STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025028	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORDOVA COMMUNITY MED LTC	**P.O. BOX 160** **CORDOVA, AK 99574**

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K 000	INITIAL COMMENTS . An unannounced Life Safety Code Survey was conducted at Cordova Community Medical Center -Long Term Care (LTC) from 12/11-12/18. The 2012 Edition of the Life Safety Code, Existing Health Care Occupancy Chapter was used for this survey per 42 CFR 483.70 Census at the time of the survey was 10 LTC residents. The facility is a single story structure with a partial basement. The type of construction is Type V (111). The facility plans were approved in 1985. The facility was fully sprinkled with an automatic fire sprinkler system and fully covered with a fire alarm system. State of Alaska Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification	K 000		
K 211 SS=F	. Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: . Based on observation and interview the facility failed to ensure an exit door was free of	K 211	• What corrective actions will be accomplished for those residents found to have been affected by the deficient	1/26/19

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

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K 211	Continued From page 1 obstruction as referecned in NFPA 101:19.2.1 in accordance with NFPA 101:7.1.10.1, for 1 smoke compartment with a census of 10 residents in that smoke compartment. This impedance to the exit passageway placed all residents, staff and visitors at risk for delayed egress in the event of a smoke or fire emergency. Findings: Observation on 12/11/18 at 8:05 am this Surveyor attempted to go out the exit from the activities room. The door had a single latch assembly that was to release upon depression of the door handle. On depression of the door handle the latch assemble failed to release from the latch plate and took several attempts to release. This Surveyor then had to place a lot of pressure on the door and push very hard to get the door to open to the exit passage way. Further observation along the frame of the door appeared to be a large linear crack in the wall of the door frame. During an additional observation and interview on 12/11/18 at 8:15 am with the maintenance team, the same result occurred when attempting to exit the door in the activity room. The door latch assembly was removed at the time of discovery by Maintenance which allowed for easy access to the exit passageway. NFPA 101 (2012) 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.	K 211	practice. The door latch assembly was removed at the time of discovery: Since this door is not on a smoke barrier wall, the CCMC's maintenance team will replace the door with a half door without impeding egress to immediate exit and provide documentation for the repair and testing of the door to the Quality Improvement Committee. • How other residents having the potential to be affected by the same deficient practice will be identified: We have identified all residents have the potential to be impacted. • What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All egress, fire and smoke compartment doors will be inspected annually by facilities staff to ensure compliance with NFPA requirements and the inspection documented. The annual door inspection documentation will be provided to the Quality Improvement Committee for review and oversight. • How the corrective actions will be monitored and evaluated for effectiveness to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: The annual door inspection documentation will be reviewed by the Quality Improvement Committee to ensure compliance. Additionally, the Environment of Care rounds team will add an inspection item to the rounds spreadsheet to inspect the	

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K 211	Continued From page 2 7.1.10 Means of Egress Reliability. 7.1.10.1* General. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 211	egress, fire and smoke doors during EOC rounds as secondary, ongoing monitoring and report any concerns to the Facilities Manager for correction. • The date each corrective action will be completed. This corrective action will be completed by January 26, 2019.	
K 712 SS=F	. Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to ensure fire drills were conducted quarterly in accordance with NFPA 101: 19.7.1.6. This failed practice placed all residents (based on a census of 10) at risk for a delayed response by facility staff during a fire event. Findings: Record review of fire drills exercises from 12/17 - 12/18 revealed no fire drill was completed for the second shift during the first quarter of 2018 or the first shift of the second quarter, 2018.	K 712	• What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: CCMC has developed a fire drill schedule for 2019 to ensure the unannounced fire drills will be completed on each shift, each quarter, at varying times. The schedule indicates what quarter the drills will be completed for each shift and what the topic will be. • How other residents having the	1/26/19

