

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

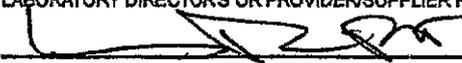
PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC	STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835
--	---

(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 11/16-19/15. The sample included 4 sampled residents, 1 closed record. 5 non-sampled residents were also included in the survey process. 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 154 SS-E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility	F 154		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/11/15
--	------------------------	-----------------------

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.

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835	
(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 154	<p>Continued From page 1</p> <p>failed to inform 3 residents (#s 1, 2, and 3), out of 3 records reviewed, of the risk and benefits of taking psychopharmacological medications. This failed practice placed the residents, and/or their designated Power of Attorneys (POAs), at risk for not being fully informed, in advance, of the care and treatment provided by the facility. Findings:</p> <p>Record review on 11/17/15 of the current medication administration record and current orders revealed Resident #s 1, 2 and 3 were prescribed scheduled and/or as needed psychoactive medications.</p> <ul style="list-style-type: none"> - Resident #1 was taking the medication venlafaxine (Effexor), a medication commonly prescribed for depression. - Resident #2 was taking the medication escitalopram (Lexapro), a medication commonly prescribed for depression. Resident #2 was also prescribed clonazepam (Klonopin), a medication commonly prescribed for seizures, panic disorder, and anxiety. - Resident #3 was taking the medication venlafaxine (Effexor), a medication commonly prescribed for depression. Resident #3 was also prescribed Ativan, a medication commonly prescribed for anxiety. <p>During an interview on 11/17/15 at 1:30 pm, the Long Term Care (LTC) Manager was asked to provide documentation of the facility's communication with Residents #s 1, 2 and 3 on the risk and benefits of taking psychoactive medications. The LTC Manager informed the surveyors the facility did not have documentation that they reviewed the risk and benefits of taking</p>	F 154	<p>F154</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • Resident #1, #2, and #3 and/or their Power of Attorneys were contacted 11/17/15 by the LTC Manager. • The informed consent documents for the risk and benefits of taking psychoactive medications were received. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> • All existing residents receiving psychotropic medications will have a signed consent form. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> • The staff will be in-serviced on Informed Consent regarding Psychoactive Medications. • All new admits who are receiving psychotropic medications will have a signed consent form. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> • The LTC Manager will monitor all consent forms and make sure they are placed in the chart as well as the "Nursing Assessments and Consents" notebook located at the nursing station. 	1/3/16

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 154	Continued From page 2 psychoactive medication with Resident #s 1, 2 and 3 and/or their respective POAs.	F 154			
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during	F 156	F156 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: • The LTC Manager posted the contact number for Health Facilities Licensing and Certification department, Adult Protective Services, and the Medicaid Fraud unit on 11/17/15. • The phone numbers for Health Facilities Licensing and Certification Department, Adult Protective Services, and the Medicaid Fraud unit phone numbers were added to the admission paperwork. • Information was added so the residents and/or families have the right to file a grievance with an advocacy agency first, should they choose to do so. How other resident's having the potential to be affected by the same deficient practice will be identified: • Sitka Community Hospital LTC recognizes that all residents residing in our center could be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: • These postings will be made permanent. How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place): • The LTC Manager will monitor that these postings and documentation changes are permanent.	1/3/16	

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC		STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 156	<p>Continued From page 3</p> <p>the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p>	F 156		

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 156	<p>Continued From page 4</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, documentation review and interview the facility failed to ensure all advocacy agency information was visibly posted in an area accessible to all residents and/or interested parties and had provided information about the residents' right to file a complaint with these agencies. This failed practice denied all residents (census of 10) and/or interested parties access to information on how to contact state agencies and provided misinformation on their rights to contact these agencies to file a complaint and/or grievance. Findings:</p> <p>Random observations of the facility on 11/16-17/15 revealed the contact number for Health Facilities Licensing and Certification department, Adult Protective Services, and the Medicaid Fraud unit were not posted.</p> <p>Review of the admission packet on 11/17-19/15, provided to residents and their families and/or Powers of Attorneys (POA) upon admission revealed it did not contain phone numbers for Health Facilities Licensing and Certification department, Adult Protective Services, and the</p>	F 156			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835	
(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 156	Continued From page 5 Medicaid Fraud unit. In addition, in the packet under the title "Complaint/Suggestion Process" revealed, "For issues that appear to be unresolvable by the facility, residents and families may contact the following State agency to voice their concerns." The Alaskan Ombudsman's contact information was then provided. The process did not provide the information the residents and/or families had the right to file a grievance with an advocacy agency first, should they choose to do so. During an interview on 11/17/15 at 10:00 am, when asked where the contact information was posted for Health Facilities Licensing and Certification department, Adult Protective Services, and the Medicaid Fraud unit, Activity Staff #1 stated it was supposed to be on the resident rights bulletin board in the back hallway of the long-term care unit. Visual confirmation with Activity Staff #1 confirmed the numbers were not posted.	F 156		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of	F 167		

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 167	Continued From page 6 their availability. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the facility failed to ensure the most recent complaint survey results were visible and accessible to all residents (based on census of 10) and/or interested parties. This failed practice denied them the right to information about the performance of the facility. Findings: Review of the Resident Council Meeting minutes, dated 2/11/15, revealed "...informed residents that over the last couple months SCH [Sitka Community Health] had both State and Federal surveyors conduct surveys...the results from the surveys and the SCH plan of corrections...can be found across from the [Long-term Care (LTC) Managers] office in the LTC hallway." Random observations on 11/16-17/15 revealed the Federal survey was located in a wooden bin on the bulletin board in the LTC hallway. The most recent complaint survey, completed 7/27-30/15, was not there. During an interview on 11/17/15 at 10:00 am, Activities Staff #1 confirmed the most recent survey wasn't in the bin.	F 167	F167 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: • The complaint survey from 7/27-30/15 was replaced on 11/19/15 when we realized that a family member took the survey with them. How other resident's having the potential to be affected by the same deficient practice will be identified: • Sitka Community Hospital LTC recognizes that all residents residing in our center could be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: • The bulletin board will be moved outside of the LTC Managers office. Until the board is moved, the LTC Manager will check on a weekly basis that the survey is in the box. How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place): • The Administrator will spot check that the most recent survey is located in the box.	Completed	
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 241 SS=D	<p>Continued From page 7 INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview and observation the facility failed to communicate with 1 resident (#4) of 4 sampled residents, during meal times using the resident's method of communication. This failed practice placed the resident at risk for isolation and loneliness and denied the resident the opportunity of a pleasant and dignified dining experience. Findings:</p> <p>Record review on 11/17-19/15 revealed Resident #4 was admitted to the facility on 4/25/14 and had diagnoses that included hemiplegia (weakness in 1 side of the body) following a stroke, hard of hearing, and aphasia (losing communication abilities).</p> <p>During a group meeting on 11/18/15 at 10:15 am, while using a dry erase board and marker to communicate, Resident #4 stated s/he could only communicate if staff used the dry erase board. During the interview the Resident stated that staff did not take the time to communicate with him/her.</p> <p>Review of the Resident's care plan, dated 10/2/15, revealed the Resident had the problem of "Compromised Understanding." interventions included "...write on white board and/or other</p>	F 241	<p>F241 What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • Resident #4 will have a communication device accessible to him at all times. The care plan will be updated to include this information. • An in-service on Communication will be performed by the LTC Manager. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> • Sitka Community Hospital LTC recognizes that all residents residing in our center could be affected. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> • Yearly Communication training will occur. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> • The LTC Manager will monitor that the care plan for Resident #4 is being followed. 	1/3/16	

