Department of Public Health
Barbara A. Garcia, MPA, Director of Health

Edwin M. Lee
Mayor

Laguna Honda Hospital and Rehabilitation Center
Mivic Hirose, RN, CNS, Executive Administrator

VIA Courier Service

November 28, 2017

Ms. Diana Marana, RN
District Manager
Licensing and Certification Program
San Francisco District Office
150 North Hill Drive, Suite 22
Brisbane, CA 94005

RE: Laguna Honda Hospital & Rehabilitation Center
Plan of Correction SNF Recertification Survey Conducted
From October 16, 2017 to October 24, 2017
Provided Number: 555020

Dear Ms. Marana:

Please find enclosed Laguna Honda Hospital's Plan of Correction to the above referenced Form CMS 2567 Summary Statement of Deficiencies.

If additional information is required, please call Regina Gomez, Director of Quality Management, at (415) 759-3053.

Very truly yours,

Mivic Hirose, RN, MSN, CNS
Executive Administrator

MH:sn

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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F 000	INITIAL COMMENTS The following reflect the findings of the California Department of Public Health during a Re-certification Survey conducted from 10/16/17 to 10/24/17. The census at the time of the survey was 761 residents with seven bed holds. The total sample was 34 residents including three random residents. The highest scope and severity was F (not substandard quality of care). Representing the California Department of Public Health: Surveyor 31794, Health Facilities Evaluator Nurse Surveyor 32718, Health Facilities Evaluator Manager 1 Surveyor 33819, Health Facilities Evaluator Nurse Surveyor 33000, Health Facilities Evaluator Nurse Surveyor 38066, Health Facilities Evaluator Nurse Surveyor 36894, Health Facilities Evaluator Nurse Surveyor 36814, Health Facilities Evaluator Nurse Surveyor 17065, Nutrition Consultant Surveyor 34975, Nutrition Consultant	F 000	This Plan of Correction is the response by Laguna Honda Hospital and Rehabilitation Center ("Laguna Honda" or "facility") as required by regulation, to the Statement of Deficiencies (Form CMS-2567) issued by the California Department of Public Health on November 16, 2017, and received by the facility on November 21, 2017, during a Re-certification survey which began on October 16, 2017, and concluded on October 24, 2017. The submission of this Plan of Correction does not constitute an admission of the deficiencies listed on the CMS Form 2567 Summary Statement of Deficiencies or an admission to any statements, findings, facts, and conclusions that form the basis of the alleged deficiencies.	
F 167 SS=E	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (g)(10) The resident has the right to- (i) 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; and	F 167	The most recent state survey results of the last 3 preceding years for the facility is available in marked binders at three (3) locations across the facility. The locations are Pavilion lobby Information Desk, Administration lobby Information Desk and Resident's Library. The binders in the lobbies are accessible to visitors, families and residents. A designee from Administration is responsible for updating the content, at a minimum annually, after	

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

Mivic Hirose, Executive Administrator 11/28/17

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

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F 167	Continued From page 1 (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility did not ensure that residents remain informed when: a) The availability of the results of the state annual survey, extended surveys and complaints surveys were not posted in multiple units and floors. b) The result of the state annual survey was kept in an unmarked area in the dining room of the units that were not accessible to residents, family members and visitors. These deficient practices had the potential to cause harm to the residents' psychosocial well-being.	F 167	a survey is conducted following acceptance of the Plan of Correction by CDPH. Thirteen additional binders of the most recent annual federal and state survey reports, including extended surveys and complaint surveys were made available and accessible in the Great Room on the 13 neighborhoods. a.and b. Signage to direct residents, families, and visitors to the most recent state survey results, certifications and complaint investigations during the 3 preceding years of the facility will be posted prominently on bulletin boards at the entrance of the neighborhoods, the Pavilion lobby Information Desk, Administration lobby Information Desk and Resident's Library. A designee from Administration is responsible for creating the signage and posting the updated signage in the Pavilion lobby Information Desk, Administration lobby Information Desk and Resident's Library. Nurse Managers or designees are responsible for posting the signage on the bulletin boards at the entrance of the 13 neighborhoods. Assistant Hospital Administrator and Nursing Program Directors are responsible for compliance. Nurse Managers or designees will inform Residents 39, 40, 41, 42 and 43 on where they can access the recent state survey results of the facility in the Great Room on the neighborhoods. This binder is located on the right side of the dining divider island and is in a binder holder. The binder holder will display "Recent State Survey Results" in visible font. In addition, the most recent 3 year state	11/23/17

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F 167	Continued From page 2 Findings: a) During observations and concurrent interviews on 10/19/17 at 8 am, there was no posting or indication of the availability of the state annual survey, extended survey, and complaint investigation results, to the residents, family members or visitors in all the units in both the north and south towers. When discussed the missing postings with five of the nurse managers (NM1, NM2, NM3, NM4 and NM5), they all acknowledged the problem and stated they would talk to administration. When discussed with the Director of Nursing (DON) 1 for units (S2, S3, S4 and S6) at 9 am, she confirmed there were no notes indicating the availability of these documents. b) During an observation and concurrent interview on 10/19/17 at 8 am, the last state annual survey results were placed in an unmarked binder holder, attached on a divider, on the right side of the dining area in multiple floors and units (S2, S3, S4, S5 and S6), and they were not accessible to the residents, family members and visitors. When discussed the missing posting with five nurse managers (NM1, NM2, NM3, NM4 and NM5), they all acknowledged the problem and stated they would talk to their administration. Also, when discussed with the Nursing Director (ND) 1 for units (S2, S3, S4 and S6) and the ND at 8:35 am for unit S5, they both confirmed there were no notes indicating the availability of the state survey results. During interviews with random residents on 10/20/17, five of six residents from different units (S2, S5, and S6) stated they did not know if there was a state annual survey result; these residents	F 167	survey results of the facility is also available in marked binders at three (3) locations across the facility. The locations are Pavilion lobby Information Desk, Administration lobby Information Desk and Resident's Library. Nursing Program Directors are responsible for compliance. Other Residents will be informed on where to access the results of the most recent state annual survey during the monthly neighborhood community meetings as a recurring agenda item to ensure that new residents are informed. The Resident's Council will also be informed and periodically reminded. Administrative and Therapeutic Activity staff are responsible for facilitating the discussion. Assistant Hospital Administrators are responsible for monitoring compliance. Laguna Honda staff will be provided with a read and sign in-service on the location, availability and accessibility of the Federal and State survey reports and where to access the reports themselves. The Nurse Educator is responsible for developing the in-service slides. Department Managers are responsible for monitoring staff review of the educational material. Neighborhood staff conducting the monthly neighborhood community meetings will poll/survey the residents' knowledge on the locations of the Federal and State Survey reports binders. Resident responses will be used to evaluate the effectiveness of the signage placed on the neighborhoods and throughout the facility and reported at	11/23/17 11/23/17 and on-going 11/23/17 11/23/17 and on-going

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F 167	Continued From page 3 were: Resident 39 in unit S2 at 10:20 am, Resident 40 in unit S6 at 11 am, Resident 41 in unit S6 at 11:10 am, Resident 42 in unit S5 at 11:25 am and Resident 43 in unit S5 at 11:45 am.	F 167	the Skilled Nursing Facility (SNF) Performance Improvement and Patient Safety (PIPS) Committee meetings four times a year. Assistant Hospital Administrators and Chief Nursing Officer are responsible for reporting compliance at the SNF PIPS Committee meeting.	11/23/17 and on-going
F 246 SS=D	REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES CFR(s): 483.10(e)(3) 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure two of 33 sampled residents (Residents 11 and Random resident 32) were treated with respect and dignity when: 1, For Resident 11, the call light was not placed within her reach. This deficient practice had the potential to delay the response to Resident 11's care needs. 2. For Random Resident 32, the clothing protector (CP) was not provided to her, as was her preference, while eating lunch in North (N) 1 Great Room on 10/17/17. Failure to adhere to residents request could negatively impact her self esteem. Findings:	F 246	**Start of F 246 POC** The facility provides residents with reasonable accommodation of their needs/preferences and promotes care for residents in a manner and in an environment that maintains the resident's dignity and respect in full recognition of his or her individuality. Resident 11's call light was promptly placed to the resident's right side by the Nurse Manager. Resident 11 was also interviewed by Nurse Manager and expressed that her needs were being met by the staff assigned to care for her. Resident 32 was promptly provided with a clothing protector during the lunch meal on 10/17/17 when she requested for one. Resident 32's clothing appeared clean, without evidence of food stains. When interviewed on 11/20/17 Resident 32 expressed that staff have consistently offered her a clothing protector prior to or during meal times.	10/17/17 10/17/17

