STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING 03 B. WING _____	01/09/2020

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
E 000	Initial Comments Surveyor: 31203 The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: 31203 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities.	E 000		
E 006 SS=D	CENSUS: 753 Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented,	E 006		

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

Margaret A. Rykowski, Acting Chief Executive Officer — 1/22/20

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.

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E 006	Continued From page 1 facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on document review and interview, the facility failed to maintain a complete written emergency preparedness plan. This was evidenced by the failure to include missing	E 006		

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E 006	Continued From page 2 residents in the facility's risk assessment. This affected 753 of 753 residents and could result in a delay in adequate response in the event of an emergency. Findings: During document review and interview with staff on 1/9/20, the emergency preparedness manual was reviewed. 1. At 9:18 a.m., the facility's emergency plan failed to include missing residents in the facility's risk assessment. When interviewed, AS 1, AS 2, and AS 3 confirmed the finding.	E 006		
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage	E 015		

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E 015	Continued From page 3 of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. "[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on record review and interview, the facility failed to maintain the Emergency Preparedness policies and procedures. This was evidenced by the failure to provide policy and procedures for alternate sources of energy to maintain temperatures to protect residents health and safety and for the safe and sanitary storage of provisions and policy, emergency lighting, fire detection, extinguishing, and alarm systems, and	E 015		

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E 015	Continued From page 4 for sewage and waste disposal. This could result in the failure to protect 753 of 753 residents during a disaster. Findings: During document review and interview with staff on 1/9/20, the emergency plan was reviewed. 1. At 9:45 a.m., the facility failed to provide to provide policy and procedures for alternate sources of energy to maintain temperatures to protect residents health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, and alarm systems. When interviewed, AS 2 confirmed the finding and stated that the facility has generators but items were not listed on the policy and procedure. 2. At 9:46 a.m., the facility failed to provide policy and procedures for sewage and waste disposal. When interviewed, the AS 1, AS 2, and AS 3 confirmed the finding.	E 015		
E 018 SS=D	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:]	E 018		

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E 018	Continued From page 5 [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC,	E 018		

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E 018	Continued From page 6 which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on document review and interview, the facility failed to maintain a complete written emergency preparedness plan. This was evidenced by the failure to provide policy and procedure that included a system to track the location of on-duty staff during and after an emergency. This could result in the failure to protect 753 of 753 residents during a disaster. Findings: During document review and interview with staff on 1/9/20, the emergency plan was reviewed. 1. At 9:59 a.m., the facility failed to provide policy and procedures that included a system to track the location of on-duty staff during and after an	E 018		

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E 018	Continued From page 7 emergency. When interviewed, AS 1, AS 2, and AS 3 confirmed the finding.	E 018		
E 020 SS=D	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at	E 020		

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E 020	Continued From page 8 §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on record review and interview, the facility failed to maintain the Emergency Preparedness policies and procedures. This was evidenced by the failure to provide policy and procedure for safe evacuation that included transportation and primary and alternate means of communication with external sources of assistance. This could result in the failure to protect 753 of 753 resident during a disaster. Findings: During document review and interview with staff on 1/9/20, the emergency plan was reviewed. 1. At 10:11 a.m., the facility failed to provide policy and procedures for safe evacuation that included transportation and primary and alternate means of communication with external sources of assistance. When interviewed, the AS 1, AS 2, and AS 3 confirmed the finding.	E 020		
E 022 SS=D	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4)	E 022		

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E 022	Continued From page 9 (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on document review and interview, the facility failed to maintain the Emergency Preparedness policies and procedures. This was evidenced by the failure to provide policy and procedure for sheltering in place. This could result in the failure to protect 753 of 753 residents during a disaster. Findings: During document review and interview with staff	E 022		

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E 022	Continued From page 10 on 1/9/20, the emergency plan was reviewed. 1. At 10:20 a.m., the facility failed to provide policy and procedure for a means to shelter in place for residents, staff, and volunteers who remain in the facility. When interviewed, the AS 1, AS 2, and AS 3 confirmed the finding.	E 022		
E 026 SS=D	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on document review and interview, the	E 026		

