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 _____	C 02/07/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an Abbreviated Standard Survey. The inspection was limited to the specific incidents investigated and does not represent the findings of a full inspection of the facility. For Facility Reported Incident nos. CA580970 regarding Quality of Care/Treatment-Resident Safety/Falls and CA582041 regarding Misappropriation of Property, the Department substantiated a violation of Federal regulations and issued a deficiencies. Representing the California Department of Public Health: Surveyor 31983, Health Facilities Evaluator Nurse	F 000	See attachment A for the Plan of Correction for FRI No.CA580970 and CA582041	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mivic Hirose	Mivic Hirose, Executive Administrator	2/21/19

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 609	Continued From page 1 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement their policy on reporting of abuse after money was misappropriated from, for one resident (Resident 1) in a sample size of three residents. This could have resulted in further abuse of Resident 1. Findings: Resident 1 was admitted with diagnoses including paraplegia (loss of function of lower extremities). During an interview on 4/24/18 at 10:35 am with Risk Manager (RM) 2, he confirmed Resident 1 reported $300 missing on 4/7/18 and that facility reported the incident to the Department greater than 24 hours after Resident 1 notified staff of the missing funds. RM 2 confirmed the facility policy and procedure requires notification to the Department within 24 hours. Record review of facility policy and procedure, "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response [sic]" (Revised 11/14/17), indicated,	F 609		

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F 609	Continued From page 2 "The nurse manager, charge nurse, and nursing supervisor shall:... v. Notify within 24 hours the State Survey Agency on weekends and holidays. During regular business days, the reporting function to the State Survey Agency is performed by Risk Management Nurses."	F 609		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to provide supervision for one resident (Resident 3) in a sample size of three, when she was left alone on a toilet, fell, and sustained a right hip fracture. This resulted in Resident 3's hospitalization for evaluation and surgical intervention. Findings: Resident 3 was admitted with diagnoses including Lewy body dementia (neurological disorder resulting in progressive failure of cognition and memory, as well as progressive loss of physical functional abilities), general debility, and failure to thrive. During an interview with concurrent observation on 4/24/18 at 12:20 pm, Risk Manager (RM) 1	F 689		

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F 689	Continued From page 3 confirmed there were no gloves inside the bathroom between the dining/activity room (called the "great" room) and the elevators and that the bathroom had a call light. During an interview on 4/24/18 at 3:35 pm, Registered Nurse (RN) 1 reported she observed Resident 3 in the great room in her wheelchair (W/C) and kept getting up and triggering a chair alarm. Resident 3 verbalized repeatedly and with urgency that she needed to go the toilet. RN 1 brought Resident 3 to the bathroom close to the great room. Resident walked from W/C to toilet with RN 1 assisting. RN 1 reported she told Resident 3: "... [Resident 3's name redacted], I will be back. I just need to get some gloves.", to which Resident 3 replied, "Okay". RN 1 reported she left the bathroom to get gloves near the sink in the great room and took, "not even a minute". RN 1 reported she returned, opened the bathroom door, and found Resident 3 on the floor on her right side. Record review of facility Medical Doctor (MD) Discharge Summary for 3/27/18 noted resident was admitted 2/15/18 for comfort care with diagnoses including Lewy body dementia, general debility, and failure to thrive. After a fall 3/26/18, resident, "... immediately felt pain in the right hip. X-ray on March 27 demonstrated an impacted comminuted [break or splinter of bone with more than two fragments] fracture of the right femoral leg.", and was transferred to a General Acute Care Hospital (GACH) for an orthopedic consultation. Radiology report dated 3/27/18 at 8:24 am noted, "Impact fracture through the right femoral neck." RN Progress Note dated 3/26/18 at 8:05 pm noted, "Resident fell in the toilet approximately 4:20 [sic] this afternoon. She was	F 689		