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F 246	Continued From page 4 1. Resident 11 was admitted on 3/31/17 with diagnoses that included left hemiparesis (a weakness of one entire side of the body, that can be caused by different medical conditions, including congenital causes, trauma, tumors, or stroke), major depressive disorder, dementia (a wide range of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities.) and history of falls. Review of two Minimum Data Set, (MDS - an assessment tool) dated 09/27/17and 06/29/17 indicated Resident 11 had a moderate cognitive impairment and needed staff assistance every shift for activities of daily living like transferring to and from bed, ambulation, eating, and personal hygiene. During an observation on 10/17/17 at 9 AM, while escorted by the Nurse Manager (NM) 6, Resident 11 was in bed and yelling loudly, "...more black coffee and blueberry yogurt..." Her call light was on her left side by her shoulder. She attempted to reach the call light with her right hand and stated, "I cannot reach it...". During an interview on 10/17/17 at 9:05 am when asked if Resident 11 had a problem with her left side, NM 6 stated, "She does not have a problem with her left side." During record review on 10/17/17, a physician's progress note dated 08/02/17 indicated, under "Assessment and Plan: ... 2. Hemiparesis affecting left side as late effect of cerebrovascular accident ..."	F 246	Charge Nurses were instructed to conduct rounds on their neighborhoods to verify that resident call lights are placed within the resident's reach, and to offer each resident the use of a clothing protector prior to meals. A neighborhood based in-service was conducted on North 1 reminding staff to offer residents the use of a clothing protector during meals. The Nursing policy and procedure on assisting residents with meals will be revised to add offering the resident with a clothing protector during meal times. A read and sign in-service will be conducted for Nursing staff on accommodating the resident's needs and preferences, and treating the resident with dignity and respect. Scenario examples will include placement of resident's call light within reach by the resident, and offering residents with clothing protectors during meal times. The Nurse Educator is responsible for developing the in-service slides. Nurse Managers are responsible for monitoring staff review of the educational material. Nurse Mangers are responsible for conducting neighborhood observations and three resident check-in's daily; including checks to verify that the resident's call light is placed within the resident's reach, and their ability to activate the call light. Nurse Managers are also assigned to conduct random meal observations covering all 3 meals to	10/17/17 11/08/17 11/23/17 11/23/17 11/23/17 and on-going

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F 246	Continued From page 5 2. During an observation on 10/17/17 at 1:10 PM, there were 17 residents eating lunch in the N 1 Great Room, some had Clothing Protectors (CP) and some did not. One Licensed Vocational Nurse (LVN) 1 was going around each table. In an interview on 10/17/17 at 1:13 PM, LVN 1 stated staff should be placing CPs when residents were eating so as not to stain their clothing's, it was "not appealing" and it was for "dignity". The LVN 1 counted and stated there were 11 out of 17 resident who did not have CPs. In an interview on 10/17/17 at 1:09 PM, Random Resident (RR) 32 was seating at a table with other three residents. When asked, RR 32 stated she used to have a CP, "I want it" and she did not want her clothing to get "dirty". In an interview on 10/17/17 at 1:20 PM, Registered Nurse ((RN) 3 stated he did not know why residents did not have CPs as there was a box full of CPs "out there."	F 246	verify that staff is offering residents a clothing protector during every meal. Results from Nurse Manager resident check-in's, meal observations and corrective actions will be aggregated quarterly and reported four times a year to Nursing Quality Improvement Council (NQIC) and the Skilled Nursing Facility (SNF) Performance Improvement and Patient Safety (PIPS) Committee. Nursing Program Directors are responsible for reporting compliance to NQIC; and Chief Nursing Officer is responsible for reporting compliance to the SNF PIPS Committee.	11/23/17 and on-going
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or	F 323	The facility maintains an environment as free of accident hazards as possible; and provides each resident with adequate supervision and assistive devices to prevent accidents. The insulin syringe left on top of the S6 medication cart was promptly discarded in the sharps container. The Nurse Manager on South 6 reminded licensed nursing staff to discard needles immediately after use in any of the sharps containers that are located in resident rooms and on medication carts.	10/18/17 10/26/17

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F 323	Continued From page 6 bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe environment when an insulin syringe (used to administer injection) was left on top of South 6 medication cart which was accesible to the residents. The deficient practice could potentially expose the residents to sharp object like the needle of the syringe that may cause harm and injury to the residents. Findings: During an observation, on 10/18/17, at 9:17 AM, there was an insulin syringe on top of South 6 medication cart. During concurrent interview, the Licensed Vocational Nurse (LVN) 2 stated, "I forgot to keep it. For safety." LVN 2 acknowledged the syringe should not have been left on top of the medication cart "because the needle can cause injury to residents."	F 323	A read and sign in-service will be provided to 24 hour Nursing staff on keeping the environment free of accident hazards, including the proper disposal of used syringes. The Nurse Educator is responsible for developing the educational slide(s). Nurse Managers are responsible for monitoring staff completion of the instructional material. Weekly environmental rounds will be conducted by Nurse Mangers to monitor the neighborhood environment for accident hazards and safety. Results of the environmental rounds and corrective actions will be reported quarterly to Nursing Quality Improvement Council (NQIC), and four times a year to the SNF PIPS Committee. Nursing Program Directors are responsible for reporting compliance to NQIC; and Chief Nursing Officer is responsible for reporting compliance to the SNF PIPS Committee.	11/23/17 11/23/17 and on-going
F 334	INFLUENZA AND PNEUMOCOCCAL	F 334		

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F 334 SS=D	Continued From page 7 IMMUNIZATIONS CFR(s): 483.80(d)(1)(2) (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 334	The facility has established policies and procedures on pneumococcal immunization that the resident or the resident's surrogate decision-maker (SDM) will receive education regarding the benefits and potential side effects of the immunization prior to staff offering and administering the vaccine. Resident 21 was informed of the benefits and potential side effects of the pneumococcal vaccine and stated that based on the education provided, he would have consented to receive the immunization on 8/3/17. The Chief Nursing Officer issued a memo to licensed nursing staff reminding them, that prior to administering the pneumococcal vaccine, to provide the resident or the resident's representative with education about the benefits and potential side effects of the pneumococcal vaccine as outlined in the Vaccine Information Statement (VIS). The medical record of other current residents who had received the pneumococcal vaccine were audited for documentation that education on the benefits and potential side effects of the pneumococcal vaccine was provided to the resident or resident's legal representative. This will serve as the baseline compliance rate to gauge improvement on documentation. A read and sign in-service will be provided to licensed nursing staff, on the facility's	11/20/17 10/24/17 11/23/17 and on-going

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F 334	Continued From page 8 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow it's policy on Pneumococcal Immunization for one of 34 (Resident 21) sampled residents when there was no evidence education was provided before pneumonia vaccine (a method of preventing a specific type of lung infection (pneumonia) that is caused by the pneumococcus (a bacteria) was administered.	F 334	protocol on pneumococcal immunizations which includes the following: a. Before offering the pneumococcal immunization each resident or resident's legal representative shall be provided with education regarding the benefits and potential side effects of the immunization; b. Each resident is offered pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; c. The resident or the resident's legal representative has the opportunity to refuse the immunization; and d. The resident's medical record requires documentation that indicates, at a minimum that the resident or resident's legal representative was provided with education on the health benefits and potential side effects of the vaccine; that resident received the immunization or did not receive the immunization due to medical contraindication or refusal. The Nurse Educator is responsible for developing the educational slides. Nurse Managers are responsible for monitoring licensed nurse compliance with review of the instructional material. The Nurse Manager is responsible for conducting monthly pneumococcal	11/23/17 11/23/17