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E 026	Continued From page 11 facility failed to maintain the Emergency Preparedness policies and procedures. This was evidenced by the failure to provide policy and procedure for the the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act. This could result in the failure to protect 753 of 753 residents during a disaster. Findings: During document review and interview with staff on 1/9/20, the emergency plan was reviewed. 1. At 10:40 a.m., the facility failed to provide policy and procedure for how they would provide care for resident when they are at a different site, in accordance with section 1135 of the Act. When interviewed, the AS 1, AS 2, and AS 3 confirmed the finding.	E 026		
E 030 SS=D	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.	E 030		

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E 030	Continued From page 12 "[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. "[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. "[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. "[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the	E 030		

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E 030	Continued From page 13 following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on document review and interview, the facility failed to maintain an emergency communication plan. This was evidenced by the failure to include the contact information for entities providing services under arrangement and other (Facilities). This affected 753 of 753 residents, and could result in a delayed response to an emergency situation.	E 030		

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	555020	A. BUILDING 03 B. WING	01/09/2020

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E 030	Continued From page 14 Findings: During document review and interview with staff on 1/9/20, the emergency communication plan was reviewed. 1. At 10:47 a.m., the emergency preparedness communication plan did not include the contact information for entities providing services under arrangement and other (Facilities). When interviewed, the AS 1, AS 2, and AS 3 confirmed the finding.	E 030		
E 035 SS=D	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) "[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years.] The communication plan must include all of the following: "[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by:	E 035		

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E 035	Continued From page 15 Surveyor: 31203 Based on document review and interview, the facility failed to maintain an emergency communication plan. This was evidenced by the failure to include a method for sharing information from the emergency plan that the facility has determined was appropriate with residents and their families or representatives in the communication plan. This affected 753 of 753 residents, and could result in a delayed response to an emergency situation. Findings: During document review and interview with staff on 1/9/20, the emergency communication plan was reviewed. 1. At 11:00 a.m., the emergency preparedness communication plan did not include a method for sharing information from the emergency plan that the facility has determined was appropriate with residents and their families or representatives. When interviewed, the AS 1, AS 2, and AS 3 confirmed the finding.	E 035		
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) "[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 039		

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E 039	Continued From page 16 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is	E 039		

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E 039	Continued From page 17 community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural	E 039		

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E 039	Continued From page 18 or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made	E 039		

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E 039	Continued From page 19 emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that	E 039		

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E 039	Continued From page 20 requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required	E 039		

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E 039	Continued From page 21 full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and	E 039		

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E 039	Continued From page 22 maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on record review and interview, the facility failed to maintain an emergency preparedness training and testing program. This was evidenced by the failure to provide document to show that the facility participated in a community based disaster drill. This could result in the failure to protect 753 of 753 residents in the event of a disaster. Findings: During document review and interview with staff on 1/9/20, the emergency preparedness plan was reviewed. 1. At 1:35 p.m., there was no document provided at time of survey to show that the facility participated in a community based disaster drill. The facility provided documents for two table top exercises. When interviewed, the AS 1, AS 2, and AS 3 confirmed the finding.	E 039		
K 000	INITIAL COMMENTS Surveyor: 31201 K3 BUILDING: 01 K6 PLAN APPROVAL: 12/2010 K7 SURVEY UNDER: 2012 Existing STRUCTURE TYPE: CONSTRUCTION TYPE I (443), FULLY SPRINKLERED.	K 000		

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K 000	Continued From page 23 North Tower: 7 Story Building South Tower: 6 Story Building Pavilion: 4 Story Building The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 31201 31203 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census = 753 Staff Identifier ES1 - Chief Engineer ES2 - Engineer Staff AS1 - Chief Operating Officer AS2 - Director of Facility Services AS3 - Manager, Administration MS - Maintenance Staff NM - Nurse Manager	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K 345		

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K 345	Continued From page 24 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on document review and interview, the facility failed to maintain the fire alarm system (FAS). This was evidenced by a trouble signal noted on the Fire Alarm Control Panel (FACP), by an alarm silence noted on the annunciators, and by the failure to provide documentation for a semi-annual fire alarm system inspection. This could result in a delay in notification in the event of a fire. This affected three of three buildings. NFPA 101, Life Safety Code, 2012 Edition 19.3.4.1 General, Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. 9.6.1.4 All systems and components shall be approved for the purpose for which they are installed. 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire	K 345		

