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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 reflects the findings of the California Department of Public Health during a first revisit of an Abbreviated Standard Survey conducted from 9/3/19 to 9/6/19. Revisit of facility reported incidents: CA00623517, CA00639036, CA00639047, CA00639051, CA00639848, CA00639918, CA00639866, CA00640598, CA00621775, CA00638524 and CA00621433 Additional facility reported incidents investigated: CA00648637, CA00650413 and CA00648652 The inspection was limited to the specific facility reported incidents investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 40537, Health Facilities Evaluator Nurse 33819, Health Facilities Evaluator Nurse 40619, Health Facilities Evaluator Nurse 29548, Health Facilities Evaluator Nurse 26917, Pharmaceutical Consultant 29915, Health Facilities Evaluator Nurse Federal deficiencies F583 and F605 were corrected. Federal deficiencies F600 was still not in compliance and F557, F607, F689 and F755 were written as a result of facility reported incidents CA00648637, CA00650413 and CA00648652 .	{F 000}	PLAN OF CORRECTION SUBMITTED AS A DOCUMENT ATTACHMENT PER AFL 17-34-ALL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark G Ryckman acting	CEO	10/7/19

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 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents are treated with dignity and respect when two staff members (Porter 1 and Patient Care Assistant 1) were photographed laying in a compromised position at the foot part of the bed of one of 18 sampled residents (Resident 34) while Resident 34 sat upright on the bed. The deficient practice could potentially have negative psychsocial outcome on the resident. Findings: Resident 34 was admitted with a diagnosis of cortical blindness (partial or total loss of eyesight). The Minimum Data Set (an assessment tool), dated 6/26/19, indicated a Brief Interview for Mental Status (a screener for cognitive impairment), score of "15" indicated that Resident 34 is, "cognitively intact". Section G of the Minimum Data Set, dated 6/26/19, indicated a functional status of, "independent", regarding mobility. During a review of the facility's digitally encrypted	F 557		

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F 557	Continued From page 2 files of photos, videos and text messages from the personal cellular phone of Licensed Vocational Nurse (LVN) 1, included two photographs dated 1/15/18 at 1:22 pm. Photograph 1, labeled IMG - 7052, showed Resident 34 sitting upright in bed from neck to foot, wearing dark shoes and partially covered with a stained white material, two staff members, identified by the facility as Porter 1 and Patient Care Assistant (PCA)1, were laying across the foot of the bed. Porter 1 was on top of PCA 1, their heads were in proximity to each other. Porter 1, who was wearing a blue shirt with a baseball cap looks like his left hand was under the head part of PCA 1, with dark long hair laying underneath him. Photograph 2, labeled IMG - 7053, also showed a stained white material and the Resident 34's feet with dark shoes and two staff members, Porter 1 and PCA1. Porter 1 is on top of PCA1 laying on the foot part of the bed. During a review of the facility document titled "Preliminary Report", dated 7/30/2019: it indicated " ...as part of concurrent Human Resources investigation regarding the pictures and videos discovered on staff member's cell phone ..." with an incident date of 7/ 2018, at [Facility Name] North One Neighborhood, "two photographs dated 1/15/18, showed two staff members laying on the foot of the resident's bed, while the resident sat up right further up the bed." The report identified Resident 34, Porter 1 and PCA1 as the two staff members. During an observation with concurrent interview on 8/2/19 at 3:45 PM with Resident 34, Resident 34 was in bed. She said, "Hi. Go away. I'm tired." to the surveyor.	F 557		

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F 557	Continued From page 3 During an interview with the Director of Quality Management (DQM), on 8/13/19, at 2:04 pm, she stated, "the city attorney interviewed the two staff in the picture and they said they accidentally fell on the resident's bed and no other explanation given why the two staff are on top of each other in the resident's bed..." During an interview with Porter 1, on 8/13/19, at 2:48 pm, he stated that no one had talked to him about the incident of abuse the last two weeks. During an interview with the Director of Regulatory Affairs (DRA), on 8/13/19, at 3 pm, he stated, "the two employees accidentally fell onto the resident's bed ..." During a subsequent interview with the Director of Quality Management (DQM) on 8/22/19, at 4 pm, she stated "Porter 1 was told yesterday by his supervisor that he will be reassigned to a non-patient area, he was upset and he called off today ..." During a review of document titled "Investigation of Alleged Abuse", page five (5) of six (6) Part VII: Conclusion, dated 7/31/19, entered by DRA, indicated " ...I conclude that the abuse is not substantiated ...abuse on the part of the two staff members in the picture was not substantiated, as they both stated that the fall/trip was accidental ..."The investigation did not provide any details or logical explanation on how the two staff "accidentally fell" on the resident's bed in a compromised position.	F 557		
{F 600} SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	{F 600}		