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F 334	Continued From page 9 Failure to provide education could potentially prevent residents or their legal representatives from receiving the needed information to understand the risk, benefits and potential side effects of the immunization. Findings: Review of the Registration and Admission Record indicated Resident 21 was originally admitted on 12/15/2011 and was re-admitted on 8/3/17 with the diagnoses that included gastrointestinal bleed (all forms of bleeding in the gastrointestinal tract, from the mouth to the rectum), end stage renal disease (hronic irreversible kidney failure) and type 2 diabetes mellitus (long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin. Common symptoms include increased thirst, frequent urination, and unexplained weight loss). During a review of the document titled: "Summary of Today's Visit", dated 8/3/17, indicated an order to start a single dose of Prevnar 13 (vaccine is used to prevent infection caused by pneumococcal bacteria) intramuscular injection (a technique used to deliver a medication deep into the muscles). During an observation accompanied by the Registered Nurse (RN) 3 on 10/19/17 at 11:10 AM, Resident 21 was asleep in bed with the head of bed elevated. During an Interview on 10/19/17 at 10:42 AM, the Licensed Vocational Nurse (LVN) 4 stated Resident 21 was alert and oriented x 3 (oriented to time, place and person) and verified Resident	F 334	immunization documentation reviews that the resident or the resident's legal representative was provided with education regarding the health benefits and potential side effects of the vaccine prior to administering the vaccine. Results of the monthly pneumococcal immunization reviews will be aggregated quarterly and reported to NQIC and the SNF PIPS Committee four times a year. Nursing Program Directors are responsible for monitoring quarterly reporting compliance to NQIC; and the Chief Nursing Officer is responsible for reporting compliance to the SNF PIPS Committee.	11/23/17 and on-going

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F 334	Continued From page 10 21 was administered the Prevnar vaccine on 8/3/17. The LVN 4 stated education should be provided to resident or Legal Representative before vaccine was administered. The LVN 4 searched the entire clinical chart and the Electronic Health Record and verified there was no evidence education was provided. Review of the facility policy, "pneumatically Vaccination", with a revised date of 9/12/17, indicated: " Policy: ... 2. Before offering the PPV (pneumococcal polysaccharide vaccine), each resident or ... will receive education regarding the benefits and potential side effects of the immunization. ... 4. The resident's medical record will include documentation indicating that education was provided ... . Purpose: ... 3. The Licensed Nurse shall provide each resident ... education using the most current federal Vaccine Information Statement (VIS). ... . "	F 334		
F 362 SS=D	SUFFICIENT DIETARY SUPPORT PERSONNEL CFR(s): 483.60(a)(3)(b) (a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. (b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on dietetic services observations, interview, and record review, the facility failed to train staff in accordance with manufacturers' guidance for use of iodine sanitizer in relationship to manual dishwashing. Failure to ensure	F 362	The Food and Nutrition Services Department will replace the use of iodine sanitizer with a quaternary sanitizer by Ecolab, Oasis 146 for manual dishwashing. The department's automatic dispensers will be replaced and calibrated, Food and Nutrition Services staff will be in-serviced on the proper use of the new product; and the Safety Data Sheet (SDS) material will be updated. The Food Service Director has developed a new departmental policy and procedure on manual ware washing. The Food and Nutrition Services staff has been trained on manual ware washing	11/23/17 11/23/17 11/23/17

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F 362	Continued From page 11 sanitizer concentrations and use are in accordance with manufacturers' guidance may result in increased residual chemical concentration of dishware and utensils. Findings: On 10/19/17 beginning at 10:35 a.m., manual dishwashing procedures were reviewed with Dietary Staff (DS) 5 should the dishwashers become unavailable. DS 5 stated that dishes and utensils would be washed in a 3-compartment sink. It was described as a 3-step process that included washing with detergent, rinsing with clear water, and sanitizing steps. The sanitizing step utilized an iodine based product. DS 5 described the required strength of the iodine product as 25 parts per million (ppm - a unit of measure). Review of manufacturers' guidance for the utilized product was documented as follows, "Sanitizing Eating, Drinking and Food Prep Utensils ...4. Sanitize in a solution of 1/4 oz. Mikroklene® to 2 1/2 gallons of water (12 1/2 ppm titratable iodine). Immerse all utensils for at least 1 minute or contact time specified by governing sanitary code ..." The manufacturers' guidance for 25 ppm was limited to sanitation of food contact surfaces. This strength was not intended for dishware or utensils.	F 362	procedures in the event that the dishwasher is unavailable for use. The Food Service Director or designee(s) will conduct quarterly observations of Food and Nutrition Services staff performance on manual ware washing procedures to assess and maintain staff proficiency. Food Services Director and Food Services Supervisors are responsible for maintaining Food and Nutrition Services staff proficiency with manual ware washing. Results of competency checks will be reported quarterly at the SNF PIPS Committee. Chief Operations Officer is responsible for reporting compliance.	11/23/17 11/23/17 and on-going 11/23/17 and on-going
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371	The facility has implemented policies and procedures for storing, preparing, distributing and serving food under sanitary conditions. 1. Food Service cooks have been instructed and in-serviced on measuring final cooking temperatures of food items	

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	555020	A. BUILDING _____ B. WING _____	10/24/2017

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LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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F 371	Continued From page 12 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on dietetic services observations the facility failed to 1) Ensure a mechanism to identify final cooking temperatures of potentially hazardous foods when ground beef patties were served with a trayline temperature of 147 degrees F; 2) Multiple food production staff had facial hair that was not covered and 3) Steam table pans were not air dried prior to storage. Failure to ensure effective food production and ware washing systems may result in promoting an environment conducive to bacterial growth associated with foodborne illness. Foodborne illness may result in nausea, vomiting and in severe instances may result in hospitalization and death.	F 371	according to minimal internal cooking temperatures, per Food Code Annex 2013. Final cooking temperatures are to be recorded on the "Temperature/Taste Testing Log" and tested for flavor, texture, appearance. The Chef Production Manager is responsible for monitoring daily compliance through observations that final cooking temperatures are checked and recorded on the Temperature/Taste Testing Log per department procedures; temperature readings are reviewed for correctness, and deviations from departmental procedures are reported during the weekly Food Services management meeting. Results from the Temperature/Taste Testing Log will be reported at the weekly Food Services management meeting; and aggregated quarterly for reporting at the SNF PIPS Committee meeting. Director of Food Services is responsible for reporting at the SNF PIPS meeting. Chief Operating Officer is responsible for reporting compliance. 2. The Director of Food Services has procured a larger 16" beard net that is approved by the Food Code Annex 2013, 2-402.11 for staff use to effectively cover facial hair. Hair and facial hair covers have been placed at the entrance of the kitchen, café, galleys, and food preparation areas for ease of access for staff use. Food Service Supervisors and Managers are responsible for monitoring the appropriate use of hair and facial hair covers by staff while in the Kitchen and	11/23/17 11/23/17 and on-going 11/20/17

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F 371	Continued From page 13 Findings: 1. The standard of practice is to ensure that items such as ground beef are cooked to an internal temperature of 155°F (degrees Fahrenheit; Food Code 2013). Elements of an effective food safety management system may include monitoring procedures and record keeping (Food Code Annex, 2013) On 10/18/17 beginning at 11 a.m., meal plating observation was conducted. Prior to initiating the process Dietary Staff (DS) 6 was observed taking food temperatures. The observed temperature for 6 hamburger patties was recorded as 147°F. In a concurrent interview DS 6 stated the minimum acceptable serving temperature for the beef patty was listed as 140°F. DS 6 stated she would not know what the final cooking temperature of the item as that was the cooks' responsibility. The item was served. In an interview on 10/19/17 at 9:30 a.m., DS 3 described a final cooking temperature of hamburger as 155°F. DS 3 also stated final cooking temperatures may be listed on the daily production sheet that was forwarded to supervisory staff; however was unsure since it was considered a small production item. In an interview on 10/19/17 at 10:15 a.m., Kitchen Supervisor (KS) 1 stated the productions sheets were discarded at the end of each day. KS 1 acknowledged there was no mechanism to evaluate the final cooking temperature of the observed item. There were no other available documents to evaluate the final cooking temperature of the observed item.	F 371	and food preparation areas. An in-service has been provided to Food and Nutrition Service staff on facility standards and the importance of covering facial hair at all times to avoid food contamination when handling food. Food Service Supervisors and Managers are responsible for monitoring staff compliance with covering their hair and facial hair. Deviations from departmental procedures are to be reported during weekly Food Services management meeting. Daily staff compliance with proper use of hair and facial hair covers will be reported at the weekly Food Services management meeting. Compliance findings will be aggregated quarterly for reporting at the SNF PIPS Committee meeting. Director of Food Services is responsible for reporting at the SNF PIPS meeting. Chief Operating Officer is responsible for reporting compliance. 3. The pot-machine has been serviced by the vendor and is in proper working order. Additional racks have been purchased for proper air drying of steam table pans and a jet dry system has been installed on the dish-machine for optimal operation. Director of Food Services responsible. An in-service has been provided for dish-washing personnel on "Proper Dishwashing Procedures" and the proper way of drying the steam table pans prior to storage. Food Service Supervisors and Managers are responsible for monitoring	11/23/17 11/23/17 and on-going 10/26/17 11/23/17