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K 345	Continued From page 25 Alarm and Signaling Code. NFPA 72 National Fire Alarm and Signaling Code. 2010 Edition 10.4.3 Inspection, Testing, and Maintenance Personnel. (SIGTMS) 10.4.3.1* Service personnel shall be qualified and experienced in the inspection, testing, and maintenance of systems addressed within the scope of this Code. Qualified personnel shall include, but not be limited to, one or more of the following: (1)*Personnel who are factory trained and certified for the specific type and brand of system being serviced (2)*Personnel who are certified by a nationally recognized certification organization acceptable to the authority having jurisdiction (3)*Personnel who are registered, licensed, or certified by a state or local authority to perform service on systems addressed within the scope of this Code (4) Personnel who are employed and qualified by an organization listed by a nationally recognized testing laboratory for the servicing of systems within the scope of this Code 10.4.3.2 Evidence of qualifications shall be provided to the authority having jurisdiction upon request. 10.12 Trouble Signals. 10.12.1 Trouble signals and their restoration to normal shall be indicated within 200 seconds at the locations identified in 10.12.6 or 10.12.7. 10.12.2 Indication of primary power failure trouble signals transmitted to a supervising station shall be delayed in accordance with 10.17.3.3. 10.12.3 If an intermittent signal is used, it shall sound at least once every 10 seconds, with a minimum duration of 1/2 second.	K 345		

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K 345	Continued From page 26 10.12.4 A single audible trouble signal shall be permitted to annunciate multiple fault conditions. 10.12.5 The trouble signal(s) shall be in an area where it is likely to be heard. 10.12.6 Visible and audible trouble signals and visible indication of their restoration to normal shall be indicated at the following locations: (1) Fire alarm control unit for protected premises alarm systems (2) Building fire command center for in-building fire emergency voice/alarm communications systems (3) Central station or remote station location for systems installed in compliance with Chapter 26 10.18.3 Records. 10.18.3.1 A complete record of the tests and operations of each system shall be kept until the next test and for 1 year thereafter. 10.18.3.2 The record shall be available for examination and, if required, reported to the authority having jurisdiction. Archiving of records by any means shall be permitted if hard copies of the records can be provided promptly when requested. 10.18.3.3 If off-premises monitoring is provided, records of all signals, tests, and operations recorded at the supervising station shall be maintained for not less than 1 year. 14.1 Application. 14.1.1 The inspection, testing, and maintenance of systems, their initiating devices, and notification appliances shall comply with the requirements of this chapter. 14.1.2 The inspection, testing, and maintenance of single and multiple-station smoke and heat alarms and household fire alarm systems shall comply with the requirements of this chapter.	K 345		

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K 345	Continued From page 27 14.2.1.1 Performance Verification. To ensure operational integrity, the system shall have an inspection, testing, and maintenance program. 14.2.1.2 Impairments. 14.2.1.2.1 The requirements of Section 10.19 shall be applicable when a system is impaired. 14.2.1.2.2 System defects and malfunctions shall be corrected. 14.2.1.2.3 If a defect or malfunction is not corrected at the conclusion of system inspection, testing, or maintenance, the system owner or the owner ' s designated representative shall be informed of the impairment in writing within 24 hours. 14.3 Inspection. 14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. 9. Initiating devices- semi-annually (b) Duct detectors (e) Manual fire alarm boxes (f) Heat detectors (h) Smoke detectors 14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. Table 14.3.1 Visual Inspection Frequencies 3. Batteries (d) Sealed lead-acid-semi-annually 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if	K 345		

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K 345	Continued From page 28 required by the authority having jurisdiction. Table 14.4.5 Testing Frequencies 6. Batteries-fire alarm systems (d) Sealed lead-acid type (1) Charger test (Replace battery within 5 years after manufacture or more frequently as needed)-annually (2) Discharge test (30 minutes)-annually (3) Load voltage test-semi-annually Findings: During a tour of the facility, document review, and interview with Staff, the FAS was observed, documentation review, and staff interviewed. 1. On 1/6/20, at 12:44 p.m., a trouble and a panel silence signal were observed on the FACP The trouble on the panel indicated "Selected Trouble, 0001 Common Trble Act, Acknowledge checked, South Roof E2A Shunt Relay." When interviewed, ES1 stated that he did not know when the trouble signal on the panel started. He stated that they have five main FACP and they are all network connected, all FACP have the same reading. On 1/6/19, at 1:15 p.m., ES1 was interviewed. He stated that their vendor was scheduled to be at the facility on 1/7/20 to troubleshoot the issue. He stated that the trouble on the FACP will not affect the devices from activating during the alarm testing. On 1/7/20, at 8:27 a.m., the annunciators were observed. The monitor on the Annunciators noted the light on the Alarm Silence was lit and System Normal. The ES1, ES2 and AS2 were interviewed. ES1 and ES2 could not determine	K 345		