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{F 600}	Continued From page 4 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure an environment free from abuse for all residents, when a corrective action to conduct employee supervision and check in with all nursing staff members to identify staff burn out and to provide opportunities for staff to privately voice concerns with regards to any peers was not implemented in 3 of 4 randomly selected nursing units (Units 1, 2 and 3). Failure to implement action plans regarding staff supervision is a potential risk for residents, who may be subject to abuse by staff. Findings: Record review of the the facility's plan of correction (POC) dated 8/9/19, indicated "...Corrective Actions: ...15. Nurse Managers for all Neighborhoods [Units] initiated a standardized tool and process to conduct employee supervision and check in with all nursing staff	{F 600}		

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{F 600}	Continued From page 5 members, this supervision...employee interview to identify any staff burn out, and establish venue if employee have any concerns with regards to any peers or overall feedback...This process gives staff an opportunity to raise concerns privately and allows the Nurse Manager to observe staff performance...Completion Date: July 15 and ongoing..." Record review of a facility form titled, "Nurse Manager Employee Supervision and Check In (FY (Fiscal Year) 2019 Thru FY 2020" showed four columns identifying the date, unit, employee's name and shift of when an employee would be supervised by the Nurse Manager on "A. Care Observation: Staff demonstrated providing care in a manner that took account resident's comfort, safety, and dignity... B. Communication: Staff Demonstrated respectful and therapeutic communication..." During an interview with the Nurse Manager of Unit North 1 (NM 1), on 9/3/19 10:30 AM, NM 1 stated, "Yes, I am expected to do check-in with 1 staff member daily, Monday to Friday, about 5 staff every week...This has been in place for about 7-8 weeks since mid July..." During an interview with the Manager of Administration (MOA) and the Director of Quality Management (DQM) on 9/4/19 at 1:25 PM, while reviewing data from the facility's POC, MOA stated, "No, we do not know how many staff members have been interviewed by each Nurse Manager from each unit...Nurse Managers in all units are expected to complete these check-in since about July 15...I understand this is an important item since the incidents of abuse involved the issue of supervision..." A random	{F 600}		

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{F 600}	Continued From page 6 sample of employees rosters from 4 of the facility's 13 units was requested. Record review of a facility form titled "[Nursing Unit] Staff Check -In", of nursing staff roster interviewed by the Nurse Manager of Unit 1 indicated 12 of 43 staff members had been interviewed per POC Corrective Action #15. (28 %). Record review of the same form for Unit 2, of nursing staff roster interviewed by the Nurse Manager of Unit 2 indicated 18 of 50 staff members had been interviewed per POC Corrective Action #15. (36%). Record review of nursing staff roster interviewed by the Nurse Manager of Unit 3 indicated 5 of 55 staff members had been interviewed per POC Corrective Action #15. (9%). During an interview with DQM on 9/5/19 at 10:15 AM, upon reviewing the information above for Units 1, 2 and 3, DQM stated "...Yes, I agree the numbers are not even the majority of staff. It has been a few weeks since July 15...Yes, I know that the investigated incidents of abuse involved the issue of staff supervision and staff did not report them..." During an interview with the Risk Manager Director, (RMD), on 9/6/19 at 11 AM, upon reviewing the numbers of staff from Units 1, 2 and 3 undergoing "check-in" with their manager, per the POC language, RMD stated "Yes, I get it... the numbers should be higher after the findings related to supervision of staff...it has been a lot work..."	{F 600}		

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{F 607} {F 607} SS=D	Continued From page 7 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a thorough investigation of abuse for one of 18 sampled residents (Resident 34) when two staff members (Porter 1 and Patient Care Assistant 1) were photographed laying at the foot part of Resident 34's bed while the resident sat upright on the bed. This failure had the potential to compromise Resident 34's psychosocial well-being. Findings: Resident 34 was admitted with a diagnosis of cortical blindness (partial or total loss of eyesight). The Minimum Data Set (an assessment tool), dated 6/26/19, indicated a Brief Interview for Mental Status (a screener for cognitive impairment), score of "15" indicated that Resident 34 is, "cognitively intact". Section G of the Minimum Data Set, dated 6/26/19, indicated a functional status of, "independent", regarding	{F 607} {F 607}		