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F 371	Continued From page 14 2. It would be the standard of practice to ensure dietetic staff wear "(6) ... where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints ... (Food Code Annex 2013, 2-402.11). During general kitchen observation on 10/18/17 beginning at 11 a.m., DS 7 was observed working with resident plates and cups in the trayline area. DS 7 had a full mustache and beard. While he was wearing a beard restraint it did not cover all his facial hair, rather was limited to the area below the lower lip. His mustache and mouth were fully exposed. During a follow up observation on 10/18/17 at 12:15 p.m., DS 7 was working with cleaned/sanitized dishes. His beard restraint was in the same position. In a concurrent interview DS 7 stated that he worked in the dish room, trayline area and on occasion worked directly with resident food. Additional intermittent observations on 10/18/17 and 10/19/17 between the hours of 9 a.m., and 2 p.m., revealed there were greater than 2 additional staff members with facial hair without coverings. In an interview on 10/19/17 beginning at 8:50 a.m., Registered Dietitian (RD) 1 acknowledged all staff with facial hair should be wearing beard restraints. The facility policy for facial hair was also requested from RD 1. On 10/20/17 at 2 p.m., the policy titled "Work Rules for Nutrition Services Department" dated 9/15 was presented. The policy did not address facial hair rather was limited to clothing, hand washing and gum chewing.	F 371	compliance through daily observations and to report findings at the weekly Food Services management meeting. Daily staff compliance with proper drying of the steam table pans will be reported at the weekly Food Service management meeting. Compliance findings will be aggregated quarterly for reporting at the SNF PIPS Committee meeting. Director of Food Services is responsible for reporting at the SNF PIPS meeting. Chief Operating Officer is responsible for reporting compliance The Chief Dietitian, or designated Registered Dietitian, and the Director of Food Service, or Food Service management designee, will discuss the operations of the kitchen on a daily basis. The weekly Food Services management meeting will include discussion of operational findings, and will be attended by the Chief Dietitian, or Registered Dietitian designee, and the Food Services Director, or Food Services management designee. Weekly meeting discussions will be documented and signed by the Chief Dietitian, or designated Registered Dietitian, and Director of Food Service, or Food Service management designee. Assistant Hospital Administrator and Chief Operating Officer will be responsible for monitoring compliance with the formalized, collaborative and comprehensive oversight of dietetic services, and guidance provided to the Director of Food Services by the Chief Dietitian.	11/23/17 and on-going 11/23/17 and on-going 11/23/17 and on-going

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F 371	Continued From page 15 3. It would be the standard of practice that "after cleaning and sanitizing, equipment and utensils Shall be air-dried or used after adequate draining ..." (Food Code 2013, 4-901.11) During general dishwashing observations on 10/18/17 at 12:13 p.m., it was noted DS 5 was removing clean/sanitized steam pans from the dishwasher. Upon removal from the dishwasher they were wet and immediately stacked together, a practice that is commonly referred to as wet-nesting. In concurrent interview DS 5 stated the pans would be moved to the food production area where they would be held until use. DS 5 confirmed there was no specified area to dry items prior to stacking. In a follow up observation on 10/19/18 at 10 a.m., in the food production area, greater than 40 stacked pans in the food production area were wet. The exception was the bottom pan that which was resting directly on the rack. The rack was slotted for ventilation. In an interview on 10/19/17 at 10:30 a.m., KS 1 stated he had not identified the lack of air drying as an issue.	F 371		
F 411 SS=D	ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS CFR(s): 483.55(a)(1)(2)(4) (a) Skilled Nursing Facilities A facility- (a)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, routine and emergency dental services to	F 411	The facility has an onsite dental clinic where residents are provided with dental evaluation and treatment as necessary. The dentist completes his or her note electronically and transmits the evaluation and recommendation(s) to the primary care physician who requested the dental consult.	

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F 411	Continued From page 16 meet the needs of each resident; (a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; (a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility to ensure dental care services were provided for one resident (Resident 2) out of 34 sampled residents when the dental recommendation to have dental extraction (removal of teeth) be done under general anesthesia (the induction of a state of unconsciousness with the absence of pain sensation over the entire body, through the administration of anesthetic drugs) was not followed thru. This deficient practice had the potential to negatively impact Resident 2's nutritional status. Findings: During review of the Registration and Admission Record, it indicated Resident 2 was originally admitted to the facility on 3/24/11. The Progress Notes dated 8/30/17 indicated Resident 2 was re-admitted with the diagnoses that included hypotension (abnormal blood pressure), altered mental status and hypothyroidism (abnormally	F 411	Resident 2 was evaluated by the Dental Clinic on 4/13/2017. Dental notes for that visit, which includes recommendations for full mouth teeth extractions under general anesthesia, was sent electronically to the primary care physician who submitted the referral for a dental consult. In a re-admission note dated 11/16/2017, the primary care physician documented that Resident 2 has not been medically stable for the past 5 months for any extractions under general anesthesia. Resident 2 has had 8 hospitalizations in the past 5 months. The Resident Care Team will continue to monitor Resident 2's condition and when deemed medically stable by the primary care physician to undergo full mouth teeth extractions, and arrangements will be made accordingly. A read and sign in-service will be provided to licensed nursing staff on standard work for communicating to the primary care physician, and documenting follow-up responses of recommendations from the dental clinic. The Nurse Educator is responsible for developing the in-service materials. Nurse Mangers are responsible for monitoring staff completion of in-service. Nurse Managers and or licensed nurse designees on other neighborhoods have been instructed to review the dental clinic notes of other residents to verify that dental clinic recommendations have been acted upon and to follow up on actions that have not been addressed.	11/16/17 11/23/17 and on-going 11/23/17 11/23/17 and on-going

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F 411	Continued From page 17 low activity of the thyroid gland). During an observation on 10/17/17 at 1 PM, in the North (N) 1 Great Room, Resident 2 was sitting in a wheelchair eating his lunch. The pureed vegetables on the plate was finished and one cup full of chopped meat was left untouched. Resident 2 stated he was "ok" and smiled, his lower teeth showed poor dentition. Review of the Outpatient e-referral Form dated 4/5/17 indicated Resident 2 was referred for dental evaluation "for extraction". Review of the Progress Notes dated 4/13/17 indicated Resident 2 had dental examination: " ... decayed root tips ... . fractured decayed teeth,... periodontically compromised tooth. ... poor oral hygiene. ... ". The plan was to send him to the hospital for "possible full mouth extractions under general anesthesia." During an interview on 10/24/17 at 8:10 AM, the Nurse Director (ND) 3 stated the Licensed Nurse should notify the Medical Physician, there should be a discussion to address the plan in the Interdisciplinary Team (IDT), and medical clearance should be obtained before sending the resident to the hospital for dental work up. The ND 3 stated the medical clearance did not happen because the resident had been in and out of the hospital. When asked, the ND 3 stated Resident 2 was sent to hospital on 3/28/17/ and was re-admitted back on 4/5/17, he was sent out again on 6/10/17 and returned back on 6/13/17. There was no period of hospitalization from 4/6/17 to 6/9/17. During a concurrent record review of the	F 411	Results from the dental clinic note audit of other in-house residents will be reported to NQIC and the next SNF PIPS Committee for further performance improvement actions if necessary. Nursing Program Directors are responsible for reporting compliance to NQIC, and the Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee.	11/23/17 and on-going