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 241	Continued From page 8 large paper/large print. Observation during the morning meal on 11/19/15 from 7:30-9:00 am revealed Resident #4 sitting in the dining room. The Resident was sitting shaking his/her head in silence while the staff conversed with other residents and each other as they served meals to the residents. CNA #6 then set up Resident #4's breakfast in front of him in silence. The Resident's dining experience was without communication or interaction from direct care staff. During an interview on 11/19/15 at 7:50 am, when asked how they communicated with Resident #4, Activity Staff #1 stated the staff used the dry erase board, but it was in the Resident's room. The staff did not retrieve the Resident's dry erase board from the his/her room. As a result, no one communicated with the Resident during the dining experience. During an observation on 11/19/15 from 12:00 - 12:30 pm Resident #4 was in the dining room while being served the noon meal. The Resident did not have the dry erase board during the observation. While setting up the meal, the staff communicated with other residents, but did not converse with Resident #4.	F 241			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or	F 242			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835	
(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)	(X6) COMPLETION DATE
F 242	<p>Continued From page 9</p> <p>her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview the facility failed to allow 1 resident (#3), out of 3 sampled residents, the choice of when to get out of bed in the morning. This failed practice denied the resident the choice in his/her own schedule and placed the resident at risk for increased fatigue and psychological harm.</p> <p>Findings:</p> <p>Record review 11/16-19/16 revealed Resident #3 had diagnoses that included left-sided hemiplegia (weakness and/or immobility on one side of the body) following a stroke and fibromyalgia (a condition that causes chronic pain, fatigue and insomnia). Further review of the medical record revealed the Resident was dependent on staff for assistance with all activities of daily living.</p> <p>Review of the Resident's care plans revealed no information about the Resident's preferred time to get out of bed in the morning.</p> <p>During an observation on 11/17/15 at 7:00 am, Resident #3 was observed fully dressed and lying in the bed. Certified Nursing Assistants (CNA) #2 and #5 used a mechanical lift to transfer the Resident into his/her wheelchair. The Resident was then taken to the dining room for the breakfast meal which arrived at 8:00 am.</p>	F 242	<p>F242</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • An in-service on Resident Rights and Self Determination will be performed by the LTC Manager. • Update the care plan of Resident #3 to include preference of wake up time. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> • All Residents will be asked during regular rounding if their preferences are being met. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> • Yearly training will occur. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> • Regular rounding will occur by leadership in which one of the questions will be asking the Resident if all their preferences are being met or addressed. 	1/3/16

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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)	(X6) COMPLETION DATE	
F 242	<p>Continued From page 10</p> <p>During an observation on 11/17/15 at 8:50 am, Resident #3 was observed sitting in his/her wheelchair in the dining room. The Resident's eyes were closed and was resting his/her head in his/her right hand. During the observation CNA # 6 walked by and stated "How are you feeling [Resident #3], still sleepy?"</p> <p>After breakfast was finished, Resident #3 was pushed in a wheelchair to the activity room at 9:40 am. While the staff pushed the Resident to the room, both of the Resident's eyes were closed. At 9:45 am, Activity Staff #1 retrieved some pillows to position the Resident and began performing range of motion (exercising joints) to the Resident's left hand. During the observation Activity Staff #1 stated Resident #3 is sleepy, s/he "likes to sleep in the morning every day."</p> <p>During an interview on 11/18/15 at 6:50 am, CNA #4 stated the CNA that comes in at 6:00 am has to help get up Resident #3.</p> <p>During a group interview on 11/18/15 at 10:15 am when asked about the rules in the facility, Resident #3 stated it's was difficult to sleep here because "They tell me to get up in the morning." During the interview Resident #10 stated the residents have to eat at specific meal times or the their food is thrown away.</p> <p>During an interview on 11/19/15 at 8:00 am Resident #3 stated s/he had experienced some pain last night and hadn't slept well. The Resident added although s/he was tired s/he had to get up early this morning.</p>	F 242			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC	STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835
---	---

(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 242	Continued From page 11	F 242		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; 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 observation the facility failed to ensure a care plan for 1 resident (#3) out of 3 sampled was accurate: Specifically, a lack of 1) standardization in the ordered diets, and 2) consistency in medication administration. Failure to ensure the diet was standardized in the care plan placed the resident at risk of receiving an improper diet.</p>	F 279	<p>F279</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • An in-service on Medication Administration and Care Plans will be performed by the LTC Manager. • The LTC Manager will review and update the care plan for Resident #3. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> • The LTC Manager will review all care plans for accuracy and consistency. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> • Yearly training will occur. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> • The LTC Manager will monitor. 	1/3/16