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{F 607}	Continued From page 8 mobility. During a review of the facility's digitally encrypted files of photos, videos and text messages from the personal cellular phone of Licensed Vocational Nurse (LVN) 1, included two photographs dated 1/15/18 at 1:22 pm. Photograph 1, labeled IMG - 7052, showed Resident 34 sitting upright in bed from neck to foot, wearing dark shoes and partially covered with a stained white material, two staff members, identified by the facility as Porter 1 and Patient Care Assistant (PCA)1, were laying across the foot of the bed. Porter 1 was on top of PCA 1, their heads were in proximity to each other. Porter 1, who was wearing a blue shirt with a baseball cap looks like his left hand was under the head part of PCA 1, with dark long hair laying underneath him. Photograph 2, labeled IMG - 7053, also showed a stained white material and the Resident 34's feet with dark shoes and two staff members, Porter 1 and PCA1. Porter1 is on top of PCA 1 across the foot part of the bed. During a review of the facility document titled "Preliminary Report", dated 7/30/2019: it indicated " ...as part of concurrent Human Resources investigation regarding the pictures and videos discovered on staff member's cell phone ..." with an incident date of 7/ 2018, at [Facility Name] North One Neighborhood, "two photographs dated 1/15/18, showed two staff members laying on the foot of the resident's bed, while the resident sat up right further up the bed." The report identified Resident 34, Porter 1 and PCA1 as the two staff members. During an interview with the Director of Quality Management (DQM), on 8/13/19, at 2:04 pm, she	{F 607}		

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{F 607}	Continued From page 9 stated, "the city attorney interviewed the two staff in the picture and they said they accidentally fell on the resident's bed and no other explanation given why the two staff are on top of each other in the resident's bed..." During an interview with Porter 1, on 8/13/19, at 2:48 pm, he stated that no one had talked to him about the incident of abuse the last two weeks. During an interview with the Director of Regulatory Affairs (DRA), on 8/13/19, at 3 pm, he stated, "the two employees accidentally fell onto the resident's bed ..." During a subsequent interview with the Director of Quality Management (DQM) on 8/22/19, at 4 pm, she stated "Porter 1 was told yesterday by his supervisor that he will be reassigned to a non-patient area, he was upset and he called off today ..." During a review of document titled "Investigation of Alleged Abuse", page five (5) of six (6) Part VII: Conclusion, dated 7/31/19, entered by DRA, indicated " ...I conclude that the abuse is not substantiated ...abuse on the part of the two staff members in the picture was not substantiated, as they both stated that the fall/trip was accidental ..."The investigation did not provide any details or logical explanation on how the two staff "accidentally fell" on the resident's bed in a compromised position. During a review of the facility policy and procedure titled "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting	{F 607}		

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{F 607}	Continued From page 10 and Response dated July 9, 2019 indicated "[Facility Name] shall promote an environment that enhances resident well-being and protects residents from abuse ... 4. Identification ...(a) Abuse may result in psychological, behavioral or psychosocial outcomes. The following signs may alert [Facility Name] staff ...(iv) illogical accounts given by resident or staff member ..."	{F 607}		
{F 689} SS=D	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 observation, interview and record review, the facility failed to provide adequate supervision to one of 18 sampled residents (Resident 33) when the resident eloped from the facility on 8/12/19 at 12:26 PM. Resident 33 was found collapsed in a park and sent to a hospital for DKA (diabetic ketoacidosis -occurs when the body produces high levels of blood acids called ketones), atrial fibrillation with relatively rapid venticular response (rapid irregular heart rate) on 8/14/19 at 9:50 AM. This deficient practice placed the resident at risk for serious injury or death. Findings:	{F 689}		

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{F 689}	Continued From page 11 Record review of physician's notes dated 6/15/18 on Neuropsychological Capacity Evaluation for Resident 33 indicated the resident had diagnoses including DM (diabetes mellitus) type 2, and peripheral neuropathy . The resident had a significant decline in cognitive functioning with a history of crack cocaine, speed, alcohol, and cannabis use. He demonstrated a lack of insight and displayed impairment in executive functioning. During observation on 9/4/19 at 10:00 AM, Resident 33 was dressed with a colorful sequenced dress with earrings and necklace. The resident had a sitter at the bedside. During an interview on 9/4/19 at 10:05 AM, Resident 33 admitted he had gone out of the facility several times. Stated that he was hospitalized, the last time he went out of the facility. During an interview with RN 3 on 9/4/19 at 10:45 AM, RN 3 said that he saw Resident 33 leave the unit on 8/12/19 at around 8:30 AM, with the thought that Resident 33 had a written Out On Pass (OOP) by the physician. During an interview with RN 4 on 9/4/19 at 11:00 AM confirmed that there was no written OOP order but rather a previous order dated 8/29/19 for "participation in organized out-of-hospital function ..." Record review of facility's policy and procedure titled, "Leave of Absence (Out On Pass) revised 5/14/19 indicated, "Residents who wish to leave the grounds of Laguna Honda Hospital and	{F 689}		