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F 411	Continued From page 18 Electronic Health Record (EHR) and interview on 10/24/17 at 8:30 AM, the Registered Nurse (RN) 6 and the ND 3 searched the entire EHR. The RN 5 and the ND 3 stated after reviewing the Physicians Progress Notes and the Nurses Notes there was no evidence the physician was notified of the dental plan. The ND 3 stated the facility was in the period of transition to electronic charting and would check the clinical chart. During a follow up interview on 10/24/17 at 9:10 AM, the ND 3 stated after searching the entire medical record there was no evidence the physician was notified and there was no evidence the dental plan was discussed in the IDT meeting.	F 411		
F 428 SS=F	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing,	F 428	The facility has implemented policies and procedures such that each resident's drug regimen is evaluated monthly and that each resident's drug regimen is free from unnecessary drugs. 1. The Director of Pharmacy Services has revised the Pharmacy policy and procedure on Medication Regimen Review to add that the pharmacist will indicate in the medical record whether or not any irregularities were identified during the monthly drug regimen review. 2. The following are responses to the Drug Regimen Review findings: Resident 2's attending physician has documented informed consent for use of oxycarbazepine for the treatment of schizophrenia and written that the target symptoms to monitor are mania, hyperverbosity and hallucinations.	11/23/17 11/23/17

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F 428	Continued From page 19 and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview of pharmacy staff and record review, the facility failed to provide pharmaceutical services necessary to maintain residents highest practical level of functioning when: 1. The irregularities found by the pharmacist in the monthly Drug Regimen Review (DRR), were	F 428	The attending physician has increased Resdent 2's Synthroid to 50mcg daily. Resident 4 is not on lorazepam or sertraline. Therefore, no corrective action can be implemented for this resident related to the drug regimen review. Resident 12's attending physician has written that the target symptoms to monitor for the diagnosis of bipolar disorder are pressured speech, visual and auditory hallucinations, mood swings, and insomnia; and the target symptoms for the diagnosis of panic disorder are panic attacks, severe anxiety and distressing thoughts. Resident 16 is no longer on glipizide, and is currently on a routine dose of Lantus insulin and PRN dose of Novolog insulin. The attending physician is monitoring the resident's HbA1C every 2 months. Resident 31's attending physician has written that the target symptoms to monitor for the diagnosis of disruptive mood dysregulation disorder are irritability, angry outbursts and refusal of care and throwing things at people. The attending physician has completed Resident 34's quarterly psychotropic preview on 10/23/17. The physician has also documented his rationale for continuing Resident 34 on donezepil and memantine in his monthly progress note dated 10/24/17.	11/23/17 11/23/17 11/23/17 11/23/17

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F 428	Continued From page 20 forwarded to the physician only when it involved a physician follow up; or to the nurse manager if it required a nursing follow up. 2. On seven instances of irregularities found involving 6 of 34 sampled residents (Residents 2, 4, 12, 16; and Random Residents 31 and 34) the reports were not acted upon, and the policy and procedure did not indicate time frames for the different steps in the process. This deficient practice is a potential risk for harm to residents due to unsafe use of medications, side effects and medical complications. Findings: 1. During an interview with a Pharmacist (Pharm) on 10/16/17 at 2:30 pm, in unit North Mezzanine, regarding facility procedure for DRR, he stated, "When irregularities are found, some are forwarded to the physician and some to the unit manager for follow up..." During an interview with the Pharmacy Director (PD) on 10/18/17 at 12:10 pm, she stated, "The pharmacist signs the monthly medication recap". When asked if the pharmacist signature meant irregularities were found or not, PD stated, "The signature means a review was done only. Irregularities found during the monthly DRR are divided in two groups for follow up: those that are physician related needing his intervention, and those sent to the nurse manager that involve the need for nursing follow up...We do not want to overwhelm the physician with unnecessary paperwork...Each following month, the pharmacist reviews the entire resident's record and checks if the recommendations were	F 428	Pharmacy Services will provide the Chief of Medicine and Chief of Staff a report of all current outstanding DRR requests to facilitate physician responding. The Chief Medical Officer will set expectations that the medication regimen review recommendations are addressed by the attending physician within 60 days. A summary report is provided to the CMO, CNO and CEO monthly. A report of outstanding recommendations >60 days will be provided to the Chief of Medicine and Chief of Staff for follow up with the attending physicians. The 60 day response rates will be reported to Medicine Executive Committee and Pharmacy and Therapeutics Committee at least quarterly.	11/23/17 and on-going 11/23/17 and on-going

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F 428	Continued From page 21 implemented or not...its ongoing..." PD did not describe time frames for steps in the process. 2. Record review of facility documents titled, "Drug Regimen Review Summary" and completed each by facility pharmacists, for Residents 2, 4, 12, 16; and Random Residents 31 and 34, regarding medications ("drug"), the pharmacist's recommendations, and "Follow up Comments"; indicated the following: For Resident 2, DRR dated 8/22/17: "Drug: levothyroxine [A medication used to treat low thyroid gland function. It can also treat an enlarged thyroid gland and thyroid cancer.] "...please consider increasing dose if deem clinically appropriate at this time...". "Drug: oxycarbazepine" [A medication to treat convulsions, epilepsy]. " Please obtain consent for the use of oxycarbazepine 900 mg in am and 600 mg q pm (evening dose). Also please have diagnosis followed with target symptoms written on the physician order form so information will be added on subsequent monthly recap of physician's orders..." "Follow up comments:" section was blank. No other notes or comments after 8/22/17, as of 10/18/17. For Resident 4, DRR dated 4/28/17: "Drug: lorazepam [A medication used to treat anxiety disorders], sertraline [A medication to treat depression]...The resident is on psychotropic medication and is due for a quarterly evaluation of the entire psychotropic regimen..." "Follow up Comments: 6/9/17: Please address this issue." No other notes or comments after 6/9/17, as of 10/18/17.	F 428		

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F 428	Continued From page 22 For Resident 12, DRR dated 5/8/17: "Drug: quietapine, lorazepam."[Quietapine, a medication used to treat schizophrenia, bipolar disorder]. "Please reevaluate the current target behaviors...note that general terms such as agitation, are considered non specific..." "Follow up Comments: 6/9/17 Please address." No notes or comments after 6/9/17, as of 10/18/17. For Resident 16, DRR dated 6/25/17: "Drug: glipizide [An oral diabetes medicine that helps control blood sugar levels] ...Please consider repeat HbA1C level [A blood test that reflects how well diabetes is controlled]to assess chronic DM [Diabetes Mellitus: a disease that includes abnormal high blood sugar levels] control." "Follow up comments:" section was blank. No other notes or comments after 6/25/17, as of 10/18/17. For Random Resident 31, DRR dated 4/20/17: "Drug: vpa" [vpa stands for valproic acid, a medication to treat seizures and bipolar disorder. It can also help prevent migraine headaches], "...please re-evaluate the current target behaviors in conjunction with the IDT [Interdisciplinary Team] to ensure that they are consistent with..." "Follow up comments: resent 7/27/17; resent 8/25/17". No other notes or comments after 8/25/17, as of 10/18/17. For Random Resident 34, DRR dated 12/2/16: "Drug: Lorazepam, Please note that GDR [gradual dose reductions] is required for all psychotropic medications regardless of indication for use...". "Follow up comments: 1/5/17 Please address"	F 428		

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F 428	Continued From page 23 On 5/11/17, the "Follow up comments" section indicated the same statement of "Please address" after each of the following dates: 6/9/17, 7/13/17, 8/10/17, 9/8/17, 10/10/17. The same Random Resident 34, DRR dated 5/10/17: "Drug: donezepil, memantine [Medications used to treat Alzheimer's dementia] "Please evaluate the benefits of continuing the above medications and consider discontinuing." "Follow up comments" section indicated the same statement of "Please address" after each of the following dates: 6/9/17, 7/13/17, 8/10/17, 9/8/17, 10/10/17. Record review of a facility policy titled, "Policy and Procedure for Medication Regimen Review" indicated under "Policy...Findings and recommendations are reported to the director of nursing, the attending physician, the medical director and if appropriate the administrator." Under "Procedure...5)Recommendations are acted upon and documented by the prescriber and or the facility staff. a)Physician accepts and acts upon suggestion or rejects and provides and explanation for disagreeing...c) The director of nursing or designated licensed nurse addresses and document recommendations that do not require a physician intervention, e.g. monitor blood pressure." The document did not indicate time frames for the different steps in the process.	F 428		
F 431 SS=E	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h)	F 431	The facility has implemented policies and procedures to properly store medications.	

