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 02/15/2019

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 incident investigated and does not represent the findings of a full inspection of the facility. For Facility Reported Incident no. CA00597769 regarding Resident/Patient/Client Abuse, the Department was able to identify a violation of Federal regulations and issued a deficiency. Representing the California Department of Public Health: ID: 31794, Health Facilities Evaluator Nurse	F 000	**See attachment A for Plan of Corection for FRI No. CA597769**	
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 adult protective services where state law provides	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Chief Executive Officer	4/8/19

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 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 observation, interview and record review the facility failed to ensure staff reported alleged incident of abuse to the State Agency (SA, which is the California Department of Public Health, CDPH) within the required reporting period following a witnessed "physical abuse" for two residents (Residents 1 and 2) on 7/27/18. Failure to report with the required time period had the potential for abuse to happen again. Findings: During a review the faxed transmittal copy of the Facility Reported Incident (FRI) dated 8/1/18 at 3:43 PM, it indicated two residents (Residents 1 and 2) were seen "hitting" each other infront of the facility. During an interview on 8/31/18 at 2 :00 PM, the Risk Management Nurse (RMN) 1 stated on 7/27/18 at 4:45 PM, the two residents (Residents 1 and 2) were both In the "Horse Shoe" area (name of the smoking area) of the facility. The RMN 1 stated, one facility staff (a Mental Health Rehabilitation Supervisor, (MHRS 1), who was on his way home, saw Resident 2 approached	F 609		

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F 609	Continued From page 2 Resident 1 from behind and did a "headlock" with his arm to Resident 1. The RMN 1 further stated Resident 2 started the "punching motion" on the face of Resident 1 while he was trying to block and defend himself. The RMN 1 stated the MHRS 1 intervened, called the Institutional Police and the two residents were separated. According to the RMN 1, the MHRS 1 no longer worked for the facility. During a review of the document titled Investigation of Alleged Abuse, dated 7/31/18 it indicated, there was a "deliberate act to harm the other resident", signed and dated by the Nurse Manger (NM) 1 on 7/31/18. During an interview on 2/4/19 at 11:10 AM, the Nurse Manager (NM) 1 verified the alleged abuse was reported to her by the MHRS 1 on 7/31/18 (4 days after the abuse incident was discovered), it was a "physical abuse", there was an intent to harm the other resident. The NM 1 stated the alleged event happened on a "Friday" (7/27/18) and the MHRS 1 was ready to leave the facility. The NM 1 stated the staff should report alleged abuse immediately, "we have two (2) hours window to report". When asked, the NM stated, so staff could start the investigation and interview residents. During a phone interview on 2/4/19 at 2:37 PM, the MHRS 1 acknowledged he witnessed the altercation between Residents 1 and 2 on 7/27/18 at 4:45 PM. The MHRS 1 stated he was recently hired at that time, he had training on abuse, he was not sure if this was categorized as abuse or not, and he could not remember there was a reporting procedure.	F 609		

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F 609	Continued From page 3 During a review of the facility policy titled Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response with the last revised date of 6/18 indicated: "XXX (Name of the facility) shall promote an environment that enhances resident well-being ... . Policy: ... . Purpose: .... Definition: 1. ... a. ... c. Physical Abuse, includes ... hitting, ... Procedure: ... 6. Reporting Protocol: a. ... c. The Nurse Manager ... i. ... iii. Notify within 24 hours to the ... CDPH of events involving allegations of abuse that are ... and do not result in serious injury. ... ."	F 609		

ATTACHMENT A

LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

PLAN OF CORRECTION FOR FACILITY REPORTED INCIDENT (FRI) NO. CA597769

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 FRI	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 March 28, 2019, and received by the facility on March 29, 2019, for an Abbreviated Standard Survey conducted for a Facility Reported Incident (FRI) investigation that was initiated on August 31, 2018, and concluded on February 15, 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.	Refer to dates below
F 609	Refer to the CMS-2567 for the above referenced FRI	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. MHRS 1 immediately separated the two residents and waved his hands to call the attention of the San Francisco Sheriff Department (SFSD) Cadet who was on duty in the hospital lobby area. A SFSD Officer responded from the lobby and walked to the scene. The SFSD Officer spoke to both residents. Resident 1 declined to press charges against Resident 2. Resident 1's physician was informed of the incident. Resident 1 was not injured and had no signs of distress following the incident and verbalized that he was feeling fine. Resident 2 was counseled and told not to be physically aggressive towards other residents and was scheduled to continue with his counseling sessions with the psychologist. Resident 2 was discharged to the community on March 7, 2019, according to his plan of care.	7/27/2018 8/2/2018

ATTACHMENT A

LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

PLAN OF CORRECTION FOR FACILITY REPORTED INCIDENT (FRI) NO. CA597769

ID PREFIX TAG	SUMMARY OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
			MHRS 1 was coached by his Supervisor on timely abuse reporting, and a Clinical Staff Meeting was held to review the facility's policy and procedure on Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response. MHRS 1 is no longer working at the facility as of 12/1/2018.	8/1/2018
			The facility has further revised its policy and procedure on "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response" that includes the 2 hour reporting requirement to the Survey agency for both F608 and F609 (regarding events involving allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and voluntary seclusion) that is reflected on a reporting grid for ease of reference.	9/11/2018
			Laguna Honda employees have been directed to complete an on-line in-service in response to the identified deficiency, F609, for failure to timely report allegations of abuse 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.	4/1/2019
			Employees will be asked to read hand-out information on what constitutes resident abuse; examples of abuse; actions to take should they see, hear or suspect possible abuse; understand and comply with the 2 hour reporting requirement for notification of allegations of abuse to the State Survey agency; attest to having read and agree to not commit acts of abuse, and knowingly be subject to disciplinary action, up to and including termination, for failure to comply with facility procedures. Managers are responsible for monitoring staff compliance in reading the hand-out material and completing the attestation.	4/19/2019
			Quality Management Nurses who are members of the Resident Safety and Abuse Prevention Performance Improvement Team have been assigned to conduct a monthly review of facility reported incidents of allegations of abuse and track facility compliance and improvement with	4/19/19 and on-going

ATTACHMENT A

LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

PLAN OF CORRECTION FOR FACILITY REPORTED INCIDENT (FRI) NO. CA597769

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			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 allegations of abuse 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.	4/19/19 and on-going