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K 345	Continued From page 29 why the alarm silence was lit. The was a total 25 Annunciators - 12 located in the North Building; 12 located in the South Building; and one in the Pavilion Building. On 1/8/20, between 9:20 a.m. to 9:57 a.m., alarm testing was conducted. The devices: smoke detectors, pull stations, water flows and tamper all activated during alarm testing and signals received by the monitoring company. It was observed during alarm testing that the alarm silence on the Annunciators were not lit. On 1/9/20, at 9:51 a.m., ES1 and ES2 were interviewed. ES2 stated that their vendor for their FACP could not resolve the trouble issue noted on the FACP. ES1 stated that their FAS was a proprietary system and the system requires diagnostic testing using a laptop. He stated that their vendor will have to sub-contract to another vendor for the diagnostic testing and this will be scheduled as soon as possible. 2. On 1/9/20, at 11:14 a.m., the facility failed to provide a semi-annual fire alarm inspection report at the time of survey. When interviewed, the ES2 confirmed that the semi-annual fire alarm inspection was not conducted.	K 345		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are	K 353		

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K 353	Continued From page 30 maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on observation and interview, the facility failed to maintain the automatic sprinkler system. This was evidenced by the failure to maintain sprinkler system component. This could affect the operation of the sprinkler system that could result in delay in extinguishing a fire. This affected one of three buildings. NFPA 101, Life Safety Code, 2012 Edition 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems (2) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes	K 353		

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K 353	Continued From page 31 (3) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height 9.7.7 Documentation. All required documentation regarding the design of the fire protection system and the procedures for maintenance, inspection, and testing of the fire protection system shall be maintained at an approved, secured location for the life of the fire protection system. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition 6.2.7 Escutcheons and Cover Plates. 6.2.7.1 Plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. 6.2.7.2* Escutcheons used with recessed, flush-type, or concealed sprinklers shall be part of a listed sprinkler assembly. Findings: During a tour of the facility and interview with the staff, the sprinkler system component was observed. Pavilion Building 1. On 1/7/20 at 12:28 p.m., the escutcheon to the sprinkler head in the walk-in freezer located in the kitchen was not flush with ceiling. The escutcheon dropped approximately 1 inch from the ceiling. When interviewed, the ES 1 confirmed the finding.	K 353		

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K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation and interview, the facility failed to maintain the fire extinguishers. This was evidenced by missing monthly inspections for one portable fire extinguisher and a portable fire extinguisher that was obstructed. This could result in a malfunction of the portable fire extinguisher. This affected of three buildings. NFPA 101, Life Safety Code, 2012 Edition 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguisher, 2010 Edition 7.2 Inspection. 7.2.1 Frequency. 7.2.1.1* Fire extinguishers shall be manually inspected when initially placed in service. 7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic	K 355		

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K 355	Continued From page 33 monitoring device/system at a minimum of 30-day intervals. 7.2.2 Procedures. Periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self-expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for non-rechargeable extinguishers using push-to-test pressure indicators 7.3* Maintenance. 7.3.1 Frequency. 7.3.1.1 All Fire Extinguishers. 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. 7.3.1.1.2 Fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Findings: During a tour of the facility and interview with Staff, the fire extinguisher was observed and staff interviewed. South Building 1. On 1/7/20, at 9:17 a.m., on the third floor, the	K 355		

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K 355	Continued From page 34 portable fire extinguisher was obstructed from immediate access. The portable fire extinguisher was between a vital sign machine and a medication cart by Room 334. The finding was confirmed by ES2. Pavilion Building 2. On 1/7/20, at 12:34 p.m., on the second floor, the portable fire extinguisher located on the roof by the Chiller machines were missing monthly inspections for the months of November and December 2019. When interviewed, ES2 stated that he was not aware of the missing monthly inspections. The annual service was conducted on 1/16/19. 3. On 1/7/20, at 12:35 p.m., on the second floor, the portable fire extinguisher in the corridor near Room 2111 was missing December 2019 monthly inspection. The finding was confirmed by ES2. The annual service was conducted on 1/16/19.	K 355		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that	K 363		