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{F 689}	Continued From page 12 Rehabilitation Center (LHH) shall have written orders from their attending physician and appropriate pass medication. Compliance/Adherence with Pass Privilege:When leaving on pass and on returning from pass, residents shall check in and out with the nursing staff on the care unit." Review of MD Note 8/14/19 1:49 PM , " ... I have remained reluctant to grant passes for resident to go ..." Record review of RN 3's Nurses Notes dated 8/12/19 at 12:26 PM indicated, "Resident left out on pass today around 8:30 AM to the community ..." Review of physician's notes dated 8/20/19 11:46 AM, " ...the next thing we heard about the resident was he had been admitted to a hospital ...sick with severe hyperglycemia/DKA. ..."	{F 689}		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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.	F 755		

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 _____	R-C 09/06/2019

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

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F 755	Continued From page 13 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide pharmaceutical services to meet the needs of each resident as evidence by: 1. The staff failed to properly dispose of medications in accordance with facility policy. 2. The facility failed to have developed a policy to dispose of disguised (hidden in food) medications. These failures resulted in Resident 31 taking medications and self-administering medications that were not prescribed which then exposed Resident 31 to the side effects of multiple non-prescribed medications. Findings:	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 14	F 755		

1. A review on 8/14/19 of Resident 31's clinical record indicated that Resident 31 has a medical history of dementia, schizophrenia, and psychogenic polydipsia (excessive drinking). Resident 31 was prescribed Olanzapine to treat these conditions. Resident 31 had behaviors that manifested as taking used cups out of the garbage bin and then filling the cups with water and drinking the contents. Resident 31's Minimum Data Set (MDS) assessment dated 5/18/19 indicated a Brief Interview of Mental Status (BIMS) score of 0 which indicated that Resident 31 had significant cognitive deficits.

During an interview on 8/14/19 at 10:51 AM, Physician 1 stated Resident 31 was her patient. Physician 1 also stated that Resident 31 had been disrobing which was not a behavior that Resident 31 had exhibited in the past. Physician 1 then ordered a urine toxicology screen (Utox) because of Resident 31's unusual behavior on 7/23/19 which then resulted in a positive test for Levetiracetam (Keppra anti-seizure medication). Physician 1 said that she reordered the Utox again on 7/29/19 which tested positive for Hydrocodone (opioid medication) and Gabapentin (Neurontin anti-seizure medication). Physician 1 also said that the Levetiracetam, Hydrocodone, and Gabapentin were non-prescribed medications.

A review on 8/14/19 of Resident 31's Interdisciplinary Team Meeting Note dated 8/7/19 at 9:30 AM indicated, "Utox test carried out on 7/23/19 revealed patient had Keppra in his urine sample. Even though patient did not have order for Keppra. A repeat test on 7/29/19 revealed he had hydrocodone and Neurontin in urine sample even though resident did not have order for these

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F 755	Continued From page 15 too ...Resident has behavior by grabbing ...patient cups and picking up cups from garbage and adding more water from it and drinking from it. Also since many other residents have their meds disguised its possible he drank from it." During an interview on 8/14/19 at 9:15 AM, Registered Nurse (RN) 1 stated that she saw Resident 31 take medication cups from the medication cart trash bin around 7/23/19 and 7/29/19. RN 1 also stated that she had seen Resident 31 take cups before and fill them with water and drink the contents of what was inside the cups. She said that Resident 31 also would take and hoarded any type of cup. RN 1 said that she had seen Resident 31 take and drink from cups in the trash for the last 8 years. She also said that if you try and take the cups away from Resident 31 he would be combative. During an observation on 8/15/19 at 8:52 AM of three medication cart trash bins with open lids contained the following: *Medication Cart Trash Bin 1-multiple used cups, a unidentifiable bottle of medication opened, and two used liquid medication cups with remnants of solution. *Medication Cart Trash Bin 2-two unit dose medication packages opened, a medication cup that had crushed medications that was visible in some sort of yellow paste, part of a medication capsule. *Medication Cart Trash Bin 3-one unit dose medication package opened, a cup with orange solution and visible particles of medications. During an interview on 9/04/19 between 2:24 PM and 2:27 PM, RN 2, LVN 1, and LVN 2 all stated that after administering medications that they	F 755		

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F 755	Continued From page 16	F 755		

would discard the used medication cups into the medication cart trash bin. They stated that the medication cart trash bin where left open instead of closing the lid so the contents of the trash were visible.