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F 431	Continued From page 24 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	1. (a). The unlabeled medication cup with four loose tablets from S3 Buena Vista medication cart were discarded, and the sealed tablet of Ativan was returned to the medication dispensing cabinet. 1. (b) The unlabeled and uncapped syringe with 2 milliliter of clear liquid from S3 Buena Vista Medication cart was discarded in the sharps container. 2. The four cans of diet soda, two reusable suction canisters, and one reusable chart bag were removed from the S5 medication room and discarded. 3. The 14 packets of white sugar and one resident identification band inside the Accucheck quality control kit were removed from the S5 medication room and discarded. 4. The two expired laboratory test kits were removed from the S5 medication room and discarded. 5. The opened and undated bottles of Promod from the S6 Pacifica and Marina medication carts were discarded. 6. (a).The graham crackers, packets of black tea, creamers, and sugar packets were removed from S6 Pacifica medication cart and discarded. 6. (b). The resident's personal belongings, comprising of two rings and four bracelets, were removed from S6 Pacifica medication cart and secured, and returned to the resident upon return to the facility following an acute care hospitalization.	10/18/17 10/18/17 10/20/17 10/20/17 10/20/17 10/17/17 10/17/17 10/17/17

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F 431	Continued From page 25 controls, and permit only authorized personnel to have access to the keys. (2) 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored and labeled according to federal regulations when: 1.(a) One unlabeled medication cup with four loose tablets, one sealed tablet of Ativan (anti-anxiety medication) and (b) One unlabeled and uncapped syringe with two milliliter (ml) clear liquid were found in South 3 (S3) Buena Vista medication cart; 2. Four cans of diet soda, two reusable suction canisters, and one reusable chart bag were stored in the cabinet in South 5 (S5) medication room; 3. 14 sugar packets and one resident identification band were kept inside the Accucheck kit (a device used to measure blood sugar) in S5 medication room; 4. Two expired laboratory test kits were found in the cabinet in S5 medication room; 5. Opened and undated bottles of ProMod Liquid Protein (food supplement that provides a concentrated source of protein) were found in	F 431	7. The opened and undated Accucheck Control Solution were removed from the S6 Marina medication cart and discarded. 8. The expired PPD solution was removed from the N6 medication refrigerator and discarded. 9. The expired laboratory tube was removed from the N6 medication room and discarded. Charge Nurses from other neighborhoods and Pharmacy staff checked the contents of other medication carts, medication refrigerators and medication rooms for expired medications, unlabeled medications, used syringes, expired Accucheck solutions, expired laboratory test kits, opened and unlabeled Promod solutions, food, condiments and personal belongings. Expired and unlabeled items found were discarded and personal belongings were removed and stored properly. Pharmacy and licensed nursing staff will receive an in-service on performing a thorough check of all parts of the medication carts, medication refrigerators, medication room and storage areas for expired medications during the monthly scheduled inspections of the medication storage areas. Pharmacy Supervisor, and Nurse Managers will monitor for compliance with proper medication storage protocols.	10/17/17 10/17/17 10/17/17 11/23/17 11/23/17

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F 431	Continued From page 26 South 6 (S6) Pacifica and Marina medication cart; 6.(a) Food items such as graham crackers, creamers, black tea and sugar packets and (b) A resident's personal belongings were stored in S6 Pacifica medication cart; 7. One opened and undated Accucheck Control Solution (a solution used to test the accuracy of a blood glucose meter and test strips) was found in S6 Marina medication cart; 8. One expired PPD (Purified Protein Derivative) solution (a solution that is used to check tuberculosis infection) was stored in North 6 (N6) medication refrigerator; and 9. One expired laboratory tube was found in N6 medication room. These deficient practices had the potential to cause harm to residents through infection, medication errors, drug diversion and inaccurate laboratory test results. Findings: 1. During S3 Buena Vista medication cart inspection, on 10/18/17 at 9:47 AM, the following items were found in the second drawer: a. Four loose tablets (two brown round, one pink oval, and one white) and one sealed Ativan tablet in an unlabeled medication cup; and b. one unlabeled and uncapped syringe filled with two ml clear liquid kept inside a plastic sleeve. During a concurrent interview, the Nurse Manager (NM) 2 stated, "It looks like they prepped medications but they did not give it. If patient refused, they (referring to medications) should be wasted and should be disposed. It (syringe) should not be there for infection control. I don't know what's in there (referring to the	F 431	The Food Services Department will place a sticker on bottles of Promod that are delivered to neighborhoods. The stickers will include a "date opened" and "date to be discarded" (3 months from when it is opened per Manufacteror's Recommendation unless there is an earlier expiration date) stickers. Licensed nursing staff is responsible for writing a date on the 2 labels on the Promod bottles to indicate when it is opened and the date for discarding the unfinished product. The monthly medication room and medication cart inspections by Pharmacy staff, Licensed Staff Team Leads will be revised to include checking of Promod bottles, locked bins in the medication cart, and Accucheck kits. Results from the monthly medication room and medication cart inspections will be reported to NQIC and the SNF PIPS Committee quarterly. Nursing Program Directors are responsible for reporting compliance to NQIC, and the Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee.	11/23/17 11/23/17 and on-going 11/23/17 and on-going

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F 431	Continued From page 27 syringe)." During an observation, and concurrent interview, on 10/18/17, at 9:52 AM, the Licensed Vocational Nurse (LVN) 3 stated, "I don't know" when asked to identify contents of the unlabeled syringe. LVN 3 added, "I don't suppose to leave the medications in the cassette, they can be lost. I have to discard (medications)." 2. During an observation on 10/20/17, at 10:01 AM, four cans of diet soda, two reusable suction canisters and one reusable chart bag were found inside the cabinet in S5 medication room. During concurrent interview, the Nursing Director (ND) stated, "They're (soda cans) not supposed to be here. They should be in the galley." The NM 3 stated, "We'll remove them (referring to the cans of soda, canisters, and bag). I'll do it now." 3. During an observation and concurrent interview on 10/20/17, at 10:06 AM, there were 14 packets of white sugar and a resident identification band inside the Accucheck quality control kit. The ND stated the night shift nurse probably left them there and that they should not be there. 4. During an observation 10/20/17 at 10:09 AM, there was one bottle of SAF Fixative (Sodium acetate-Acetic acid-Formalin Fixative is used for stool specimen examination) with expiration date of "4/2017" and one canister of Gastroccult (a test for detecting presence of blood from stomach contents) with expiration date of "2/2017" inside the cabinet in S5 medication room. During concurrent interview, NM3 stated, "They (test kits) shouldn't be there. We either throw them away or return back to the pharmacy."	F 431		

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F 431	Continued From page 28 During an interview on 10/24/17 at 9:57 AM, , the Chief Nursing Officer (CNO) stated, "A checklist was created to check for expiring items. (Items) must be removed once expired and plan to remove all lab test kits to the laboratory only." 5. During an observation, on 10/17/17, at 2:13 PM, one open and undated bottle of ProMod was found in the bottom drawer of South 6 (S6) Pacifica medication cart. RN 4 acknowledged the findings. During an observation, on 10/17/17, at 2:30 PM, one opened and undated bottle of Promod was found in the bottom drawer of S6 Marina medication cart. RN 4 and ND 2 acknowledged the findings. ND 2 stated that she will check the policy of dating the Promod bottle. Review of Promod manufacturer's guidelines (Obtained from https://abbottnutrition.com/promod-liquid-protein, on 10/26/17), indicated, "...Storage and Handling: Discard 3 months after opening..." During an interview, on 10/18/17, at 2:59 PM, the ND 2 and Chief Dietician acknowledged an open date should be indicated in the bottle of Promod. The ND 2 stated, "We will work on something to make sure we follow the (manufacturer) guidelines." 6 a. During an observation on 10/17/17, at 2:13 PM, graham crackers, packets of black tea, creamers, and sugars were found in the first drawer of S6 Pacifica medication cart. RN 4 acknowledged the findings and stated, "Some nurses keep it for emergency but it should not be there."	F 431		

