

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

PRINTED: 04/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2016
NAME OF PROVIDER OR SUPPLIER PETERSBURG MEDICAL CENTER LTC			STREET ADDRESS, CITY, STATE, ZIP CODE P.O. BOX 589 PETERSBURG, AK 99833		
(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	
F 000	INITIAL COMMENTS The following deficiencies were noted during an unannounced recertification Medicare/Medicaid survey conducted 2/16 -19/16. The sample included 8 residents which included 1 closed record. 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	F 000			
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review, interview and policy review the facility failed to ensure the conveyance of personal trust fund balances within 30 days after death for 1 of 1 closed record (#7) reviewed for trust funds. This failed practice resulted in funds not conveyed after death. Findings:	F 160	Resident #7's Resident Trust Account was closed out and check mailed to conservator. Audit was done of all Resident Trust Accounts to ensure there were no other	2/25/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/04/2016

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.

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F 160	Continued From page 1 Record review on 2/18/16 revealed Resident #7 passed away on 11/15/15. Review of the trust fund balance on 2/18/16 at 12:00 pm, revealed Resident #7 had money still in his/her trust account. During an interview on 2/18/16 at 12:00 pm, Business Office Staff #1 stated Resident #7 was deceased and confirmed the Resident's trust fund balance had not been closed, even though the Resident passed away 3 months ago. During an interview on 2/18/16 at 2:50 pm the Director of Fiscal Services stated the facility had no policy on conveyance of personal trust fund monies.	F 160	open accounts for residents that no longer reside in the Petersburg Medical Center LTC. 'Conveyance of Funds Upon a Resident's Death' policy was drafted and approved by the Policy Committee. All fiscal services staff reviewed and understood the 'Conveyance of Funds Upon a Resident's Death' policy on 2/25/16. The business office manager or designee will audit the resident trust accounts monthly to ensure policy is being followed and submit findings to the Quality Committee quarterly for one year.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		4/4/16	

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F 279	<p>Continued From page 2</p> <p>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview and policy review the facility failed to ensure the comprehensive care plan for 1 resident (#2) out of 5 care plans reviewed had specific goals and approaches to meet an identified problem. Specifically, the facility failed to address significant weight loss. The failure to develop care plan goals and approaches placed the resident at risk for further decline. Findings:</p> <p>Record review from 2/16-19/16 revealed Resident #2 was admitted to the facility with diagnoses of dementia and Parkinsonism (a condition relating to a series of symptoms that mimic the movement disorders in Parkinson's disease. This includes impaired speech, stiffness of the muscles, slow movement, and visible tremors).</p> <p>Review of the most recent MDS (Minimum Data Set) assessments; an admission assessment, dated 3/19/15; and a quarterly assessment, dated 12/20/15, revealed the Resident was coded as having significant weight loss of 5% or more on both assessments. The admission MDS showed a weight of 150 pounds and the quarterly weight was 111 pounds.</p> <p>Review of the Resident's care plan, initial and</p>	F 279	<p>The LTC Manager developed a care plan for unintentional weight loss for Resident #2.</p> <p>An audit of all residents was done by the LTC Manager to ensure that all residents with unintentional weight loss or gain have a care plan in place.</p> <p>The LTC Manager will do an audit comparing resident care plans the Care Assessment Reports to ensure that all triggered areas are care planned as appropriate by 4/4/16.</p> <p>The LTC Manager will perform care plan audits with each ongoing annual and quarterly MDS submissions to ensure changes with the resident have been captured in the care plans. The LTC Manager will present the audits quarterly to the Quality Committee.</p>		

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F 279	Continued From page 3 revised, revealed no care planning goal or approach was done for the Resident's identified weight loss. During an interview on 2/18/16 at 8:25 am, the Long Term Care Manager confirmed weight loss was not on the care plan, but it should have been. Review of the facility policy "Care Management", dated 5/14, revealed "...assessments are used to develop and maintain a personalized plan of care for each resident...The plan of care is reviewed and revised as needed to reflect the current needs of the resident." Review of the facility policy "Care Planning, LTC [Long Term Care]", dated 5/14, revealed "The comprehensive care plan will include the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."	F 279			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		3/24/16	