The above indicated that the nurses would leave used medication cups with medication left in the cups which could be available for residents to take and self-administer the left over medication.

A review on 9/5/19 of the facility policy dated 7/9/19 entitled, "Medication Administration" indicated "If medications have been prepared/removed from packaging, and resident does not take, medication must be wasted and documented in eMAR ...Medications that are not administered must be disposed of in the appropriate medical waste container ..."

During an interview on 9/5/19 at 10:27 AM, the Director of Pharmacy stated that non-hazardous medications were to be disposed of in the white and blue bins and hazardous (potential threat to public health) medications were to be disposed of in the yellow bins. The DOP said that the medication cart trash bin should not have any medications discarded in it.

2. During an interview on 8/14/19 at 8:41 AM Administrator 1 stated that Resident 32 was the only resident that was on Hydrocodone where Resident 31 resided. He said that Resident 31 and Resident 32 resided in a locked unit. He also stated that Resident 32 had his medication disguised because he did not like taking his medications. Resident 32 would take his medications with ice cream.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 17 During an interview on 8/14/19 at 11:06 AM the Laboratory Services Personnel 1 stated that for Resident 31 to test positive for Hydrocodone he would have had to have taken more than a ½ a tablet of Resident 32's Hydrocodone. If it was less than a ½ a tablet Resident 31 would not have tested positive. The above indicated that Resident 32's Hydrocodone was disguised in ice cream which would mean that Resident 31 had to have taken Resident 32's ice cream which would have had more than a ½ a tablet of Hydrocodone. During an interview on 9/5/19 at 10:27 AM the DOP stated that there was no specific facility policy that addressed disposal of medications that are disguised. She acknowledged that developing and implementing facility policy to securely dispose of disguised medications could prevent reoccurrence of residents taking medications that were not prescribed.	F 755		

F000

This Plan of Correction is the response by Laguna Honda Hospital and Rehabilitation Center ("LHH" 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 September 25, 2019, and received by the facility on September 29, 2019, for an revisit survey to assess substantial compliance with the Corrective Action plan submitted in response to . 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.

F557 SS=D

§483.10 Residents Rights

(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:

(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

This **REQUIREMENT** is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure residents are treated with dignity and respect when two staff members (Porter 1 and Patient Care Assistant 1) were photographed laying in a compromised position at the foot part of the bed of one of 18 sampled residents (Resident 34) while Resident 34 sat upright on the bed.
The deficient practice could potentially have negative psychosocial outcome on the resident.

Immediate Corrective Actions:

Resident 34 was informed of the photograph as part of the investigative interview with her. During the interview she stated that she did not remember the incident.
Resident 34 was seen, examined and assessed by their attending physician on 7/30/2019.
Their Care Plan was reviewed by the Resident Care Team.

Responsible Person:

Nurse Manager, North One

Completion Date:

July 7, 2019

Immediate Corrective Actions:

The supervisor of Porter 1 was given all of the information regarding the allegation of abuse and subsequent investigation. Porter 1 was reassigned to duties where there is no resident or patient contact.

Responsible Person:

Manager of Environmental Services

Completion Date:

September 6, 2019

Immediate Corrective Actions

Patient Care Assistant 1 had already been placed on Administrative Leave.

Responsible Person:

Nurse Manager, North One

Completion Date:

September 6, 2019

F557 Continued

1. **To acheive the detection of other residents having the potential to have been affected by the same deficient practice, Nurse Managers and other members of the resident care team will conduct resident check-ins with each resident on every neighborhood on a weekly basis. This is to ensure that residents are: treated with respect; feel safe at Laguna Honda; and provided an additional avenue of communication if they have any concerns regarding the manner in which care has been provided, including any allegations of abuse or neglect, to ensure that their concerns are reported and investigated in a timely manner. Check-in responses will be evaluated. The tool used for this also includes assessment methods for residents unable to communicate. The questions and frequency of the check-in will be adjusted based on data outcomes. Any issues identified during resident interviews are immediately escalated according to the abuse protocol. Nurse Managers and other members of the resident care team are responsible for conducting weekly check-ins and Nursing Program Directors and other department managers are responsible for monitoring compliance.**

Responsible Person:

Chief Nursing Officer

Completion Date:

October 6, 2019 and ongoing

Monitoring:

Data from the "Weekly resident check-in" process will be reported to the NQIC and to PIPS. The Nursing Program Director is responsible for reporting compliance to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC. 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.

