STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025020	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DENALI CENTER	**1510 19TH AVENUE** **FAIRBANKS, AK 99701**

(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
K 000	INITIAL COMMENTS An unannounced Life Safety Code Survey was conducted at Denali Long Term Care Center in Fairbanks, Alaska on 3/21/19 by a member of the State of Alaska Department of Health and Social Services - Health Facilities Licensing and Certification. The 2012 Edition of the Life Safety Code was utilized for this survey, in accordance with 42 Code of Federal Regulations, Part 483.70 Requirements for Long Term Care Facilities. Type of structure: A one-story, Type V(000), combustible wood frame construction. This facility has complete coverage by an automatic (wet) sprinkler system for interior areas and an automatic (dry) sprinkler system with separated risers which provide coverage for the exterior and loft/attic areas. The facility had no active Life Saftey Code waivers. Census: 80 residents Department of Health and Social Services Division of Health Care Services Health facilities Licensing and Certification 4501 Business Park Blvd. Ste. 24, Building L Anchorage, AK 99503 .	K 000		
K 345	Fire Alarm System - Testing and Maintenance	K 345		4/22/19

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

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K 345 SS=F	Continued From page 1 CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to ensure a sensitivity test was conducted on the fire alarm system's smoked detectors in accordance with NFPA 72: 14.4.5.3 as referenced by NFPA 101: 9.6.1.3. This failed practice placed all residents (based on a census of 80) at risk for delay in fire alarm smoke detectors activation. Findings: Record review on 3/21/19 of fire alarm reports provided by the facility revealed no documentation of sensitivity testing that had been completed on the facility's fire alarm system. During an interview on 3/21/19 the Facility Engineer stated he/she couldn't find any documentation of a current or previous sensitivity test of the fire alarm's smoke detectors. .	K 345	K0345 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Sensitivity report was done in February but report was not in Fire book. Report was pulled from computer and shows test was completed on February 6th, 2019. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recoginizes that all residents residing at Denali Center could be affected by the deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? * A tab for sensitivity testing was put into the Fire book. Report will be pulled	

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K 345	Continued From page 2	K 345	from computer each year and put into correct tab. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * Contractor and Engineering staff have a document check off list to assure all requirements are met monthly, quarterly, semi-annual, and annual testing. * Completed 4/9/19	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363		4/22/19

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K 363	Continued From page 3 of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: . Based on observation and interview the facility failed to ensure a corridor door to a resident's room was free from impediments that may have resulted in delayed closure as referenced by NFPA 101: 19.3.6.3. This failed practice placed occupants in 1 out of 5 smoke compartments (24 residents out of a total census of 80) at risk for exposure to a fire and/or smoke environment. Findings: Observation on 3/21/19 at 12:45 pm revealed an electric wheelchair located in the corridor outside resident room #205. Further observation revealed the power supply cord led from the wheelchair through the resident's room doorway and was plugged into an outlet located inside room #205. As a result, the door was not able to close to prevent the passage of smoke. During an interview on 3/21/19 at 12:47 pm Resident Care Coordinator #1 stated the	K 363	K0363 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Facilities immediately addressed the issue by finding appropriate storage for the wheelchair identified in the finding. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * All residents residing at Denali Center would be affected by the indentified deficiency. 3) What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?	

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K 363	Continued From page 4 observation had been an ongoing concern and stated it was not best practice to run the electrical cord through the door opening. The Facilities Engineer and Safety Officer acknowledged the finding at the time of discovery. .	K 363	* Administration and facilities will do a walkthrough of Denali Center to identify all residents with an electric wheelchair and ensure they are stored in rooms or in storage areas and do not have a cord run from inside the room to outside the room potentially obstructing a fire door. Education will be provided to staff regarding the finding and solutions for storage. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * An audit will be created to screen the environment for the finding. Audits will be done weekly for 6 weeks and with Red Team rounding twice a year. Audits will be reported to the Quality team. * Completed 4/9/19	
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:	K 712		4/22/19

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K 712	Continued From page 5 . Based on record review and interview the facility failed to ensure night shift fire drills were conducted at various times in accordance with NFPA 101: 19.7.1.6. This failed practice placed all residents (based on a census of 80) at risk for delayed response from staff during a smoke/fire emergency. Findings: Record review of the facility's fire drills, dated 3/22/18 to 12/6/18 revealed the following night shift drills: - 3/22/18 at 3:00 am; - 3/27/18 at 3:00 am; - 4/29/18 at 2:14 am; - 9/18/18 at 3:00 am; and - 12/6/18 at 3:34 am. During an interview on 3/21/19 the Security Manager (designated person to oversee fire drills) stated the drills conducted on night shift were completed by members of the security team. When presented with the night shift fire drill times, the Security Manager noted the frequent occurrence of night shift fire drills at or around 3:00 am. The Security Manger stated he/she would implement a new process to ensure drills are held at various times on the night shift. .	K 712	K0712 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Fire drill times will be performed randomly to test staff ability to appropriately respond. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Denali Center recognizes that all residents residing at Denali Center could be affected by the deficient practice. 3) What measures will be put into place or what systemic changes will be made to * The Security Supervisor will make a schedule available to night shift security officers conducting fire drills so they can ensure all fire drills are conducted at random times. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * The Security supervisor will audit the fire drills monthly for one year, to ensure there is no pattern forming. * Initiated by 4/9/19 and ongoing.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and	K 920		4/22/19