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F 689	Continued From page 4 found lying on her right side with the garbage can beside her. Noted 4 cm (centimeters, a metric measure of length/distance) x 2 cm superficial abrasion [scrape] on her right posterior [back of head] scalp. Also, complained of right groin pain." Record review of Resident 3's 2/15/18 admission falls risk assessment noted resident with history of falls, cognitive deficit/wandering/confusion, mobility or gait problems, and on medications which placed her at risk for further falls. Record review of Resident 3's Minimum Data Set (MDS) dated 2/26/18 noted resident was, "not steady, only able to stabilize with staff assistance", for, "moving on and off toilet", and used a W/C for mobility. MDS noted resident was on two antidepressants, had a pressure reducing device for the bed, had a diagnosis of dementia with Lewy bodies (non-Alzheimer's dementia), was frequently incontinent of urine, was occasionally incontinent of bowel, had cognitive impairment, and resident required extensive assistance by one person for toileting. Record review of Resident 3's care plans indicated a care plan dated 2/15/18 for, "Risk for falls related to: History of falls, Attempts to get out of bed without using call light for assistance, impaired safety assistance, Mobility or gait problems, BLE [bilateral lower extremity] weakness, Sensory deficits: Low vision, Cognitive deficits, confusion, and/or wandering; and Medications such as psychotropics, diuretics, cardiovascular, anticonvulsants or polypharmacy. Care plan (undated) for "Resident Needs" noted fall risk with bed and chair alarms and: "needs assist with transfer to W/C and toilet".	F 689		

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F 689	Continued From page 5 Record review of GACH operative report dated 3/28/18 indicated resident had a right hip hemiarthroplasty for fracture. Record review of GACH Discharge Summary dated 4/2/18 noted GACH Physical Therapy saw Resident 3 last on 4/1/18: "Patient seen for 45 minutes for bed mobility and transfers training. Attempted to have patient sit up in w/c per charge RN recommendation but patient unsafe and became hyper aware of Rt [right] hip when seated... Unable to perform stand step transfer to w/c from bed; stand pivot transfer to w/c with 2nd person managing operative leg to maintain precautions while patient pivots on nonoperative leg." D/C Summary also indicated Resident 3 was prescribed enoxaparin (anticoagulant medication) for 30 days, oxycodone (opioid analgesic) 10 milligrams every four hours as needed, along with acetaminophen (generic Tylenol, an analgesic) around the clock.	F 689		

ATTACHMENT A

LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

PLAN OF CORRECTION FOR FACILITY REPORTED INCIDENTS (FRI) NO. CA580970 and CA582041

ID PREFIX TAG	SUMMARY OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
F 000	Refer to the CMS-2567 for the above referenced FRIs	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 and Plan of Correction (CMS-2567) issued by the California Department of Public Health on February 8, 2019; and received by the facility on February 11, 2019; for two Abbreviated Standard Survey conducted for Facility Reported Incident (FRI) investigation CA580970 and CA582041, that were initiated on April 24, 2018; and completed on February 7, 2019. The submission of this Plan of Correction does not constitute an admission of the deficiencies listed on the Summary Statement of Deficiencies or an admission to any statements, findings, facts, and conclusions that form the basis of the alleged deficiencies.	N/A
F 609	Refer to the CMS-2567 for the above referenced FRIs	F 609	Laguna Honda has developed and implemented written policies and procedures that prohibit abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. The facility has an abuse prevention program that includes the seven required elements of screening, training, prevention, identification, investigation, protection and timely reporting/response. Resident 1 was provided with lanyard to keep her drawer key in her possession at all times. Care team monitored resident and there was no negative impact or change from baseline resulting from incident. The Executive Administrator will issue a memo to remind staff of the mandated 2-hour reporting requirement involving allegations of abuse including theft and misappropriation of property. The policy and procedure titled "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response" was revised on September 11, 2018 to include an informational grid to emphasize the 2-hour	4/10/2018 2/28/2019