2. **Nurse Managers for all Neighborhoods will continue to use the standardized tool and process to conduct employee supervision and check in with all nursing staff members, Nurse Managers will conduct one check in per day Monday through Friday**

   This supervision takes the form of direct observation of staff member undertaking resident care, employee interview to identify any staff burn out, and establish venue if employee have any concerns with regards to any peers or overall feedback, and manager also provides feedback to employee based on care observation. This process gives staff an opportunity to raise concerns privately and allows the Nurse Manager to observe staff performance.

Responsible Person:

Chief Nursing Officer

Completion Date:

October 6, 2019

Monitoring**:**

Completion of check ins is logged by each nurse manager into the Nursing Sharepoint site, on a weekly basis the Program Manager, Nursing Services is collating and reporting this to the Chief Nursing Officer. Compliance reports will be presented at Performance Improvement and Patient Safety committee on a monthly basis until three consecutive months of 95% or greater compliance has been achieved.

3. **The event described above occurred in 2018, earlier in 2019 the following education, training and resources were provided to all staff regarding Abuse Prevention, detection and reporting. LHH is creating several strategies that will combine to robustly educate, reinforce and sustain the staff's knowledge and awareness of their role as mandated reporters at LHH. These actions include, but are not limited to;**
    - **"Badge Buddies" (physical cards that hang behind the ID badges that each staff member is required to wear at all times) are being created with the reporting requirements to State Agencies, Ombudsmen, Law enforcement and Nursing Operations to provide a quick reference. These badge buddies will include the relevant telephone numbers.**
    - **In-services with accompanying post-tests. This training includes procedures and information as mandated reporters to report incidents of abuse directly and within 2 hours to CDPH, the Ombudsman, local law enforcement (when applicable), and Nursing Operations. This in-service will include identification and prevention of abuse, resident monitoring and support.**
    - **Additional posters for all neighborhoods with reporting guidelines and contact information for State Agencies, Ombudsmen and Law Enforcement and Nursing Operations.**
    - **A written communication from the Chief Executive Officer describing the chain of events that occurred leading up to the discovery of these cases of abuse and an overall summary of all the actions undertaken by LHH to correct the issues identified.**
    - **Case Presentations for staff on all shifts in each neighborhood, to emphasize, using a scenario-based approach, and the role of mandated reporter.**

Responsible Person:

Chief Nursing Officer

Monitoring:

Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.

F600 SS=E

§ 483.12 Freedom from abuse, neglect, and exploitation.

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

(a) The facility must -

(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to ensure an environment free from abuse for all residents, when a corrective action to conduct employee supervision and check in with all nursing staff members to identify staff burn out and to provide opportunities for staff to privately voice concerns with regards to any peers was not implemented in 3 of 4 randomly selected nursing units.

Immediate Corrective Actions:

Nurse Managers on North One and North Two Neighborhoods completed check-ins with ALL staff.

Nurse managers were on all neighborhoods were instructed to have completed check-ins with ALL staff as soon as possible

Responsible Person:

Chief Nursing Officer

Completion Date:

September 13, 2019

Corrective Actions:

4. **Nurse Managers for all Neighborhoods will continue to use the standardized tool and process to conduct employee supervision and check in with all nursing staff members, Nurse Managers will conduct one check in per day Monday through Friday**

   This supervision takes the form of direct observation of staff member undertaking resident care, employee interview to identify any staff burn out, and establish venue if employee have any concerns with regards to any peers or overall feedback, and manager also provides feedback to employee based on care observation. This process gives staff an opportunity to raise concerns privately and allows the Nurse Manager to observe staff performance.

Responsible Person:

Chief Nursing Officer

Completion Date:

October 6, 2019

Monitoring**:**

Completion of check ins is logged by each nurse manager into the Nursing Sharepoint site, on a weekly basis the Program Manager, Nursing Services is collating and reporting this to the Chief Nursing Officer.

Compliance reports will be presented at Performance Improvement and Patient Safety committee on a monthly basis until three consecutive months of 95% or greater compliance has been achieved.

F607 SS=D

§ 483.12 Freedom from abuse, neglect, and exploitation.