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F 323	<p>Continued From page 4</p> <p>Based on record review, observation and interview the facility failed to ensure: 1) resident (#3) was free from injury while smoking; 2) staff were appropriately trained to supervise resident #3 during smoking; and 3) an accurate smoking assessment was completed. These failed practices resulted in 1 resident (#3) out of 1 resident who smoked receiving a burn injury which caused minimal harm to the resident during a smoking session. Findings:</p> <p>Record review from 2/16-19/16 revealed Resident #3 had diagnoses that included lung cancer, chronic obstruction pulmonary disease (COPD, chronic lung disorders resulting in blocked air flow in the lungs), and nicotine addiction.</p> <p>Record review of the Resident's Care Plan, revised date 2/12/16, revealed "Potential for Injury Related To...Desire to continue smoking...Goals...Able to smoke without injury...Approaches...See smoking safety plan, following care plan."</p> <p>Record review of Resident's Smoking Safety Plan, dated 9/21/15, revealed "Purpose... To promote safety for all staff and residents... [Resident #3] will...Smoke with supervision by staff...Staff will...Report any warning signs to LTCC [Long Term Care Coordinator] by using an incident report...Burns on skin."</p> <p>During an observation on 2/17/16 at 9:45 am the Activities Coordinator (AC) accompanied Resident #3 to smoke on the outside patio. The</p>	F 323	<p>The staff members responsible for taking Resident #3 out to smoke were immediately reminded of their responsibilities, including use of the smoking apron, watching the resident at all times, reminding the resident to follow safe smoking practices, observing the patient's skin and clothing for signs of burns, and the importance of notifying the LTC Manager if there were any unsafe practices seen.</p> <p>The order allowing Resident #3 was discontinued by mistake and a new order was placed on 2/18/16.</p> <p>Resident #2 was discharged (anticipated) on 3/1/16 and there are no other resident smokers living in LTC.</p> <p>Petersburg Medical Center LTC will transition to being a smoke free facility. The smoking policy was amended and is waiting official approval by the policy committee and board of directors. The policy is anticipated to be approved at the board meeting scheduled on March 24, 2016.</p> <p>No Smoking signs will be posted in the former smoking area outside as soon as the revised policy is approved by the board of directors.</p>		

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F 323	<p>Continued From page 5</p> <p>Resident sat down on the chair and the AC sat to the right of the Resident. The Resident held a lit cigarette in the right hand between the index finger and the second finger. While smoking, the Resident continuously had his/her eyes closed. The Resident flicked ashes randomly off to his/her right side missing the ashtray. Each inhalation of the cigarette caused the lit end to come extremely close to the inside of the fingers holding the cigarette. The Resident continued to smoke the cigarette to the yellow colored portion. When the Resident finished the cigarette, a reddened area was noted to the inside areas of the index and second finger.</p> <p>During an interview and observation on 2/17/16 at 9:58 am, LTCC and the Wound Care Nurse evaluated the reddened area and stated the area looked like a blister. The LTCC stated "I wonder if it is from smoking?" to the Wound Care Nurse. In addition, the LTCC stated the reddened area had not been brought to her attention prior to the Surveyor's observation.</p> <p>During an interview on 2/17/16 at 9:59 am, the Wound Care Nurse also stated the reddened area had not been brought to her attention prior to the Surveyor's observation.</p> <p>During a second interview on 2/17/16 at 10:38 am, the Wound Care Nurse stated the area on Resident #3's right hand appeared to have some correlation with the Resident's smoking behaviors.</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>During an interview on 2/17/16 at 10:00 am, the AC stated she had not been aware of the reddened area prior to the Surveyor's observation.</p> <p>During a second interview on 2/17/16 at 11:00 am with the AC, she was asked what training she was provided in regards to supervising the Resident during a smoking session. The AC stated she had to apply a smoking apron; listen to/and follow Resident's preferences; and ensure nothing fell into the Resident's lap. The AC also stated she had not received formal training on what to look for in appropriate versus non-appropriate smoking behaviors. When asked if she was familiar with the smoking assessment, the AC stated she knew one existed but had not reviewed it.</p> <p>During an interview on 2/17/16 at 6:37 pm Certified Nursing Assistant (CNA) #3 stated he/she was the assigned staff to accompany Resident #3 during the scheduled afternoon smoking time. When asked what training he/she was provided in regards to supervising the Resident during a smoking session, the CNA replied he/she had not received any training specific to duties while supervising Resident #3 while smoking.</p> <p>Record review on 2/17/16 of a physician's progress note, date 2/17/16, revealed "Asked by nursing to look at a lesion on [Resident #3's] R [right] long finger...It's a site where [Resident #3]</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>holds [his/her] cigarettes when...smoking. It had not apparently been noted and [Resident #3] hasn't mentioned it." Further review revealed the area to the right middle finger had discoloration from cigarettes, and a "clear fluid-filled blister". The physician's plan stated "[Resident #3] says 'it could certainly be' a cigarette burn," as this is the site where [Resident #3] holds [Resident #3] cigarettes, which [Resident #3] tends to smoke to the very end. That seems most likely."</p> <p>Record review on 2/17/16 of the "Physician's Nursing Orders Report", undated, revealed no current order was in place for the Resident to smoke.</p> <p>During an interview on 2/18/16 at 10:16 am the LTCC stated she spoke with Resident #3's wife and stated the wife claimed the Resident had a long history of smoking cigarettes close to his fingers and completely smoking down to the yellow colored portion. She further stated staffs were aware of this smoking behavior. In addition, the LTCC confirmed the facility did not provide training specific to staffs supervising residents when smoking. When asked to review the physician's order for the Resident to smoke, the LTCC stated she was unable to find a current order in the chart. When asked about how the smoking assessments were completed, the LTCC stated they were a subjective assessment and no one did observations of the Resident smoking before the form was completed. The information was gathered based on the Resident's history and capabilities.</p>	F 323			