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ID PREFIX TAG	SUMMARY OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
			reporting protocol to the California Department of Public Health Licensing and Certification Program. Other Laguna Honda employees have been directed to complete an in-service in response to the issued deficiency for failure to timely report allegations of abuse including theft to the State Survey agency. The Nurse Educator is responsible for developing the in-service. Respective Department Managers and Supervisors are responsible for monitoring staff completion of the in-service. Quality Management Nurses who are members of the Resident Safety and Abuse Prevention Performance Improvement Team will be assigned to conduct a monthly review of facility reported incidents of allegations of abuse, including theft and misappropriation of resident property to track facility compliance and improvement with timely reporting. Results of the monthly audits will be aggregated and reported to the Resident Safety and Abuse Prevention Performance Improvement Team to identify opportunities for improvement. The Quality Management Nurse Manager or designee is responsible for reporting compliance to the Resident Safety and Abuse Prevention Performance Improvement Team. Results of the monthly audit on timely reporting of abuse allegations including theft and misappropriation of resident property will also be reported to the Nursing Quality Improvement Council (NQIC) on a quarterly basis; and to the Skilled Nursing Facility (SNF) Performance Improvement and Patient Safety Committee (PIPS) on a bi-annual basis. The Quality Management Nurse Manager is responsible for reporting compliance to NQIC on a quarterly basis, and to the SNF PIPS Committee bi-annually. Nursing Program Directors and the Chief Nursing Officer are responsible for developing on-going improvement action plans to address instances of non-compliance with regulatory requirements.	3/1/2019 2/26/2019 and on-going 2/11/2019 and on-going

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F 689	Refer to the CMS-2567 for the above referenced FRIs	F 689	Laguna Honda has developed and implemented policies and procedures for safe-handling of high-fall risk residents. Additionally, the facility also has implemented standard work for staff in resident fall-prevention and post-fall management.	
			Resident 3 was immediately examined by MD and RN on 3/26/2018 and was sent to ED for evaluation and underwent a right hemiarthroplasty. Pain management, and Rehab evaluation was initiated, and coach was assigned for safety.	03/26/2018
			A root cause analysis (RCA on the incident was performed by the Nurse Manager on 4/4/2018. The neighborhood staff were educated on the RCA findings related to the incident. Changes were made based on results of the RCA to help prevent future incidents, which include reviewing toileting plans for residents who require a scheduled toileting schedule, instructing staff to not leave residents with limited or extensive assistance unattended.	03/29/2018
			Charge Nurses monitor and ensure residents whose care plans need frequent toileting are met. Nurse Managers started tracking daily incidents of falls (when applicable) and created visual displays of aggregated data for unit staff to understand their performance related to falls over specific time periods.	03/29/2018 and on-going
			Glove boxes were installed directly outside the doors of all neighborhood t hallway entrance restrooms.	4/26/2018
			All facility employees received a hospital-wide in service on fall prevention and post-fall management on 5/22/2018. The Nurse Educator was responsible for developing the in-service.	5/22/2018

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			All Laguna Honda employees have been directed to complete an in-service in response to the issued deficiency for failure to ensure free of accident hazards as possible. The Nurse Educator is responsible for developing the in-service. Respective Department Managers and Supervisors are responsible for monitoring staff completion of the in-service. If a resident fall with major injury occurs, all Nurse Managers are required to complete an RCA. Results of the post-fall RCA will be reported to the Nursing Quality Improvement Council (NQIC) on a quarterly basis for data and trends analysis; and to the Skilled Nursing Facility (SNF) Performance Improvement and Patient Safety Committee (PIPS) on a bi-annual basis. The assigned Nurse Manager or Clinical Nurse Specialist and/or designee is responsible for reporting compliance to NQIC on a quarterly basis, and to the SNF PIPS Committee bi-annually. Nursing Program Directors and the Chief Nursing Officer are responsible for developing on-going improvement action plans to address instances of non-compliance with regulatory and safety standards.	3/1/2019 06/10/2018 and on-going