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

(b) The facility must develop and implement written policies and procedures that:

(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

(2) Establish policies and procedures to investigate any such allegations, and

(3) Include training as required at paragraph § 483.95.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure a thorough investigation of abuse for one of 18 sampled residents (Resident 34) when two staff members (Porter 1 and Patient Care Assistant 1) were photographed laying at the foot part of Resident 34's bed while the resident sat upright on the bed.

This failure had the potential to compromise Resident 34's psychosocial well-being.

Immediate Corrective Actions:

Resident 34 was informed of the photograph as part of the investigative interview with her. During the interview she stated that she did not remember the incident.

Resident 34 was seen, examined and assessed by their attending physician on 7/30/2019.

Their Care Plan was reviewed by the Resident Care Team

Responsible Person:

Nurse Manager, North One

Completion Date:

September 6, 2019

Immediate Corrective Actions:

The supervisor of Porter 1 was given all of the information regarding the allegation of abuse and subsequent investigation. Porter 1 was reassigned to duties where there is no resident or patient contact.

Responsible Person:

Manager of Environmental Services

Completion Date:

September 6, 2019

Immediate Corrective Actions

Patient Care Assistant 1 had already been placed on Administrative Leave.

Responsible Person:

Nurse Manager, North One

Completion Date:

September 6, 2019

F607 Continued

Corrective Actions:

A set of factors led to this investigation not being handled in the typical manner under the Quality Management Department, and those factors resulted in some communication delays regarding the findings of the investigation that occurred. Although LHH took this matter seriously throughout, we have identified ways that the process can be standardized and improved. The communication issues arose from the seriousness of the employee misconduct issues recently discovered at LHH, which had this incident being undertaken first as a human resources process and not a quality process. The Quality Management Department use a standardized tool and process for investigation of resident-related quality of care and abuse issues. The human resources process uses a separate process to investigate misconduct, and here there were complicating factors related to recent discoveries of employee misconduct, including potential criminal activity. The seriousness and breadth of those recent discoveries warranted extra caution in investigating this patient-related issue in order to determine who had knowledge of and involvement with the apparent misconduct and improper resident care. As a result of the caution stemming from that deliberate investigatory process, in this case the conclusions regarding the misconduct were not shared as quickly as they could have been.

To prevent this kind of delay in communicating issues regarding resident care-related concerns in the future, the following actions have been taken:

The separate quality and human resources investigation processes have been more clearly explained to Quality Management and Human Resources in order for each to better understand the purposes and timing of the other parallel process.

Guidelines have been developed for what information is shared between the two processes, and when any allegations regarding patient care or abuse are made, the manager of the employee who engaged in the misconduct or deficient care will be informed in a timely manner as a part of standard investigation and corrective action protocols.

Education will be presented at LHH Executive Committee and Leadership Forum regarding these concurrent investigative processes and the need to ensure that when allegations of abuse or deficient care involve staff from more than one department, this information is appropriately shared confidentially between managers to enable them to manage the staff involved and protect residents.

Responsible Person:

Director, Quality Management

Completion Date:

October 9, 2019

Monitoring:

Sign in sheet was reviewed to ensure all staff required to understand this information were present, for those staff that did not attend presentation is available for staff to access.

Quality Management leadership will review all Abuse Investigations that involve departments other than nursing to ensure that all managers and supervisors are aware of the circumstances.

Overall data regarding compliance with this corrective action will be reported to PIPS.

F689 SS=D

§ 483.25 Quality of care.

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, including but not limited to the following:

(d) ***Accidents***. The facility must ensure that -

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide adequate supervision to one of 18 sampled residents (Resident 33) when the resident eloped from the facility on 8/12/19 at 12:26 PM. Resident 33 was found collapsed in a park and sent to a hospital for DKA, atrial fibrillation with relatively rapid ventricular response on 8/14/19 at 9:50 AM.

This deficient practice placed the resident at risk for serious injury or death.

Immediate Corrective Actions:

Resident 33 left LHH August 8, 2019 at 08:30hrs

At 16:10hrs the resident had not returned to the neighborhood, at this time the LHH Code Green (elopement) Protocol was initiated:

i. **All Emergency Rooms and San Francisco Police Stations alerted that we have a Resident missing.**
ii. **Attempted to inform Surrogate Decision maker but voice mail full.**
iii. **MSW alerted community agency Ward 86, who is familiar with the Resident, so they can look out for him and report to LHH if he is seen. They sent out a BOLO to all their Nurses, MSW and Providers.**

On August 19, 2019, on return from the General Acute Care Hospital (GACH) resident 33 was seen, examined and assessed by their attending physician. Their Care Plan was reviewed by the Resident Care Team and they were assessed as "HIGH AWOL RISK"