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 279	<p>Continued From page 12</p> <p>Failure to ensure medications were given in a consistent manner placed the resident at risk for not receiving the medications and/or chocking. Findings:</p> <p>Record review on 11/16-18/15 revealed Resident #3 had diagnoses that included left-sided hemiplegia (weakness and/or immobility on one side of the body) following a stroke.</p> <p>Review of the most recent Minimum Data Set quarterly assessment, dated 9/10/15, revealed the Resident held food in the mouth/cheeks or had residual food in the mouth after meals. The assessment identified the Resident as being on a mechanically altered diet.</p> <p>Diet:</p> <p>Review of Resident #3's meal ticket during the am meal on 11/17/15 at 7:45 am revealed the Resident was on the "dysphagia [difficulty with swallowing] 2" diet.</p> <p>Review of the Resident's care plans revealed:</p> <ol style="list-style-type: none"> "Resident Care Plan LTC [long-term care]," dated 6/13/15, revealed the problem " Monitor Vital Parameters," the approach plan included "Provide prescribed diet-reg [regular] mechanical soft." "Sitka Community Hospital LTC Daily Care Plan," dated 6/9/15, revealed "Diet Ground." <p>During an interview on 11/16/15 at 3:15 pm, the Long-Term Care Manager stated there were problems with the care plans.</p>	F 279			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 279	<p>Continued From page 13</p> <p>During an interview on 11/18/15 at 12:30 pm, the Dietary Manager (DM) stated Resident #3 was on a Dysphagia 2 diet. The DM stated a mechanical soft was a different diet and was similar to a "slurry." When questioned about the Resident's dietary care plan not matching the current orders, the DM acknowledged a lapse in communication between the dietary and nursing departments because the facility no longer had a full time dietitian.</p> <p>Review of the American Dietetic Association guidelines at www.dysphagia-diet.com <http://www.dysphagia-diet.com> revealed a Dysphagia 2 diet is for mild to moderate and/or pharyngeal dysphagia. This diet consists of foods that are moist, soft-textured and easily formed into a bolus. All foods on Level 1 are allowed. Meats and other select foods may be ground or minced into small pieces no larger than ¼ inch. All food items should be easy to chew.</p> <p>According to "Basic Nursing" 5th edition, a mechanical soft diet has ground meat and soft textured foods.</p> <p>The National Dysphagia Diet was designed to establish shared terminology and practice applications in dietary texture management.</p> <p>Medications:</p> <p>Review of the physician's orders revealed there were no instructions on how to give Resident #3's oral medications. The Resident was known to hold/pocket food in his/her mouth following meals.</p> <p>During an observation on 11/18/15 at 10:15 am</p>	F 279			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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)	(X6) COMPLETION DATE	
F 279	Continued From page 14 Licensed Nurse (LN) #1 entered the activity room and administered oral medications to Resident #3. The medications were whole and the larger Augmentin (antibiotic) was broken in half for ease of swallowing. During a second medication administration observation on 11/19/15 at 8:00 am, LN #7 opened the pill capsules and crushed Resident #3's medications and put them in pudding for the Resident to consume. During an interview on 11/19/15 at 8:00 am, when asked about administering the medications, LN #7 replied "We crush [his/her] meds; if we give them whole [Resident #3] swirls them around in [his/her] mouth and pockets them [holds in the mouth]." When asked how nurses were to know what the instructions were, the LN replied it is passed along during shift report or already known by staff from experience in working with the Resident.	F 279			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835	
(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 309	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview the facility failed to ensure 1 resident's (#3), of 3 sampled residents, acute pain was managed to prevent pain and promote comfort, failed to: 1) ensure the care plan reflected treatment for an acute pain episode and provide nursing staff guidance on how to provide preventative pain management, 2) ensure pain identified by the resident was assessed and treated, and 3) ensure there was communication with another facility to promote coordination of care and pain management. These failed practices caused the resident actual harm from acute pain and discomfort following a tooth extraction. Findings:</p> <p>Record review on 11/17-19/15 revealed Resident #3 was admitted to the facility with diagnoses that included chronic pain, arthritis, fibromyalgia (a condition that can cause chronic pain, headaches, insomnia, and fatigue). In addition, the Resident had an acute dental abscess (infection) that required treatment with antibiotics.</p> <p>The Resident's medication regime included oxycodone IR (immediate release) 5 mg 4 times a day; Effexor XR (extended release) 37.5 mg 2 times a day; oxycodone IR 5 mg PRN (as needed) every 4 hours; Baclofen 5 mg as needed every 8 hours; and Tylenol 650 mg as needed every 4 hours.</p> <p>Review of the Resident #3's separate care plans revealed the problem musculoskeletal pain related to chronic pain. The goal was "Have controlled pain at an acceptable level" with</p>	F 309	<p>F309</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • In-services on 24 Hour Report, Outside Medical Procedures Documentation, Pain in the Elderly and Pain Management will be performed by the LTC Manager. • The LTC Manager will implement a pain documentation flow sheet. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> • Sitka Community Hospital LTC recognizes that all residents residing in our center could be affected. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> • Yearly training will occur. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> • The LTC Manager will monitor nursing system. 	1/3/16

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 309	<p>Continued From page 16</p> <p>nursing interventions that included, "Administer pain medications per orders-note relief; position for comfort."</p> <p>Review of the computerized care plan, dated 10/2/15, revealed the outcome "Activity Intolerance...knowledge...medication...pain control...reduced pain."</p> <p>Further review of the computerized care plan revealed interventions included "assess for behavioral and psychological indicators of pain...discharge planning...guided imagery...heat/cold application...maintain quiet environment ...positioning...range of motion...relaxation exercises...simple relaxation therapy ...teaching: individual ...teaching: prescribed medication."</p> <p>During an observation on 11/18/15 at 6:40 am, Licensed Nurse (LN) #5 reminded the Resident of a dental appointment that morning.</p> <p>Review of the medical record revealed the Resident had a scheduled tooth extraction at the dental clinic on the morning of 11/18/15.</p> <p>During an observation on 11/18/15 the Resident returned from the dental appointment at 9:45 am.</p> <p>During an observation on 11/18/15 at 10:15 am, LN #1 entered the room to give the Resident regularly scheduled medications. During the interaction, the LN told the Resident "let me know when your mouth starts hurting so I can give you some pain medications." The Resident stated at that time his/her mouth was still numb.</p> <p>Observation on 11/18/15 at 4:00 pm, LN #1</p>	F 309			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 309	<p>Continued From page 17</p> <p>entered the resident dining room and told CNA #s 1, 6 and 7 that Resident #3 was in pain but could not have his/her pain medications yet because it was "too early" and s/he was trying to get the Resident back on schedule.</p> <p>Observation on 11/18/15 at 4:45 pm, crying was heard outside Resident #3's bedroom door. Upon entering, Resident #3 was observed in bed. CNA #1 and #6 were preparing to assist the Resident out of bed. The Resident was crying out, visibly tearing, red-faced, and holding the side of his/her right jaw in hand. The Resident confirmed s/he was having dental pain. During the observation, CNA #6 stated "S/he's hurting; the hot packs don't work."</p> <p>During an interview on 11/18/15 at 4:55 pm, when asked about Resident #3's post-dental procedure pain management, LN #1 stated the Resident had just had his/her routine dose of oxycodone at 4:30 pm. The LN stated s/he had been trying to space it out because Resident #3 was off schedule. When questioned about the PRN (as needed) medication available, the LN stated "I can't give 10mg of oxycodone; I could give her PRN [as needed] Tylenol."</p> <p>When asked about what the post procedure instructions were regarding dental surgery, LN #1 stated they had received a verbal report from the transport aide Activity Staff #2 and the dental clinic had not sent over any post discharge instructions. When asked how staff knew what interventions to follow when treating a Resident following a tooth extraction, the LN stated they were expected to go back to the regular schedule (for pain management).</p>	F 309			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 309	<p>Continued From page 18</p> <p>Further review of the medical record revealed no information about the type of or level of pain the Resident had been experiencing until 8:15 pm that night, more than 4 hours later. At 8:15 pm, Resident #3 identified the pain was a 6/10 (moderate to severe pain on a verbal pain scale with 10 being excruciating).</p> <p>Review of the medication administration record on 11/18/15 at 5:00 pm, revealed Resident #3 did not receive any PRN Tylenol or PRN oxycodone for pain relief.</p> <p>Review of the nurse's note for 11/18/15 at 6:00 pm revealed, "Repetitive Health Complaints, Repetitive anxious complaints/concerns." Under "comments" Resident had tooth extraction and fillings this AM. Had several episodes of tearfulness and wanting to call her daughter (daughter [name], visited at lunch aware of dental procedure). Frequent requests for pain medication and to 'Call SEARHC [dental clinic].' Frequent reminders about where she was this AM. Will continue to reassure, educate, and active listening."</p> <p>During an interview on 11/19/15 at 8:20 am when asked about documenting pain before and after a PRN (as needed) medication intervention, LN #7 stated the pain would have to be documented in the general notes because there was no place to document reassessment after PRN medication in the Medication Administration Record (MAR). When asked about the communication from the dental clinic, LN #7 stated the residents used to come back from procedures and appointments with a communication slip that informed staff what the follow up should be.</p>	F 309			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 309	<p>Continued From page 19</p> <p>There was no medical information in the record that provided information to what dental procedure had been performed and which tooth/teeth had been extracted.</p> <p>During an interview on 11/19/15 at 12:00 pm, Activity Staff #2 confirmed s/he had accompanied Resident #3 to the dental appointment on 11/18/15. The Activity Staff stated the dental clinic had not sent post procedure information and instructions post tooth extraction on 11/18/15. The Activity Staff stated they had called the dental clinic and they were supposed to email something over to him/her.</p> <p>During an interview on 11/19/15 at 12:30 pm, when asked what procedure the Resident had done the Long Term Care (LTC) manager stated the Resident had multiple fillings at the gum line of the lower jaw and a tooth extraction on the lower right side. When questioned about the communication between the facility and the dental clinic the LTC Manager stated information should have been communicated to the nurse yesterday.</p> <p>During an observation on 11/19/15 at 3:30 pm, Activity Staff #1 entered Resident #3's room and stated s/he had gotten some more ice for the Resident's tooth pain. At that point LN #7 entered the room and stated that was wrong, the ice was only supposed to be for the first 24 hours, then it was supposed to be warm packs to the affected area.</p> <p>Review of Resident #3's prior dental appointment note from the dentist following a tooth extraction on 10/16/15, revealed "Ice pack to (R) and (L) [right and left] side of face for first 12 hours. 20</p>	F 309			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 208 MOLLER AVENUE SITKA, AK 99835		
(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 309	Continued From page 20 minutes/ 1 hour. Recommend to increase oxycodone if needed for post-op pain. No straws for 5 days." Review of the "Core Principles of Pain Management, accessed at www.geritaricpain.org < http://www.geritaricpain.org > on 11/23/15 revealed "Every older adult deserves adequate pain management. Certain populations, including racial minorities, people with limited ability to communicate, older adults, and people with past or current substance abuse, are at higher risk for inadequate pain management ...Evaluate the effectiveness of all therapies to ensure that they are meeting the resident's goals. Achievement of an effective treatment plan requires therapy to be individualized for each older adult, often requiring adjustments in drug, dosage, or route. Consistent reassessment is critical to good outcomes."	F 309			
F 323 SS=D	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			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835	
(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 323	<p>Continued From page 21</p> <p>Based on observation, interview and document review the facility failed to ensure a WanderGuard system was monitored according to manufacturer's specifications. This failed practice placed 1 resident (#6) out of 10 residents using the WanderGuard system at risk for elopement, injury or death. Findings:</p> <p>Random observation from 11/16-19/15 revealed each exit of the long term care unit was monitored by WanderGuard door modules.</p> <p>Observation on 11/17/15 at 9:00 am revealed Resident #1 was wearing a WanderGuard device.</p> <p>During an interview on 11/17/15 at 5:30 am Licensed Nurse (LN) #6 stated Resident #1 was wanting to leaving the facility.</p> <p>During an interview on 11/18/15 at 1:00 pm the Biomed Tech stated the facility reviewed the system every six months.</p> <p>According to the WanderGuard manufacturer's instructions provided by the facility, copyright dated 2002, stated "Door modules must be tested at least weekly on each shift... Failure to do so could result in injury or death to a person in your care."</p>	F 323	<p>F323</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • Per manufacturer's suggestion, testing will be performed by the appropriate nursing shift staff in the following manner: <ul style="list-style-type: none"> o Signaling (bracelets) devices will be tested daily per shift • Per manufacturer's suggestion, testing will be performed by the Maintenance Department in the following manner: <ul style="list-style-type: none"> o Door modules will be tested weekly per shift. • Training will be given by Nursing to the appropriate nursing shift staff <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> • Sitka Community Hospital LTC recognizes that all residents residing in our center could be affected. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> • Documentation will be checked on a weekly basis to ensure compliance. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> • The LTC Manager will track and trend this system for the bracelets, and the Maintenance Department will track the door modules. 	1/3/16
F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any</p>	F 329		