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F 323	Continued From page 8 Review of the facility's "Smoking Policy," signed 8/1/14, revealed "...Staff will report any unsafe smoking practices to the LTC manager."	F 323			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to provide documentation for one resident's (#7) belongings upon death for 1 resident whose closed record was reviewed. As a result, there was a greater risk for misappropriation of the resident's belongings due to no documentation. Findings: Record review on 2/18/16 revealed Resident #7	F 514	A 'Resident Belongings Disposition Flowchart was developed to guide staff in documenting the details surrounding resident's discharges or deaths, including personal belonging disposition. Nurses will receive education on the new flowchart and the importance of accurate documentation of the disposal of resident belongings at the next nursing staff	3/23/16	

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F 514	Continued From page 9 was admitted to the facility 8/31/15 and died 11/15/15. Further review revealed there was no documentation that the Resident's personal belongings were given to the power of attorney or how they were disposed of upon the death of Resident #7. During an interview on 2/18/16 at 10:45 am the Chief Nursing Officer confirmed there was no documentation regarding where the belongings of Resident #7 went.	F 514	meeting scheduled for March 23, 2016. The charts of all residents who are discharged will be audited by the Director of Nursing or designee for one year to ensure that documentation is complete. The Director of Nursing will give feedback to nurses as needed if documentation is not complete. The Director of Nursing will present the results of the audit to the quality committee at least annually for one year.		
F 518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation the facility failed to ensure: 1) the fire plan accurately described staff responsibilities in the event of a fire emergency after business hours and 2) staffs were trained and knowledgeable in the area of fire emergency response. Specifically, staffs were not trained or knowledgeable of medical gas shut off locations and procedures. These failed practices placed all residents at risk for delayed response time for a	F 518	The fire plan was updated to accurately reflect the nursing personnel responsibilities of shutting off the medical gas system on 3/3/16. All Petersburg Medical Center staff will review the updated fire plan by 4/4/16. All Petersburg Medical Center staff will receive training on fire safety by 4/4/16.	4/4/16	

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F 518	<p>Continued From page 10 fire emergency (based on a census of 14).</p> <p>Review of the facility's procedure "Fire Plan", dated 12/4/14, revealed the nursing department had the duty of ensuring that oxygen was turned off in all the resident rooms. Additional review revealed a maintenance staff was to isolate the medical gas system.</p> <p>During an interview on 2/18/16 at 5:40 pm, Licensed Nurse (LN) #1 was asked who was responsible for ensuring the medical gas was shut off during a fire emergency. In response, the LN stated it would be the responsibility of Maintenance Staff #s 1 and 2. During the interview (at 5:40 pm) LN #1 was asked if either maintenance staff were currently in the facility and would be able to respond to a fire. LN #1 stated they were not in the building at the current time. In addition, the LN stated it would be assumed the licensed nurse on duty would then be responsible for isolating the medical gas system. LN #1 further stated it would take too long for maintenance staff to respond from home to isolate the medical gas system during a fire emergency.</p> <p>During an observation on 2/18/16 at 5:40 pm the Surveyor requested LN #1 to demonstrate how to isolate the medical gas system. The LN was unable to locate the medical gas shut off valves.</p> <p>During an interview and observation on 2/18/16 at 5:41 pm, LN #2 was unable to locate the medical gas shut off valves.</p>	F 518	<p>The education will include basic fire safety (RACE, PASS), what to do in a fire emergency and the location and function of the medical gas valves.</p> <p>All Petersburg Medical Center staff will participate in a drill to show competence and understanding of their responsibility in the event that a fire occurs by 4/4/16.</p> <p>New staff will continue to receive the above education on hire during their fire tour led by the maintenance manager.</p> <p>Staff on all shifts will have at least annual drills to ensure that the knowledge is ongoing.</p> <p>Reports of the drills and any 'lessons learned' will be reported to the quality committee by the maintenance staff at least quarterly.</p>		

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