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K 920	Continued From page 6 Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: . Based on observation and interview the facility failed to ensure power strips used within the patient care vicinity were used in accordance with NFPA 99: 10.2.3.6 and 10.2.4, as well as, NFPA 70: 400-8 and 590.3. Specifically, the facility placed patient-care-related electrical equipment (PCREE) and non-PCREE on the same power strip within the patient care vicinity. This failed practice place 3 residents (based on a census of 80) at risk for electrical related injuries, electrical fire potential and exposure to an unsafe environment. Findings:	K 920	K0920 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Facilities immediately corrected the findings during the survey. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * All of the residents at Denali Center have the potential to be affected by the	

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K 920	Continued From page 7 Observation of room #213 on 3/21/18 at 12:50 pm revealed a power strip located next to a resident's bed. The power strip supplied power to a Masimo Rad-87 (devices used to monitor such things as oxygen levels of the blood, pulse and respiratory rate), lamp, phone, and EverGlo oxygen concentrator (device used to supply oxygen to a resident). Observation of room #221-2 on 3/21/18 at 12:59 pm revealed a power strip located at the foot of a resident's bed. The power strip supplied power to a Masimo Rad-87, television, air-bed control unit (device used to alter a resident's position while in bed to alleviate pressure on areas of the body), and a fan. Observation of room #221-1 on 3/21/18 at 1:00 pm revealed a power strip located next to a resident's bed. The power strip was supplying power to a glucose testing machine and two phone chargers. The facility's Safety Officer acknowledge the findings at the time of their discovery and stated the facility had insufficient outlets and power strips were used to power both non-medical and medical equipment at resident bedside. NFPA 99 (2012): 3.3.137 Patient-Care-Related Electrical Equipment. Electrical equipment appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity. .	K 920	deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? * Facilities and nursing are completing weekly walking rounds to ensure that patient care related elecrical equipment(PCREE) is plugged directly into outlets. All other non-PCREE will be placed into the power strips. Education will be provided at the Weekly Education Learning and Development team meetings across the organization. Education will include that PCREE is plugged directly into outlets. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * An audit will be created to screen the environment for the finding. Audits will be done weekly for 6 weeks and with Red Team rounding twice a year. Audits will be reported to the Quality team. * Completed 4/9/19 and ongoing.	

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E 000	Initial Comments . An unannounced Emergency Preparedness survey was conducted at Denali Center-Long Term Care (LTC) 3/21-22/19. Census: 80 residents Department of Health and Social Services Division of Health Care Services Health facilities Licensing and Certification 4501 Business Park Blvd. Ste. 24, Building L Anchorage, AK 99503	E 000		
E 015 SS=F	. Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following:	E 015		4/22/19

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 015	Continued From page 1 (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to ensure the emergency disaster plan included policies and/or procedures for the provision of providing food for staff and patients whether they evacuate or shelter in place per 42 CFR 483.73(1)(i). These failed practice placed all residents (based on a census of 80) at risk for	E 015	E015 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Will add to the Emergency Operations Plan 2019 the provision of	

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E 015	Continued From page 2 inadequate planning and suboptimal supply of food by the facility during an emergency event. Findings: Review on 3/21/19 and 4/3/19 of the facility's emergency preparedness plan, last revised 1/2019 revealed no policies and/or procedures related to the planning and implementation of providing food to staff and patients during an emergency event. During an interview on 3/21/19 the Senior Manager of Emergency Preparedness (SMEP) was unable to locate information related to provision of food. Review of facility provided emergency plan crosswalk (document used to aide in locating information within the plan) on 3/22/19 revealed the provision of subsistence needs information were found at Section IV; IV-9, A-4, C-18, D-11, E-4, E-11, H-16, L-4, R-7, X-10, Z-5, Z-9, and Z-11. Additional review of the emergency preparedness plan revealed no information pertaining to the provision of food. .	E 015	subsistence needs for staff and patients whether they evacuate or shelter in place to include food. 2) How other residents having the potential to be affected by the same deficient practice will be identified? * Will identify average resident census, resident meal requirements, resident meal plans and average staff ratios to address all food shortages in an emergency. 3) What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? * Researching Nationally recognized tools to determine need. * Will conduct an annual review of the FHP Emergency Management Plan that will include a review of Census and Staffing. 4) How the corrective action(s) will be monitored and evaluated for effectiveness to ensure the deficient practice will not recur? * Annual review of the FHP Emergency Management Plan. * Completed by 5/5/19 and ongoing.	