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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)	(X6) COMPLETION DATE	
F 329	<p>Continued From page 22</p> <p>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to ensure medications had an adequate indication for use for 1 resident (#1), of three sampled residents whose records were reviewed. This failed practice placed the resident at risk for receiving unnecessary medication.</p> <p>Medical record review from 11/16-19/15 revealed Resident #1 was prescribed the medication venlafaxine (Effexor, a medication commonly prescribed for treatment of depression). Further review of the electronic medical record (EMR)</p>	F 329	<p>F329</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • The MD was contacted regarding Resident #1. • The LTC Manager will meet with all providers to educate them on the need for a diagnosis for all medications. • The LTC Manager will determine with the EMR team if we can program a way for all new orders to require a diagnosis in order to be processed. • Nursing will be in-serviced to obtain a diagnosis for any and all new prescriptions via telephone or verbal order. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> • The LTC Manager will audit charts to make sure that all prescriptions have a corresponding diagnosis. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> • Yearly training will occur. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> • The LTC Manager will perform an end of month drug review to make sure that all new medication orders have a diagnosis. 	1/3/16	

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 329	Continued From page 23 and paper record revealed no indication for use of Effexor. During an interview on 11/18/15 at 10:40 am, the Long Term Care (LTC) Manager was asked to provide the original order for Effexor, as well as, the documented indication for use. The LTC Manager stated the original order and indication for use could not be found. During an interview on the morning of 11/19/15, Licensed Nurse (LN) #7 was asked why Resident #1 was taking Effexor. The LN searched in the EMR and could not find the indication for use of the medication.	F 329			
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to ensure hot food served to residents was maintained at appropriate temperature. This failed practice had the potential to affect 9 out of 10 residents receiving food from the kitchen and placed the residents at risk for diminished oral	F 364			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 364	<p>Continued From page 24</p> <p>Intake due to unpalatable food temperatures. Findings:</p> <p>During a group interview on 11/18/15 at 10:15 am Resident #4 stated the food was too cold.</p> <p>During an observation on 11/19/15 at 12:00 pm Dietary Staff delivered the lunch trays to the long-term care (LTC) dining room. The cart contained a test tray that had been requested by the surveyor prior to meal service. The tray contained pork roast, noodles and cabbage, dilled green peas, fresh fruit cup, a carton of 2% milk, a cup of coffee, and a slice of bread, the same meal served to the residents. The nursing staff immediately began serving lunch to the residents seated in the dining room and to the rooms. When the last tray was delivered at 12:20 pm (20 minutes after the trays had been sent from the kitchen), the surveyors removed the test tray from the metal cart and checked the food temperatures. The thermometer used to check the food had been provided by the Dietary Manager (DM). The pork roast, noodles and cabbage, and dilled green peas were on a covered insulated plate; the temperature of the pork roast was 90° Fahrenheit (F), the noodles and cabbage was 98° F and the dilled green peas was 90° F, cooler than body temperature. When the Surveyor tasted the food it was lukewarm.</p> <p>During an interview on 11/19/15 at 1:30 pm, when asked about the food temperatures, the DM confirmed kitchen staff had difficulty maintaining palatable food temperatures during food service on the unit due to the kitchen set up despite heating up the plates.</p>	F 364	<p>F364 What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> Renovation and upgrade of kitchen facilities including installation of tray line with integrated steam table projected for July 15, 2016. Pending this completion, food services staff will continue to ensure the shortest possible time between preparation of trays and transfer to food cart. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> Sitka Community Hospital LTC recognizes that all residents residing in our center could be affected. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> The completion of the new tray line will resolve the issue of maintaining optimal food service temperatures. Food temperatures will be tested weekly just prior to transfer to food cart. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> Food temperatures will be tested weekly just prior to transfer to food cart. 	1/3/16 for minimization of tray service time; 7/15/16 for completion of new tray line.	

