

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>024002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/13/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALASKA PSYCHIATRIC INSTITUTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3700 PIPER STREET</b> <b>ANCHORAGE, AK 99508</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{A 000}	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced survey was conducted at Alaska Psychiatric Institute (API) on 7/16-19/18. The survey found API was not in substantial compliance with Center for Medicare and Medicaid Services (CMS) requirements for hospitals.</p> <p>During a revisit survey conducted at API on 11/27-30/18 and 12/5-7/18. The survey found API was not in substantial compliance with CMS requirements for hospitals.</p> <p>During a second revisit survey conducted at API on 1/28-30/19. The survey found API was not in substantial compliance with CMS requirements for hospitals as evidence by an immediate jeopardy under CFR 482.13: Patient Rights.</p> <p>An unannounced revisit and complaint investigation survey (AK#3606 and #3607) was conducted at API in 3/11-13/19. The following standard level deficiency was identified. The facility was in compliance with the condition CFR 482.13: Patient Rights. The sample size was 10 patients.</p> <p>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, Bldg L Anchorage, Alaska 99503</p>	{A 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.