it. The DON added that if the LN preferred to use the bed, the