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835	
(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 364	Continued From page 25	F 364		
F 368 SS=E	<p>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure bedtime snacks were offered to all residents receiving food from the kitchen. This failed practice affected 3 residents (#s 3, 4 and non-sampled resident #10) out of 9 residents receiving food from the facility and placed residents at risk for undernourishment. Findings:</p> <p>During a group interview on 11/18/15 at 10:15 am Resident #s 3, 4, 10 stated they were not offered bedtime snacks at night. Resident #10 stated</p>	F 368	<p>F368</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • Food Services will add that a bedtime snack is provided by the facility to all Residents in the meal time policy. • The LTC Manager will provide an in-service on the passing and documentation requirements for snacks. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> • Sitka Community Hospital LTC recognizes that all residents residing in our center could be affected. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> • Yearly training will occur. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> • The LTC Manager will monitor that all documentation is complete. 	1/3/16

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 368	Continued From page 26 they could receive a snack, but had to ask for one. Review on 11/18/15 of the snack label stickers (used to mark the afternoon and bedtime snacks sent to the nursing unit) provided by the Dietary Manager (DM) revealed Resident #s 3, 4 and 10 were not on the list to receive bedtime snacks. During an interview on 11/18/15 at 12:30 pm, the DM stated only the Resident's with orders from the Dietician regularly received bedtime snacks. During an interview on 11/18/15 at 4:00 pm, Certified Nursing Assistant (CNA) #1 stated only some of the residents received ordered snacks. The other residents had to request the snacks. Review of "Admission Information" (provided to the residents upon admission to the Long Term Care) on 11/18/15 revealed "Meals...upon appropriate orientation to the kitchen facilities, residents are allowed to prepare their own snacks..." The information listed the meal times as 8:00 am, 12:00 pm and 6:00 pm, there was no other information about the provision of bedtime snacks being provided by the facility.	F 368			
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 431	<p>Continued From page 27</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: F431</p> <p>Based on observation, record review and interview the facility failed to ensure: 1) the temperature of refrigerators storing vaccines were monitored appropriately; and 2) narcotic packaging integrity. These failed practices placed</p>	F 431	<p>F431</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> The Pharmacy Staff will monitor the refrigeration temperatures daily. The LTC Manager will give an in-service on Medication Passes, Narcotics Handling and Reconciliation. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> Sitka Community Hospital LTC recognizes that all residents residing in our center could be affected. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Yearly training will occur. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> Pharmacy will provide monthly documentation of daily checks to the LTC Manager. 	1/3/16	

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 431	<p>Continued From page 28</p> <p>all residents at risk (census of 10) of receiving improperly stored medications and vaccines. In addition, this created a risk for compromised medication stability and narcotic diversion.</p> <p>Vaccine Refrigerator:</p> <p>Observation of the pharmacy room on 11/18/15 at 8:30 am revealed a refrigerator containing vaccines.</p> <p>Record review on 11/18/15 at 8:31 am of temperature monitoring logs, dated 1/1/15 to 11/15/15 revealed the facility was monitoring temperatures once a day. Additional review revealed 134 days out of the 319 days reviewed revealed no documentation of temperature monitoring.</p> <p>During an interview on 11/18/15 at 8:45 am the Pharmacist confirmed the refrigerator contained vaccines. In addition, the Pharmacist confirmed monitoring and documenting temperatures had not been occurring each day.</p> <p>Narcotic Bubble Packs:</p> <p>Observation on 11/17/15 at 10:25 am of the medication supply room narcotic cabinet, located in the long term care unit, revealed narcotic bubble packages that were perforated and taped over. The perforated packages included:</p> <ul style="list-style-type: none"> - Hydrocodone 5/325 mg (milligram) tabs, 1 compromised bubble that was taped over. - Lorazepam 1 mg tabs, 9 compromised bubbles, 3 of which were taped over. - Lorazepam 1 mg tabs, 3 compromised bubbles, 2 of which were taped over. 	F 431			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 431	Continued From page 29	F 431			
F 441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their</p>	F 441	<p>F441 What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • Mandatory Infection Control in-servicing will be held for all applicable staff to include Hand Hygiene, Wound Care, Safe Food Handling, and Appropriate Isolation Precautions. • The IC Nurse will perform assessments as well as tracking and trending of infections. She will also implement an infection control program that includes on-going training and education. • The IC Policy and Procedure Manual will be reviewed and signed by the Chief Nursing Officer. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> • The LTC Manager will perform chart audits regarding isolation precautions. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> • This training will be completed on a yearly basis. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> • The LTC Manager will add hand washing and isolation precautions tracking to her quality program. The IC Nurse will provide on-going tracking and trending of infections to report at the infection control meetings. 	1/3/16	