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F 431	Continued From page 29 b. In the second drawer of S6 Pacifica medication cart, two yellow ring with colorless stone and four yellow bracelet were found inside a plastic bag. The plastic bag had a resident sticker. During concurrent interview, RN 4 stated the resident who owns the rings and the bracelets was discharge recently, and stated "It should not be there. It should be kept at Nurse Manager's room." Review of facility policy titled, "Handling Resident's Property And Prevention Of Theft And Loss" dated 7/14/15, indicated, "...3. Resident's Property on Transfer and Discharge...d. Valuables not taken by the resident upon discharge will be listed by nursing staff on the IRP (Inventory of Resident's/Patient's Property) and the property will be placed in an envelope labeled with the resident's name, unit, medical record number, contents, and date of discharge and brought to Admissions and Eligibility office..." 7. During an observation, on 10/17/17, at 2:30 PM, an opened and undated Accu-Chek Inform II control solution was found in the fourth drawer of S6 Marina medication cart. RN 4 acknowledged the findings. Review of Accu-Chek Inform II Controls product insert, dated 2014, indicated, "...Note: Write the date the bottle was opened on the bottle label. The control solution is stable for 3 months from that date or until the "Use by" date on the bottle label, whichever comes first..." Review of the facility's LHH Nursing Policies and Procedures, Revised January 10, 2017, titled: "Obtaining, Handling, and Storage of	F 431		

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F 431	Continued From page 30 Medications" indicated, " ...Purpose: Correct medications will be available and stored properly ... Procedures: ...D. Storage of Medications, 1. Condition of Containers and Contents, a. Medications are to be kept in the containers received from Pharmacy ...2.Orderliness of Medications ...c. Medication Room ...All unlabeled and expired medications are to be discarded in the medication waste bin." 8. During an observation on 10/17/17 08:30 AM in the medication room of unit N6, while inspecting items in the designated "Refrigerator for Medications", a vial of opened PPD (Purified Protein Derivative) solution (a solution that is used as a diagnostic aid in the detection of tuberculosis infection) dated 07/27/2017 was found inside....NM 6 stated "We remove these after 28 days of opening..It should not be in the refrigerator...", and proceeded to place in a secured container to discard it. 9. During an observation on 10/17/17, at 08:30 AM in the medication room of unit N6, while escorted by NM 6, a purple top lab tube with an expiration date of "04/2017" was found on a shelf with other lab supplies. NM 6 acknowledged the observation and stated, "It is expired..it should not be there..."	F 431		
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441	The facility has a well-established infection control program designed for preventing, identifying, reporting, investigating, and controlling infection and communicable diseases for residents, staff, volunteers, visitors, and other individuals providing contractual services.	

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F 441	Continued From page 31 (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 441	a. Signage was placed in the Great Room next to the water and ice machine dispensers on S2 neighborhood providing instruction to residents, families, visitors and staff to use a new cup whenever they get a cup of water to drink. The Nurse Manager reviewed and explained the new signage instruction with Resident 31 to use a new cup whenever he gets a cup of water to drink from the water dispenser. Resident 31 indicated that he understood the explanation provided to him. b. The electric toothbrush on South 5 that belongs to the Resident in Room S523 was cleaned, removed from the shared bathroom, labelled with the resident's name and stored in the resident's room. c. The Nurse Manager met with the Resident in Room S426A to explain that the undated bottle of peanut butter, the unrefrigerated bottles of A1 sauce and chili sauce may pose a health hazard to the resident. The Resident agreed to discard the two jars of undated peanut butter, one bottle of A1 sauce, and one bottle of chili sauce. Charge Nurses and Nurse Managers were instructed to conduct rounds on their respective neighborhoods to look for unlabeled personal items in shared bathrooms and remove them; and to discard any opened, unlabeled or undated perishable food items at bedside.	10/24/17 10/24/17 10/16/17 10/16/17 10/24/17

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F 441	Continued From page 32 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement infection prevention program when: a. Residents were allowed to refill used drinking cups by pressing the lip of the cup to the water dispenser tab. b. An unlabeled electric toothbrush was found in a shared bathroom in Room South 523. c. Open, unlabeled, and undated two jars of peanut butter, A1 sauce, and Chilli sauce were found on the overbed table in Room South 426A. Failure to ensure sanitary environment and resident care equipment may result in cross contamination and spread infection.	F 441	A read and sign In-service will be provided to 24 hour Nursing staff on the importance of the following infection control standards to prevent the spread of infections and hazardous conditions: 1. Use a new cup each time when obtaining water and ice from the water and ice dispensers in the Great Room 2. Label resident personal belongings, do not leave them in shared bedrooms and store them in the resident's storage cabinets or drawers. 3. Inform residents, families, visitors and volunteers the importance of properly labeling and dating food items kept at the resident's bedside and refrigerating perishable items. The Nurse Educator is responsible for developing the in-service materials. Nurse Mangers are responsible for monitoring staff completion of the in-service. Signage was also placed next to the water and ice machine dispensers in the Great Rooms on other neighborhoods providing instruction to residents, families, visitors and staff to use a new cup whenever they get a glass of water to drink. Residents will be provided with education during the monthly neighborhood community meetings on using a new cup whenever they get a cup of water to drink from the water and ice dispensers. Signage has been placed by each water and ice dispenser in the Great Room to remind residents, families, visitors, volunteers and staff to use a new cup every time.	11/23/17 11/23/17 11/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	10/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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F 441	Continued From page 33 Findings: a. An observation on 10/18/17 at 1:30 p.m. showed Random Resident (RR) 31 filled up a cup of water from a water dispenser without supervision. She pressed the lip of the cup to a metal tab which dispensed the water. In a concurrent interview with Registered Nurse (RN) 1, she stated that it was okay for this resident to get her own drinks. She said that water was also dispensed into cups by staff for other residents who lived in that neighborhood (the unit where RR 31 lived). She said there was the possibility of spreading infection if residents used their cups multiple times to refill water but there were times when they could not stop residents from getting their own drinks. In an interview on 10/20/17 at 9:50 a.m., Volunteer 1 (V1) stated he helped with activities on the unit in the dining area one day a week for over a year. He said that RR 31 did drink her water from a cup and then refilled the same cup multiple times. He said that other residents were allowed to refill their own cups with water from the dispenser if they had that ability. In an interview on 10/20/17 at 8:50 a.m., RD 1 stated that the same water dispensers were used on every unit. A policy and procedure, titled "1.71 Replenishing Juice and Coffee Dispensers in the Neighborhood Great Room" dated 8/15, was provided by the facility when the policy and procedure for the water dispenser was requested. The policy and procedure read, "Policy: To ensure that residents and staff have access to juice and coffee at all times, a Food service worker will replenish the juice and coffee dispensers located in each	F 441	The policy and procedure titled "Replenishing Juice and Coffee Dispensers in the Neighborhood Great Room" has been revised to include instructions on using a new cup whenever they get a cup of water to drink from the water and ice dispensers. Charge Nurses on every shift are responsible for conducting environmental rounds on infection control standards and implementing corrective actions when deviations are found. Nurse Managers are responsible for conducting weekly environmental rounds of the neighborhood as part of quality assurance activity. Nursing Program Directors are responsible for monitoring compliance. Results from environmental rounds will be aggregated and reported quarterly to NQIC and the SNF PIPS Committee. Nursing Program Directors are responsible for reporting compliance to NQIC, and the Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee	11/23/17 11/23/17 and on-going 11/23/17 and on-going