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K 712	Continued From page 3 During an interview on 12/11/8 the Facility Manager confirmed the findings. Code Reference NFPA 101 (2012) 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. .	K 712	potential to be affected by the same deficient practice will be identified: We have identified all residents have the potential to 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 Facilities Manager will document on the fire drill schedule the date and time the quarterly drill was completed for each shift and will communicate the fire drill schedule and status to the Quality Improvement Committee on a quarterly basis. • How the corrective actions will be monitored and evaluated for effectiveness to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: The corrective action will be monitored by the Quality Improvement Committee. The Quality improvement committee will review the fire drill schedule at each meeting to monitor completion of the quarterly fire drills for each shift. The lapse in conducting fire drills was due to a staffing change within the Facilities Manager position earlier this year. In order to prevent this from happening due to any future changes in the Facilities Manager position, the Quality Coordinator will work with the Maintenance staff to ensure drills are being done per the schedule, and reported to the Quality Improvement Committee. • The date each corrective action will	

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K 712	Continued From page 4	K 712	be completed: This corrective action will be completed by January 26, 2019	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA	K 918		1/26/19

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K 918	Continued From page 5 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to ensure an annual fuel quality test was performed in accordance with NFPA 110: (10) 8.3.8 as referenced by NFPA 101: 9.1.3.1. This failed practices placed all residents (census of 10) and occupants at risk for loss of emergency power. Findings: Record review on 12/11/18 of the Life Safety Code inspection reports revealed no documentation of a fuel quality test used to power the generator. The Facility Manager confirmed a diesel fuel test had never been completed. Code Reference NFPA 101 (2012) 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 (2010) 8.1* General. 8.1.1 The routine maintenance and operational testing program shall be based on all of the following: (1) Manufacturer's recommendations	K 918	• What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: A diesel fuel sample collection kit has been ordered from FOI Laboratories, located in Vancouver, Washington, for fuel quality testing per NFPA 110: (10) 8.3.8. The full spectrum test recommended for life safety situations tests for the following: water by Karl Fischer, microbial growth, flash point, sulfur, distillation – 90%, visual appearance, water and sediment, distillation – 50%, copper strip corrosion, cetane index, API gravity by hydrometer and acid number. Once the sample collection kit is received, the sample will be sent back to FOI Laboratories, who stated they have a 72 hour turnaround time for the results. • How other residents having the potential to be affected by the same deficient practice will be identified: We have identified all residents have the potential to be impacted. • What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Annual fuel quality inspection will be added to the generator testing protocol and testing documents will be reviewed by the maintenance department and maintained in the facility's generator room.	

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K 918	Continued From page 6 (2) Instruction manuals (3) Minimum requirements of this chapter (4) The authority having jurisdiction 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards. .	K 918	• How the corrective actions will be monitored and evaluated for effectiveness to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: The Facilities Manager will submit a copy of the documentation from the annual diesel fuel test to the Quality Committee annually to verify and ensure the inspection is completed and this deficient practice does not recur. • The date each corrective action will be completed: This corrective action will be completed by January 26, 2019.	

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E 000	Initial Comments . An unannounced Emergency Preparedness survey was conducted at Cordova Community Medical Center -Long Term Care (LTC) 12/11-12/18. Census at the time of the survey was 10 LTC residents. State of Alaska Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification	E 000		
E 007 SS=F	. EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: . 007 Based on emergency disaster plan review and	E 007	• What corrective actions will be accomplished for those residents found to have been affected by the deficient	1/26/19

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E 007	Continued From page 1 interview, the facility failed to ensure planning for the safety of at-risk residents with unique vulnerabilities were in the emergency disaster plan per 42 CFR 483.73(a)(3) . This failed practice placed all residents (based on a census of 10) at risk for loss in continuity of care. Findings: Review of the facility's emergency disaster plan, reviewed 12/11-12/18, revealed no plan that specified how at-risk residents with unique vulnerabilities were identified and planned for interventions during an emergency. This finding was confirmed by the Materials Manager and Emergency Preparedness Coordinator at time of discovery. .	E 007	practice: All resident population needs and unique safety risk vulnerabilities will be identified and included as a part of the emergency disaster plan. • How other residents having the potential to be affected by the same deficient practice will be identified: We have identified that all residents have the potential to 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 LTC Director of Nursing and the Emergency Preparedness Coordinator will make sure each resident has a new, individualized Emergency Preparedness form filled out to identify unique vulnerabilities, which will be the basis for developing a plan for interventions that might be needed during an emergency. These unique vulnerabilities, and interventions plan will be reviewed with each resident/representative so they are aware of, and comfortable with, the emergency intervention plans. • How the corrective actions will be monitored and evaluated for effectiveness to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: The Emergency Preparedness plan will be reviewed and updated at least annually by the Safety Committee, and then the Emergency Preparedness Coordinator will present the updated plan to the Quality Improvement Committee for review, no	