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 441	<p>Continued From page 30</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to operationalize an effective infection control program. Specifically, the facility failed to: 1) perform and monitor appropriate hand hygiene; 2) perform appropriate isolation precaution technique; 3) monitor, assess and re-assess need for isolation precautions; 4) provide evidence of training and education of ongoing infection prevention; and 5) Provide evidence of ongoing tracking/trending of past and present infections. These failed practices placed all residents (census of 10) at risk for infection and/or illness. Findings:</p> <p>1) Perform appropriate hand hygiene, monitor effectiveness:</p> <p>During an observation on 11/17/15 at 7:00 am, Certified Nursing Assistant (CNA) #s 2 and 3 were observed wearing disposable gloves while assisting Resident #3 with a transfer out of the bed. After which, CNA #3 pushed the Resident to the dining room in the Resident's wheel chair still wearing the gloves on both hands. The CNA then removed both gloves and tossed them in the</p>	F 441			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 441	<p>Continued From page 31</p> <p>trash located in the hall way outside the nurses' station. Without preforming hand hygiene, CNA #3 entered Resident #7's room and donned a new pair of gloves.</p> <p>During an observation on 11/17/15 at 11:45 am CNA #s 1 and 2 assisted Resident #1 from the wheel chair to the bed using a mechanical lift. While wearing gloves CNA #2 removed the Resident's soiled disposable breif. The CNA then washed the Resident's peri area with soap and water. CNA #2 then removed the gloves and donned a new pair without preforming hand hygiene. The CNA then applied powder under the Resident's breasts and positioned the Resident on his/her side with pillows. The CNA then turned on the wall oxygen and put the nasal cannula on the Resident's face and repositioned the call light.</p> <p>During an observation on 11/18/15 at 5:40 am, Licensed Nurse (LN) #5 retrieved an apple from the refrigerator without preforming hand hygiene or washing the apple, began to use both hands (ungloved) to cut the apple up. The LN cut through the sticker on the apple, leaving it on the skin, placed the apple on a plate, and served it to Resident #6.</p> <p>During an interview on 11/18/15 at 12:30 pm the Dietary Manager stated the nursing staff had not received any education on handling ready to eat food.</p> <p>During an observation on 11/18/15 at 6:15 am CNA #s 4 and 5 assisted Resident #3 with morning care. CNA #5, with hands gloved, washed the Resident's peri area. Then, CNA #4, with gloved hands, washed the Resident's buttocks. CNA #4 then removed the soiled gloves</p>	F 441			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 441	<p>Continued From page 32</p> <p>from both hands and donned another pair of gloves pulled from his/her scrub pocket without performing hand hygiene. CNA #5 with same soiled gloves used his/her fingers to scoop some protective barrier cream out of a jar and applied the cream to the Resident's buttocks. The CNA then removed the soiled gloves and donned a new pair without performing hand hygiene. Both CNAs then assisted the resident with putting on a disposable brief, dressing and transferring out of bed using a mechanical lift.</p> <p>During observation of wound care for Resident #1 on 11/18/15 at 9:10 am, LN #1 performed a dressing change to a wound located on the Resident's buttocks. After removing the soiled dressing, cleansing the wound, and applying a new dressing the LN proceeded to position the call light, pillows, and put the Resident's nasal cannula for oxygen on the Resident's face while wearing the same soiled gloves.</p> <p>Record review on 11/19/15 of the "Guidelines for Isolation Precautions" policy provided by the facility revealed, "Hand hygiene is performed before entry and at exit from the room... Decontaminate hands in the following clinical situations, whether or not gloves are being worn:... When moving hands from a contaminated-body site to a clean-body site; After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient;... After removing gloves."</p> <p>2 & 3) Perform appropriate isolation precaution technique; monitor, assess and re-assess need for isolation precautions:</p> <p>Resident #6</p>	F 441			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 441	<p>Continued From page 33</p> <p>During an observation on 11/17/15 at 9:30 am LN #6 stopped at an isolation cart located outside Resident #6's room. The LN donned disposable gloves and put on a mask. When questioned about the precautions the LN replied the Resident was on contact precautions. The LN further stated, but you only have to wear gloves and gown when caring for the Resident's wound.</p> <p>Review of Resident #6's care plan revealed no information about contact precautions for infections. Further review of the medical record revealed no physician orders and/or positive cultures that would indicate a need for contact precautions.</p> <p>Resident #9</p> <p>During a medication pass observation on 11/18/15 at 9:00 am LN #1 prepared to give Resident #9 a nebulizing treatment. During the observation the LN stopped at the isolation cart outside the Resident's door and donned gloves, gown, and mask. When questioned what isolation precautions the Resident was on the LN replied the Resident is on droplet precautions because s/he had MRSA (Methocillin Resistant Stapholoculous Aurous- an antibiotic resistant bacterial strain) in the sputum. Observation of the sign located on the wall outside the Resident's door stated "Contact Precautions."</p> <p>Review of Resident #9's medical record revealed no orders for isolation and/or positive culture. In addition the Resident's care plan did not address the need for isolation precautions. The Long Term Care (LTC) Manager was unable to provide supportive documentation concerning the</p>	F 441			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 441	<p>Continued From page 34</p> <p>residents care plan or isolation precautions upon request.</p> <p>During an interview on 11/19/15 at 11:05 am, the LTC Manager was asked for a copy of the orders that placed Resident #s 6 and 7 on isolation. The LTC Manager was unable to provide the requested isolation orders.</p> <p>Record review on 11/19/15 of the "Guidelines for Isolation Precautions" policy provided by the facility revealed, "It is the responsibility of the charge nurse to obtain the order from the physician after placing the patient on isolation precautions other than Standard Precautions... Healthcare personnel will select appropriate Personal Protective Equipment (PPE) and use appropriate isolation techniques when caring for potentially infectious patients... The Infection Control Coordinator is responsible for periodically evaluation adherence to policy and compliance with the use of Personal Protective Equipment (PPE), using findings to direct improvements... The Infection Control Coordinator will monitor laboratory and clinical findings and serve as a resource person for guidance in caring for infectious patients... An isolation sign corresponding to the appropriate level of precautions will be placed on the room door... The isolation status is documented on the Inpatient Nursing Unit Plan of Care card (Kardex)."</p> <p>4 & 5) Provide evidence of training and education of ongoing infection prevention; Provide evidence of ongoing tracking and/trending of past and present infections:</p> <p>During an interview on 11/19/15 at 9:00 am, the</p>	F 441			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 441	<p>Continued From page 35</p> <p>Interim Infection (IC) Control Coordinator did not have documented evidence to demonstrate the facility's compliance in investigating and preventing infections within long term care. During the interview the surveyors requested documentation specific to the tracking, trending and record keeping of incidents and corrective actions related to infections on the long term care unit. Interim IC coordinator, accompanied by several members of the IC committee, were unable to provide requested documentation.</p> <p>Record review on 11/19/15 of the IC policy and procedure binder provided by the Interim IC Coordinator revealed the functions of the Infection Control Committee include: "To establish and implement a surveillance system for evaluation and reporting infections in patients/residents, discharged patients and hospital personnel... To review information collected from quality assurance activities, directing change to policies, procedures, and practices as indicated by the data..."</p> <p>Review of the IC policies and procedures under the section titled "Surveillance" revealed, "The Infection Control Coordinator will maintain a system of surveillance for identifying, reporting and evaluating the following epidemiologic significant infections... Multidrug-resistant organisms (MDROs);... Urinary tract infections associated with indwelling catheters"</p> <p>Review of the IC policies and procedures under the section titled "Prevention and Control" revealed, "...The Infection Control Coordinator... provides infection control surveillance by investigating, collecting, recording, and reporting infection control data;... Provides appropriate</p>	F 441			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP-CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 441	Continued From page 36 in-service education related to Infection control issues;... Monitors Hospital Acquired Infections..." Review of the IC policies and procedures under the section titled "Hospital Acquired Infection Surveillance" revealed, "The Infection Control Coordinator will develop a plan for surveillance, evaluation, and maintenance of records of Hospital Acquired Infections. The Infection Control Coordinator will collect and analyze the data and will report the findings to the Infection Control Committee as well as the Quality Control Committee." Record review on 11/19/15 at 12:00 pm of the "Infection Control and Employee Health" and the "Policy Manual Staff Review Certification" annual review signature forms revealed the last time the Infection control policies and procedures had been reviewed was 3/19/14 and 8/4/13 respectively. According to the signature forms, the last time the IC policies and procedures were reviewed was approximately 20 months from the date of present survey. Review of the IC policies and procedures under the section titled "Policy and Procedure Manual" revealed, "All policies and procedures will be reviewed annually by the Infection Control Committee..."	F 441			
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential	F 456			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 456	<p>Continued From page 37 mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview the facility failed to ensure a resident transfer device was in good working condition. This failed practice placed all residents (based on a census of 10) at risk for injury. Findings:</p> <p>Record review from 11/17-19/15 revealed Resident #1 was dependent on staff for transfers and required a mechanical lift to get in and out of the bed.</p> <p>During an observation on 11/17/15 at 1:49 pm, CNA #s 1 and 2 transferred Resident #1 from the chair to the bed using the electronic "Maxi Move" lift (ID# 2308). When the Resident was raised in the air, the lift emitted a squealing sound, the lift continued to squeal while the Resident was lowered to the bed at which point CNA #1 replied "It's been doing that a long time."</p> <p>During an interview on 11/19/15 at 11:34 am the Biomed Tech examined the "Maxi Move" lift (ID# 2308) and stated the device was not supposed to make that noise and the staff should have completed a maintenance report. In addition, the Biomed Tech confirmed he had not received a maintenance report for the "Maxi Move" lift (ID# 2308).</p> <p>During an interview on 11/19/15 at 11:34 am the Engineering Coordinator stated the staff needed further education on how to report items needing</p>	F 456	<p>F456 What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • In March and April of 2015, work requests were submitted by staff for the lift making a squeaking noise. • All of our lifts were serviced by Arjo in June of 2015 and determined to be safe, despite the noise. • Biomedical services also re-inspected the lift 11/23/15 and determined it to be safely functioning. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> • Sitka Community Hospital LTC recognizes that all residents residing in our center could be affected. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> • The lift is on a yearly preventive maintenance schedule. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> • Staff get yearly instruction on submitting maintenance requests. 	Completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 456	Continued From page 38 repair.	F 456			
F 514 SS=F	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to maintain complete, organized and accessible clinical records for all residents (census of 10). Specifically, the facility failed to ensure: 1) documentation of the risk and benefits to psychoactive medication use was in the residents' medical record; 2) the electronic medical record (EMR) was complete, organized and readily accessible; and 3) continuity among three different care plans utilized. Incomplete, unorganized and inaccessible medical records</p>	F 514	<p>F514 What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • The LTC Manager will implement an improved documentation system, going back to a mostly paper chart. • Resident #1, #2, and #3 and/or their Power of Attorneys were contacted 11/17/15 by the LTC Manager. • The informed consent documents for the risk and benefits of taking psychoactive medications were completed. • An in-service on Care Plans and Appropriate Isolation Precautions. will be performed by the LTC Manager. • The LTC Manager will review and update the care plan for Resident #3 regarding diet. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> • All existing residents receiving psychotropic medications will have a signed consent form. • The LTC Manager will review all care plans for accuracy and consistency. • The IC Nurse will perform chart audits regarding isolation precautions. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> • Yearly training will occur. • All new admits who are receiving psychotropic medications will have a signed consent form. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> • The LTC Manager will monitor all consent forms and make sure they are placed in the chart as well as the "Nursing Assessments and Consents" notebook located at the nursing station. • The LTC Manager will track and trend all care plans, make sure they are up to date and make sure they are personalized and goal oriented. • The LTC Manager will add isolation precautions tracking to her quality program. 	1/3/16	