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F 441	Continued From page 34 Neighborhood. In addition, the dispensers will be cleaned and sanitized once a day." This policy and procedure did not address the use of the water dispenser or infection prevention and control when a dirty cup is used. b. During an observation, on 10/16/17, at 10:35 AM, an unlabeled electric toothbrush was found inside the shared bathroom in South Room 523. During concurrent interview, the Nursing Director acknowledged the findings and stated, the toothbrush should be kept at the bedside "to avoid cross contamination." c. During an observation, on 10/16/17, at 11:07 AM, an open, unlabeled, and undated two jars of peanut butter, one bottle of A1 sauce, and one bottle of Chilli sauce was found on the overbed table in South Room 426A. During concurrent interview, the Nurse Manager (NM) 4 acknowledged the findings and stated, "It should be dated and labeled."	F 441		
F 456 SS=D	ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION CFR(s): 483.90(d)(2)(e) (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on dishwashing observations, interview, and record review, the facility failed to ensure	F 456	The facility maintains mechanical, electrical and patient care equipment in safe operating condition. Facility Services staff serviced and repaired the dish washing machine to achieve the proper final rinse temperature range of 180 to 195 degrees Fahrenheit.	10/18/17

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F 456	Continued From page 35 equipment was maintained in accordance with manufacturers' guidance when the final sanitation water temperature was in excess of manufacturers' guidance. This may result in ineffective sanitation of dishes. Findings: During review of dishwashing procedures on 10/18/17 beginning at 9:50 a.m., the water temperature of the final rinse cycle, of the dish machine adjacent to the 3-compartment sink. over multiple wash cycles, ranged between greater than 195°F (degrees Fahrenheit) and 202°F. In a concurrent interview with Dietary Staff (DS) 5 he stated that the final rinse often goes above 200°F. In an interview Kitchen Supervisor (KS) 1 stated his understanding was that the minimum temperature for the rinse cycle was 180°F and anything above that would be acceptable. Concurrent review, in the presence of KS 1, noted the manufacturer recommended a final rinse temperature range of 180-195°F. Review of hospital document titled, "CQI: Equipment Temperature" from 10/3-10/17/17 demonstrated that the final rinse temperature was greater than manufacturers specifications 25 of 49 entries or 51 percent of the time. Guidance printed on the form asked staff to notify a supervisor, chef or plant services if the final rinse temperature was below 180°F. There was no guidance provided to staff if the temperature was above manufacturers' specifications. According to the 2013 Food Code Section 4.501.12 (A)" ...In a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than	F 456	An in-service has been provided to the Food and Nutrition Service staff on the importance of following manufacturer recommended final rinse temperature ranges (180-195 degrees Fahrenheit) for the dish washing machine; recording the temperature checks on the CQI equipment temperature log; and notifying the Food Services Supervisor, Chef or Facility Services staff when the final rinse temperatures are outside of the recommended temperature limits, below 180 degrees or above 195 degrees Fahrenheit. Food Services Supervisors and Chefs are responsible for monitoring compliance. Recorded readings on CQI equipment temperature log that are below 180 degrees or above 195 degrees Fahrenheit will be reported at the weekly Food Services management meeting; and results aggregated quarterly for reporting at the SNF PIPS Committee meeting. Director of Food Services is responsible for reporting at the SNF PIPS meeting. Chief Operating Officer is responsible for reporting compliance.	11/23/17 and on-going 11/23/17 and on-going

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F 456	Continued From page 36 194 degrees Fahrenheit." The temperature of the hot water delivered from a ware washing sanitizing manifold must be maintained according to the equipment manufacturers' specifications and temperature limits ...to ensure surface of multi-use utensils such as kitchenware and tableware accumulate enough eat to destroy pathogens that may remain on such surfaces after cleaning ...When the sanitizing rinse temperature exceeds 194°F at the manifold, the water becomes volatile and begins to vaporize reducing its ability to convey sufficient heat to utensil surface (2013 Food Code Annex). According to the 2013 Food Code Annex, "proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed ...Adequate cleaning and sanitation of dishes and utensils using a ware washing machine is directly dependent on the exposure time during the wash, rinse and sanitizing cycles. Failure to meet manufacturer and Code for cycle times could result in failure to clean and sanitize. For example, high temperature machines depend on the build-up of heat on the surface of the dishes to accomplish sanitation. If the exposure time during any of the cycles is not met, the surface of the items may not reach the time-temperature required for sanitation."	F 456		
F 518 SS=E	TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS CFR(s): 483.75(m)(2) 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	F 518	The facility trains new employees in fire emergency procedures and abuse reporting protocol as part of new hire orientation when staff begin work at the facility; provides for annual fire safety in-services and abuse prevention protocol for current staff; periodically review fire safety procedures with staff and carry out unannounced fire drills every month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	10/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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F 518	Continued From page 37 those procedures. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to train employees in emergency procedures when: 1) two staff members did not state the activation of the pull station fire alarm and the location of the nearest fire alarm when given a scenario of a fire in a resident room, 2) one staff member did not know where the water and gas shut-off were located, how to access emergency electricity, and who the abuse coordinator was. These failures had the potential to put residents, staff, and visitors at risk for harm or injury. Findings: 1) During an interview with Patient Care Assistant (PCA) 2 on 10/24/17 at 8:25 am, in unit North Mezzanine, and after twice presented with a fire scenario in a resident room, he stated, "I will remove the resident, ask for help and let other staff know...". PCA 2 acknowledged he did not referenced to activating manually a pull station fire alarm. Asked for the location of the nearest fire alarm to the resident room, PCA 2 was not able to locate the closest alarm, which was located about 8 feet from the resident room. During an interview with Patient Care Assistant (PCA) 3 on 10/24/17 at 8:45 am, in unit North Mezzanine, after twice presented with a fire scenario in a resident room, he stated, "I will remove the resident, ask for help and let other staff know and wait for my charge nurse...". PCA 3 acknowledged he did not make reference to activating manually a pull station fire alarm.	F 518	The Nurse Manager on North Mezzanine reviewed the facility's fire safety procedures with PCAs on the unit; including the location of fire alarms, water and gas shut-offs, how to access emergency power, Code Red procedures, the acronym R.A.C.E, (Rescue, Alarm, Contain, Extinguish) and P.A.S.S. (Pull, Alarm, Squeeze, and Sweep); and reminded staff to refer to their badge buddy to assist them in recalling the facility's fire emergency procedures. A read and sign review of educational slides will be provided to 24 hour facility staff reminding them of the facility's emergency and abuse prevention procedures which includes the following content: 1. Activation of fire or Code Red procedures, including the acronym R.A.C.E and P.A.S.S.; 2. Locations of the fire alarm pull stations on the neighborhoods; 3. Locations of the gas shut-off valves on the neighborhoods; 4. How to access emergency power; 5. Location of the hospital's water shut-off valve that only trained Facility Services may shut off; 6. Facility protocol for reporting abuse and the names of abuse coordinators The Nurse Educator is responsible for developing the educational slides. Department Managers are responsible for monitoring staff compliance with review of the instructional materials.	10/24/17 11/23/17

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F 518	Continued From page 38 Record review of a nine-page facility document titled, "Fire Response Plan" indicated on page 1 under "Purpose"...is to set forth procedures for responding to a fire with the primary objectives of life safety, continuity of operations, and preservation of property." Under "Procedure: 1. when you see smoke of fire a. Follow RACE acronym for basic fire response steps: I. Rescue...II. Alarm by continuing to shout "Code Red" to nearby staff and by activating the alarm using the nearest manual pull station...". 2) During observation and interview on 10/20/17, at 2:45 PM, PCA 4 did not know where the water and gas shut-off valves were located, how to access emergency electricity and who the abuse coordinator was.	F 518	Fire safety drills are conducted on the neighborhoods by the Facility Services Safety Engineer monthly, including quarterly on every shift, at unexpected times under varying conditions. Facility Services staff assigned to conduct fire drills has been trained to review the Fire Drill Participation forms, and analyze staff responses for completeness and if review criteria are met. Quarterly reports from fire drills will be submitted to the SNF PIPS Committee four times per year by the Director of the Facility Services. Chief Operating Officer is responsible for reporting compliance. Nurse Managers, and Nurse Educators will periodically quiz random neighborhood on their ability to respond to fire emergency procedures and abuse reporting protocol. Results from the random quizzes will be aggregated quarterly and reported four times a year to NQIC and the SNF PIPS Committee. Nursing Program Directors will be responsible for monitoring compliance. Chief Nursing Officer will be responsible for reporting compliance.	11/23/17 and on-going 11/23/17 and on-going