Completion Date:

August 20, 2019

Responsible Person:

Nurse Manager, South Two

Corrective Actions:

5. **To ensure that the defective practice does not affect other residents when any resident states they are going off campus the Licensed Nurse (LN) will check the resident's chart to ensure that the Resident has a current order to go Out On Pass (OOP). By checking this information in the residents chart the LN will verify that Resident has an order and not rely on verbal communication when a Doctor, another staff family, volunteer or a resident state they have an order to go Out on Pass.**

Completion Date:

October 6, 2019

Responsible Person:

Director of Nursing

Monitoring:

Nursing leadership will do one random spot check a week on each unit to ensure that the process is being followed.
Results from the Quality Assurance (QA) check will be reported to NQIC and PIPS monthly for 6 months.

6. **A memo has been sent by the Chief Executive Officer and Chief Medical Officer to all staff and providers that all Residents need a current Out on Pass order to leave the facility and this needs to be a written order in EPIC. To follow up on this memo education will be provided to all staff on the OOP process regarding the need to ensure that all steps are completed before a Resident goes OOP.**

Completion Date:

October 6, 2019

Responsible Person:

Director of Nursing

Monitoring:

Nursing leadership will do one random spot check a week on each unit to ensure that the process is being followed.
Results from the Quality Assurance (QA) check will be reported to NQIC and PIPS monthly for 6 months.

7. **Due to the specific resident population of South Two (S2) having a higher number of "AWOL Risk" residents this unit has a "Elopement Zone Manager" that is assigned to directly observes S2 residents who are off the unit but still on the LHH premises, this staff member has clear instructions on how to address a resident who attempts to leave without and order or an escort, up to and including activation of the Code Green Procedure.**

Completion Date:

October 6, 2019

Responsible Person:

Director of Nursing

Monitoring:

Nurse Manager will include the all staff who undertake the Elopement Zone Manager role in their staff check ins.

8. **Due to the specific resident population of South Two (S2) having a higher number of "AWOL Risk" residents this unit has developed a smart phrase into the electronic health record. When used this will provide the licensed nurse a guide on what should be verified and documented to ensure all steps have been taken and documented correctly when a Resident goes OOP.**

Completion Date:

October 6, 2019

Responsible Person:

Director of Nursing

F755 SS=E

§ 483.45 Pharmacy services.

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in § 483.70(g). 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-

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

(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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and document review the facility failed to provide pharmaceutical services to meet the needs of each resident as evidence by:

1. The staff failed to properly dispose of medications in accordance with facility policy.
2. The facility failed to have developed a policy to dispose of disguised (hidden in food) medications.

These failures resulted in Resident 31 taking medications and self-administering medications that were not prescribed which then exposed Resident 31 to the side effects of multiple non-prescribed medications.

Immediate Corrective Actions:

Resident 31 was examined by a physician on July 23 and again on July 29, 2019 with no noted ongoing health issues related to the unintended ingestion of medications not prescribed to them. The resident's care plan was reviewed and revised.

Completion Date:

September 6, 2019

Responsible Person:

Nurse Manager, North Mezzanine

Corrective Actions:

11. **The Nursing Policy and Procedure LHHPP J1.0 has been reviewed and revised to describe the process of disposing all remaining medication (including crushed medications, receptacles used for such and any remaining disguised medication) in a pharmacy medication disposal bin and never in the "household' or "clinical" trash containers.**

Completion Date:

October 6, 2019

Responsible Person:

Chief Nursing Officer

Monitoring**:**

The policy will be reviewed and approved by the governing body.

12. **The Pharmacy Policy and Procedure LHHPP02.01.02 has been reviewed and revised. Section VI. A. has been revised to describe the disposal of all medications including any remaining crushed, dissolved or disguised medications are disposed of in a pharmacy waste bin**

Responsible Person:

Director of Pharmacy

Completion Date:

October 6, 2019

Monitoring**:**

The policy will be reviewed and approved by the governing body.

13. **A memo regarding medication wastage focused on disguised, crushed and dissolved medications has been provided to all licensed staff throughout LHH.**
14. **Education regarding the change in policy will be provided to all licensed staff.**

Responsible Person:

Chief Nurse Executive

Completion Date:

October 6, 2019

Monitoring:

Respective Department Managers and Supervisors are responsible for monitoring staff completion of the this required education. Compliance with all in-service and education will be reported as part of the report from Quality Management regarding overall compliance with the corrective action to PIPS.

Observation of the disposal of medication waste (including disguised meds) will be incorporated into the med pass audit process.