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 514	<p>Continued From page 39</p> <p>places the residents at risk for numerous inconsistencies in the care provided by all staff. Findings:</p> <p>During an interview on 11/16/15 at 11:50 am the Director of Nursing (DON) and Administrator stated the facility was going through a transition with their electronic medical records and expressed concerns that it is not user friendly for the purposes of long term care resident charting and record keeping.</p> <p>1) Documentation of risk and benefits:</p> <p>Record review on 11/17/15 of the current medication administration record and current orders revealed Resident #s 1, 2 and 3 were prescribed scheduled and/or as needed psychoactive medications.</p> <ul style="list-style-type: none"> - Resident #1 was taking the medication venlafaxine (Effexor), a medication commonly prescribed for depression. - Resident #2 was taking the medication escitalopram (Lexapro), a medication commonly prescribed for depression. Resident #2 was also prescribed clonazepam (Klonopin), a medication commonly prescribed for seizures, panic disorder, and anxiety. - Resident #3 was taking the medication venlafaxine (Effexor), a medication commonly prescribed for depression. Resident #3 was also prescribed lorazepam (Ativan), a medication commonly prescribed for anxiety. <p>During an interview on 11/17/15 at 1:30 pm, the Long Term Care (LTC) Manager was asked to</p>	F 514			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 514	<p>Continued From page 40</p> <p>provide documentation of the facility's communication with Residents #s 1, 2 and 3 on the risk and benefits of taking psychoactive medications. The LTC Manager informed the surveyors the facility did not have documentation that they reviewed the risk and benefits of taking psychoactive medication with Resident #s 1, 2 and 3 and/or their respective POAs.</p> <p>EMR complete, organized and readily accessible:</p> <p>Medical record review from 11/16-19/15 revealed Resident #1 was prescribed the medication venlafaxine (Effexor, a medication commonly prescribed for treatment of depression). Further review of the electronic medical record (EMR) and paper record revealed no indication for use of Effexor.</p> <p>During an interview on 11/18/15 at 10:40 am, the LTC Manager was asked to provide the original order for Effexor, as well as, the documented indication for use. The LTC Manager stated the original order and indication for use could not be found.</p> <p>During an interview on the morning of 11/19/15, Licensed Nurse (LN) #7 was asked why Resident #1 was taking Effexor. The LN searched in the EMR and could not find the indication for use of the medication.</p> <p>During an interview on 11/19/15 at 11:05 am, the LTC Manager was asked for a copy of the orders that placed Resident #6 and #7 on isolation. The LTC Manager was unable to provide the requested isolation orders.</p> <p>Review of Resident #9's medical record revealed</p>	F 514			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 514	<p>Continued From page 41</p> <p>no orders for isolation and/or positive culture. In addition the Resident's care plan did not address the need for isolation precautions. The LTC Manager was unable to provide supportive documentation concerning the residents care plan or isolation precautions upon request.</p> <p>While onsite from 11/16-19/15 surveyors requested documentation that was often challenging for the facility's floor staff and management to locate. The staff were unsure of the location of documents, and they were observed searching through paper and electronic medical records. An EMR trainer was required for the location of numerous documents requested. The LTC Manager, DON, and Administrator all acknowledged deficits in the current charting and medical records system for the long term care unit.</p> <p>2) Continuity among care plans:</p> <p>Record review from 11/16-19/15 revealed the facility used 3 different forms of care planning: 1) the EMR care plan; 2) the comprehensive paper care plan; and 3) the daily certified nurse assistant (CNA) care plan.</p> <p>Review of Resident #3's meal ticket during the am meal on 11/17/15 at 7:45 am revealed the Resident was on the "dysphagia [difficulty with swallowing] 2" diet.</p> <p>Review of the Resident's care plans revealed:</p> <p>1. "Resident Care Plan LTC [long-term care]," dated 6/13/15, revealed the problem "Monitor Vital Parameters," the approach plan included "Provide prescribed diet-reg [regular] mechanical</p>	F 514			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC		STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 514	<p>Continued From page 42 soft.</p> <p>2. "Sitka Community Hospital LTC Daily Care Plan," dated 6/9/15, revealed "Diet Ground."</p> <p>During an interview on 11/16/15 at 3:15 pm, the Long-Term Care (LTC) Manager stated there were problems with the care plans.</p> <p>During an interview on 11/18/15 at 12:30 pm, the Dietary Manager (DM) stated Resident #3 was on a Dysphagia 2 diet. The DM stated a mechanical soft was a different diet and was similar to a "slurry." When questioned about the Resident's dietary care plan not matching the current orders, the DM acknowledged a lapse in the communication between the dietary and nursing departments because the facility no longer had a full time dietitian.</p> <p>Review of the American Dietetic Association guidelines at www.dysphagia-diet.com <http://www.dysphagia-diet.com> revealed a Dysphagia 2 diet is for mild to moderate and/or pharyngeal dysphagia. This diet consists of foods that are moist, soft-textured and easily formed into a bolus. All foods on Level 1 are allowed. Meats and other select foods may be ground or minced into small pieces no larger than ¼ inch. All food items should be easy to chew.</p> <p>According to "Basic Nursing" 6th edition, a mechanical soft diet has ground meat and soft textured foods.</p> <p>The National Dysphagia Diet was designed to establish shared terminology and practice applications in dietary texture management.</p>	F 514		