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E 007	Continued From page 2	E 007	less than annually. • The date each corrective action will be completed: The Resident-specific information will be updated by January 26, 2019.	
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced	E 031		1/26/19

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E 031	Continued From page 3 by: . Based on record review and interview the facility failed to ensure the emergency preparedness communications plan included the contact information for the Federal, State tribal, regional and local emergency agencies in accordance with CFR 483.73(c)(2)(ii). This failed practice placed all residents (based on census of 10) at risk for delay in services provided by those agencies. Findings: Review of the facility's emergency preparedness communications plan, from 12/11-12/18 revealed no listing of the contacts in one central area of the emergency plan. The contact information for the agencies, was located within multiple tabs, policies, forms and or memorandum of agreements throughout the Emergency Preparedness binder. In the event of an emergency the agency contacts should be readily accessible. This finding was confirmed by the Materials Manager and Emergency Preparedness Coordinator at time of discovery. .	E 031	• What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: An Emergency Preparedness Communication policy will be in place that includes contact information to the federal, state, tribal, regional, local emergency preparedness staff, the State licensing and certification agency and the State ombudsman. • How other residents having the potential to be affected by the same deficient practice will be identified: We have identified that all residents have the potential to 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 Emergency Preparedness Coordinator will make sure the Emergency Preparedness Communication policy is reviewed and updated with the correct contact information annually. The Emergency Preparedness Communications policy will be made readily accessible so it can be easily obtained and used during an emergency. • How the corrective actions will be monitored and evaluated for effectiveness to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: The Emergency Preparedness Communication plan will be reviewed and	

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E 031	Continued From page 4	E 031	updated at least annually by the Safety Committee, and then the Emergency Preparedness Coordinator will present the updated plan to the Quality Improvement Committee for review, no less than annually. • The date each corrective action will be completed: The Emergency Preparedness Communications policy and procedure will be updated by January 26, 2018.	
E 033 SS=F	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).	E 033		1/26/19

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E 033	Continued From page 5 *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to ensure the emergency preparedness communication plan contained: 1) a method for sharing information and medical documentation for residents under the facility's care with other health providers as required by CFR 42 483.73(c)(4); 2) a means, in the event of an evacuation, to release patient information as permitted under Health Insurance Portability and Accountability Act (HIPAA) as required by 42 CFR 483.73(c)(5); and 3) a means of providing information about the general condition and location of patients under the facility's care under 45 CFR 164.510(b)(4) - Uses and disclosures for disaster relief purposes. These failed practices placed all residents (based on a census of 10) at risk for loss in continuity of	E 033	• What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Emergency Preparedness Communication plan will be updated with a method of sharing information to others during an emergency event. • How other residents having the potential to be affected by the same deficient practice will be identified: We have identified that all residents have the potential to 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 Long Term Care Director of Nursing and the Emergency Preparedness Coordinator will update the Emergency Preparedness Communication plan to include: 1) a method for sharing information and medical documentation for residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025028	A. BUILDING _____ B. WING _____	12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 033	Continued From page 6 care and infringement of private health information. Findings: Review of the facility's emergency preparedness plan, from 12/11-12/18, revealed no method of sharing information to other providers during an emergency event. Further review revealed the plan did not contain a means, in the event of evacuation, to release patient information in compliance with HIPAA and under 45 CFR 164.510(b)(4) - Uses and disclosures for disaster relief purposes. This finding was confirmed by the Materials Manager and Emergency Preparedness Coordinator at time of discovery. .	E 033	under the facility's care with other health providers, 2) a means, in the event of an evacuation, to release patient information as permitted under HIPAA, and 3) a means of providing information about the general condition and location of patients/residents under the facility's care. • How the corrective actions will be monitored and evaluated for effectiveness to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: The Emergency Preparedness Communications plan will be reviewed and updated, if needed, at least annually by the Safety Committee, and then the Long Term Care Director of Nursing and the Emergency Preparedness Coordinator will present the updated plan to the Quality Improvement Committee for review, no less than annually. • The date each corrective action will be completed: The Emergency Preparedness Communications plan will be updated by January 26, 2018.	