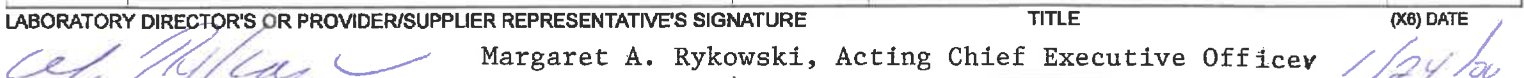
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING ______ B. WING ______	C 11/21/2019

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. Facility reported incident: 640555 Representing the California Department of Public Health: ID: 31794, Health Facilities Evaluator Nurse The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was written as a result of facility reported incident 640555.	F 000	**Please see attachment A**	
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



Margaret A. Rykowski, Acting Chief Executive Officer 1/24/20

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.

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 609	Continued From page 1	F 609		

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 report allegation of abuse to the California Department of Public Health (CDPH)within the required reporting time of "not later than 2 hours". This deficient practice had the potentials for abuse to continue and to cause delay in state investigation.

Findings:

During review of the Progress Notes dated 6/4/19 at 10:38 PM, it indicated, "Late entry for 5/31/19. Patient's fanny pack (a belt bag) was taken from him" by another resident (Resident 2) on the first floor at 7:30 pm, it was witnessed by a "coach" who intervened and returned it back to Resident 1.

During an interview on 7/5/19 at 10:01 AM, the Risk Management Nurse (RMN) 1 verified the alleged abuse was witnessed by a staff and it happened on 5/3/19 at 7:30 pm, when Resident 2 asked for a cigarette but Resident 1 refused, then, Resident 2 grabbed the fanny pack of

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	555020	A. BUILDING ______ B. WING ______	C 11/21/2019

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F 609	Continued From page 2	F 609		

Resident 1.

During an observation accompanied by RMN 1 and the Charge Nurse (CN) 1 on 7/5/19 at 2:11 PM, the CN 1 stated Resident 2 refused to be interviewed but Resident 1 was available. Resident 1 stated he had his belt bag on the wheelchair arm and Resident 2 "take the bag and walk away".

During an interview on 7/5/19 at 10:16 am, the RMN 1 stated the the allegation of abuse was substantiated and CDPH was notified of the abuse allegation on 6/3/19 at 6:30 pm (3 days after the allegation of abuse was discovered). The RMN 1 acknowledged the reporting time was "late".

Review of the facility policy titled "Abuse and Neglect, Prevention, Identification, Investigation, Protection, Reporting and Response" with the last revised date of 5/14/19 indicated: "Philosophy: ... Policy: ... Purpose: 1. ... 5. To meet reporting requirements as mandated by federal and state laws and regulations. ... Definitions: 1. ... 4. Misappropriation of resident property means "the deliberate ... wrongful ... use of resident's belongings ... without the resident's consent. Procedure: 1. ... 6. Reporting Protocol: a, ... c. ... i. ... ii. ... Notify within 2 hours to the ... CDPH, ... of events involving alleged violations of abuse ... ."

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

375 Laguna Honda Blvd., San Francisco, CA 94116-1411
Provider ID: 555020
Facility Reported Incident CA640555
Date of Survey Completed 11/21/2019

Plan of Correction

F 000

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 November 21, 2019 and received by the facility on January 13, 2020 as part of facility reported incident CA640555. 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.

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Plan of Correction

F609
§ 483.12 Reporting of Alleged Violations
(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(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 for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(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.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to report allegation of abuse to the California Department of Public Health (CDPH) within the required reporting time of "not later than 2 hours". This deficient practice had the potentials for abuse to continue and to cause delay in state investigation.

Immediate Corrective Actions:

1. **Upon noticing that Resident 1's fanny pack was taken by Resident 2, the Coach immediately intervened and asked Resident 2 to give the fanny pack back to Resident 1. The Coach immediately separated the Resident 1 and Resident 2 after the fanny pack was returned to Resident 1.**
   Responsible Person:
   Unit Nurse Manager.
   Completion Date:
   May 31, 2019.

2. **Nursing Supervisor and Nurse Manager promptly initiated an investigation upon receiving report of the alleged abuse. Abuse protocol was implemented.**
3. **The Unit physician was notified of the allegation of abuse and a wellness assessment was conducted.**
4. **The residents were monitored for 72-hours by the Resident Care Team (RCT) for any change in mood, behavior and activities.**
5. **The Coach was provided with a verbal reminder regarding timely reporting of allegations and incidents of abuse and the federal code of what constitutes abuse including theft and property. Furthermore, the Unit Nurse Manager reviewed the following with the Coach:**
   a. **Report immediately to the Charge Nurse(s) on Unit(s) of resident(s) involved in altercation.**
   b. **Report to CDPH, within 2 hours of learning of alleged abuse, and protective measures taken that were specific to the incident/allegation.**

   Responsible Person:
   Unit Nurse Manager.
   Completion Date:
   June 4, 2019.

Plan of Correction

Immediate Corrective Actions (continued):

6. **All staff on the unit were received education regarding timely reporting of allegations and incidents of abuse and the federal code of what constitutes abuse including theft and property.**
   Responsible Person:
      Unit Nurse Manager.
   Completion Date:
      June 4, 2019.

Corrective Actions:

7. **To sustain 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 continue resident check-ins with each resident on every neighborhood on a weekly basis. The tool 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.**
   Responsible Person:
      Chief Nursing Officer.
   Completion Date:
      June 30, 2019 and ongoing.
   Monitoring:
      The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body.

8. **A memo was created that was circulated to all staff, requiring a read and sign. This memo contained information on what actions to take should they see, hear or suspect abuse in their role as mandated reporters.**
   Responsible Person:
      Chief Nursing Officer.
   Complete:
      July 12, 2019.
   Monitoring:
      Respective Department Managers and Supervisors are responsible for monitoring staff completion of the read and sign. Compliance with all in-service and education will be monitored and reported monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.

Plan of Correction

9. **Nurse Managers for all Neighborhoods initiated a standardized tool and process to conduct employee supervision and check in with all nursing staff members, 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:

   July 15 and ongoing.

   Monitoring:

   Completion data will be reported to the Chief Nursing Officer. Individual staff members will receive feedback as part of the process. Staff with opportunities to improve their practice will be coached and counselled in real time by the nurse manager. Staff with ongoing performance issues will be managed according to LHH Human Resources processes. Compliance shall be monitored and reported monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.

10. **All Laguna Honda employees completed two in-service trainings, the first regarding their role as mandated reporters and timely reporting to the California Department of Public Health (CDPH), submission of Ombudsman report (SOC-341). The second in-service contains education regarding identification of abuse, abuse prevention, privacy and confidentiality, and resident monitoring and support.**

    Responsible Person:

    Nurse Educator.

    Completion Date:

    August 15, 2019.

    Monitoring:

    Respective Department Managers and Supervisors are responsible for monitoring staff completion of the in-service. Compliance with all in-service and education will be monitored and reported monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to JCC.

Plan of Correction

11. **LHH developed several strategies 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) were 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.**

    Responsible Person:

    Chief Nursing Officer.

    Completion Date:

    August 15, 2019 and ongoing.