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC	STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835
--	---

(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 514	Continued From page 43	F 514		
F 518 SS=F	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview the facility failed to ensure staff were educated on the use of stair chair evacuation equipment. This failed practice placed all residents (based on a census of 10) at risk of delayed evacuation from the facility during an emergency situation. Findings:</p> <p>Random observations of the exit stairwell from 11/16-18/15 revealed two evacuation stair chairs.</p> <p>During an interview on 11/18/15 at 12:10 am the Long Term Care Manager stated the facility did provide a stair chair training.</p> <p>During multiple interviews on 11/18/15 from 2:56 pm to 4:45 pm Licensed Nurse #s 1, 2, 3 and 4 stated they did not receive training on how to use the stair chairs.</p>	F 518	<p>F518</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> Evacuation training for all stair chairs and evacuation sleds will be provided. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> Sitka Community Hospital LTC recognizes that all residents residing in our center could be affected. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> This training will be included in the yearly employee training. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> Actions will be monitored through yearly (per shift) fire drills with partial evacuations to adjacent smoke barriers, and during any emergency drills or exercises that need to address evacuations. 	1/3/16

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to have a functioning Quality Assurance Performance Improvement (QAPI) program designed to identify, track and trend concerns specific to the long-term care. Specifically, the facility failed to: 1) identify necessary quality assessment and assurance activities; 2) develop and implement plans of action to improve</p>	F 520	<p>F520 What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • The LTC Manager will implement a more thorough Quality program. • The LTC Manager will perform an in-service on Resident Rights to include, but is not limited to: dignity and respect, access to information, freedom of choice, money and personal property, privacy and confidentiality, complaints, concerns, and grievances, the grievance procedure, groups and activities, visitors and communication, admission, transfer, and discharge. <p>How other resident's having the potential to be affected by the same deficient practice will be identified:</p> <ul style="list-style-type: none"> • Sitka Community Hospital LTC recognizes that all residents residing in our center could be affected. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> • The performance of a Quality program will be added to the job description of the LTC Manager. • Yearly training on Resident Rights will be mandatory. <p>How the corrective action will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place):</p> <ul style="list-style-type: none"> • The LTC Manager and/or Chief Nursing Officer will present the LTC findings at the scheduled quarterly Quality meetings. • Training will be part of our yearly required trainings and documented in the HR file. 	1/3/16	

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 520	<p>Continued From page 45</p> <p>resident care and resident quality of life; and 3) implement systemic changes to address identified quality deficiencies, to include monitoring and revising action plans as needed. These failed practices placed all residents in the facility (based on a census of 10) at risk for not receiving necessary care and services.</p> <p>Based on record review and interview the facility failed to sustainably correct past non-compliance as evidence by multiple repeated deficiencies from the previous re-certification survey (12/11/14). This failed practice placed all residents in the facility (based on a census of 10) at risk for not receiving necessary care and services.</p> <p>Findings:</p> <p>Quality Assessment and Assurance (QAA)/Quality Assurance and Performance Improvement:</p> <p>During an interview on 11/19/15 at 10:25 am the Quality Improvement Director (QID) was asked what projects the facility's Long-Term Care (LTC) QAPI was working on. The QID stated a committee comprised of the nursing staff, activities, the Administrator and the Long Term Care (LTC) Manager had developed a resident mobility program that focused on improving ambulation for 1 resident. In addition, the QID said a Root Cause Analysis following a resident injury had been completed for the LTC last summer with several recommendations. There was no follow up to ensure the plan had been implemented nor was there evidence the process had been reevaluated to see if the fall rates in the facility had improved. The QID stated the</p>	F 520			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835		
(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 520	<p>Continued From page 46</p> <p>committee was not currently working on other projects. In addition, the QID stated the prior LTC manager would report data to the committee but confirmed the data had not been utilized in quality improvement nor was there a functioning QAPI program in the LTC prior to September, 2015.</p> <p>When asked about the electronic medical record (EMR) program, the QID stated QAPI had not been involved in that project because the EMR system had complications.</p> <p>Review of the resident mobility program revealed a written plan with interventions written as a nursing care plan to improve ambulation for 1 resident residing in the LTC. There was no information how the program would improve quality of care/life for all residents residing in the facility.</p> <p>Review of a QAPI manual provided by the LTC Manager revealed all the pages in the manual, tabbed for areas that may be of concern in the LTC, were not filled out. Print outs of the Quality Measure Reports (areas of potential improvement) were located in the back pocket of the manual with a note from a staff member that worked for a LTC Quality Improvement Organization. No additional evidence was provided to validate a functioning QAPI program was in place.</p> <p>Past non-compliance/repeated deficiencies:</p> <p>While onsite from 11/16-19/15, the survey team identified multiple areas of repeated deficiencies from the previous re-certification survey.</p> <p>Documentation review of the facility's previous</p>	F 520			

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

PRINTED: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SITKA COMMUNITY HOSPITAL-LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MOLLER AVENUE SITKA, AK 99835	
(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 520	Continued From page 47 re-certification survey Statement of Deficiencies (CMS-2567 form), dated 12/11/14, revealed the facility was cited for non-compliance in the following areas (not a comprehensive list of the facility's citations from the 12/11/14 survey): - Residents' Rights, related to informing the Resident/POA (Power of Attorneys) of the risk and benefits of side rail use. - Quality of Life, related to maintaining and promoting dignity for the residents. - Resident Assessment, related to developing appropriate and comprehensive care plans. - Quality of Care, related to providing care and services to maintain the resident's highest well-being. - Quality of Care, related to the resident's environment being free from accidental hazards. - Quality of Care, related to a resident at risk of receiving unnecessary medication. - Infection Control, related to infection control, hand washing, perineal care, monitoring and trending all facility infections, trending of all infection types, and action planning. - Administration, related to the EMR being accessible. Reference the CMS-2567 Statement of Deficiencies, dated 12/11/14, under the regulatory prefix #'s: F154; F241; F279; F309; F323; F329; F441; F514.	F 520		