STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025019	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Petersburg Medical Center Ltc	103 Fram Street Petersburg, AK 99833

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. .Based on record review, observation, and interview, the facility failed to ensure an infection control procedure was followed during resident cares for 1 resident (#6), out of 9 sampled residents. Specifically, staff failed to perform a glove change and hand hygiene when going from a dirty task to a clean task. This failed practice had the potential to increase the development and transmission of communicable disease and infections. Findings:.Record review on 7/28/25-8/4/25, revealed Resident #6 was admitted to the facility with diagnoses that included peripheral vascular disease (a disease affecting the blood vessels outside of the brain and the heart involving narrowing, blockage, or spasms in the blood vessels, which restricts blood flow to the arms, legs and other body parts), stroke, and hemiplegia (one sided paralysis)/ hemiparesis (one sided weakness).An observation on 7/30/25 at 12:40 PM, revealed Resident #6 stood at the bedside after using the bedside commode, with swim trunks around the lower legs and a gait belt secured around the resident's waist. Certified Nursing Assistant (CNA) #2 stood in front of the resident, holding the gait belt to assist with stability. CNA #1, wearing gloves, cleansed the resident's buttocks and anal area using a wet washcloth, followed by a dry washcloth to pat the area dry. Without changing gloves or performing hand hygiene, CNA #1 pulled up the resident's swim trunks.During an interview on 7/31/25 at 10:10 AM, the Chief Nursing Officer (CNO) and the Infection Control Preventionist (ICP) stated that it was expected that staff perform hand hygiene and change out their gloves when going from a dirty task to a clean task. They further stated the CNA should have changed his/her gloves prior to touching the resident's clothes.Review of the facility's policy, Hand Hygiene, LTC [Long Term Care], last revised on 6/2025, revealed: . All personnel shall practice proper hand hygiene in the following situations:. before moving from a contaminated body site to a clean body site during resident care.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. .Based on observation and interview, the facility failed to post the daily total number, and the actual hours worked for resident care per shift worked by the Certified Nurse Assistants (CNA), Licensed Practical Nurses (LPN), and Registered Nurses (RN). This failed practice provided inaccurate information to the residents and their families.Findings: Random observations on 7/28-31/25, revealed a whiteboard in the long-term care unit hallway labeled Petersburg Medical Center Long Term Care. The board included the date, first names of nursing staff and CNAs on duty, general shift times, and the resident census. The whiteboard did not include the total number of licensed nurses or CNAs per shift, nor did it display the total actual hours worked by each staff type.During an interview on 8/4/25 at 12:00 PM, the Chief Nursing Officer (CNO) stated that the facility did not post nurse staffing hours. She explained that the whiteboard was updated daily to show only the current shift and that the facility maintained a file at the nurse's desk with historical staff schedules. She confirmed this file was not posted publicly and there was no reference directing residents or visitors to its existence