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K 363	Continued From page 35 do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by a corridor door that was obstructed and corridor doors that failed to latch. This affected three of three buildings and could result in the passage smoke and flames in the event of a fire. Findings: During a tour of the facility and interview with	K 363		

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K 363	Continued From page 36 Staff, the corridor doors were observed. North Building 1. On 1/6/20, at 11:15 a.m., on the 6th floor, the door to the Telecom Room (Room N6046) was equipped with a self-closing device. The door failed to latch when allowed to self-close. When interviewed, ES2 confirmed the finding. 2. On 1/6/20, at 12:03 p.m., on the 4th floor, the door to the Telecom Room (Room N4046) was equipped with a self-closing device. The door failed to latch when allowed to self-close. When interviewed, ES2 confirmed the finding. 3. On 1/6/20, at 12:06 p.m., on the 4th floor, the door to the Spa Room (Room 4051) was equipped with a self-closing device. The door failed to latch when allowed to self-close. When interviewed, ES2 confirmed the finding. 4. On 1/6/20, at 12:23 p.m., Mezzanine floor, the door to the Telecom Room (Room NM046) was equipped with a self-closing device. The door failed to latch when allowed to self-close. When interviewed, ES2 confirmed the finding. Pavilion Building 5. On 1/7/20, at 1:04 p.m., on the first floor, the double door to the Gift Shop was equipped with a self-closing device. The right door failed to latch. When interviewed, AS2 confirmed the finding and stated that the air pressure prevented the right door to close and latch. Surveyor: 31203 North Building	K 363		

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K 363	Continued From page 37 6. On 1/6/20 at 11:43 a.m., the corridor door to the Laundry room (Room N2013) was equipped with a self-closing device. The door was held open by a stool. The room was left unattended. The room was located on the second floor. When interviewed, the ES 1 confirmed the finding. South Building 7. On 1/7/20 at 10:04 a.m., the corridor to resident Room S526 failed to latch when manually closed by staff. The room was located on the fifth floor. When interviewed, ES 1 stated that the door will need adjustment. 8. On 1/7/20 at 10:33 a.m., the corridor to resident Room S425 failed to latch when manually closed by staff. The room was located on the fourth floor. When interviewed, ES 1 confirmed the finding.	K 363		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.	K 372		

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K 372	Continued From page 38 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation and interview, the facility failed to maintain the smoke integrity of the smoke barrier walls. This was evidenced by unsealed penetrations in the smoke barrier walls. This could result in the spread of smoke and fire in the event of a fire. This affected two of three buildings. NAPA 101, Life Safety Code, 2012 Edition 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1/2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(ac). (B) Not less than two separate smoke compartments shall be provided on each floor. (2) Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling	K 372		

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K 372	Continued From page 39 assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. 8.5.6.3 Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met. Findings: During a tour of the facility and interview with Staff, the smoke barrier walls were observed. North Building 1. On 1/7/20, at 12:47 p.m., the smoke barrier wall in North 1, elevator lobby west wall towards the Pavilion building was observed with three penetrations. One penetration measured approximately ½-inch top right of a flex conduit pipe and the other two measured approximately ¼- inch around flex conduit pipes. When interviewed, the AS2 confirmed the finding. Surveyor: 31203 North Building 2. On 1/6/20 at 1:00 p.m., there was an approximately 1 inch unsealed penetration around an electrical conduit in the smoke barrier wall above the cross corridor doors (NM-FD6) in the Cedar Suite. Cedar Suite was located on the	K 372		

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	555020	A. BUILDING 03 B. WING	01/09/2020

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K 372	Continued From page 40 Mezzanine floor. When interviewed, the ES 1 confirmed the finding. 3. On 1/6/20 at 1:11 p.m., there was an approximately 1/2 inch unsealed penetration around a network cable in the smoke barrier wall above the cross corridor doors (N1-FD15) in the Redwood Suite. Redwood Suite was located on the first floor. When interviewed, the ES 1 confirmed the finding. South Building 4. On 1/7/20 at 9:35 a.m. , there was an approximately 1/2 inch unsealed penetration in the smoke barrier wall above the cross corridor doors (S6-FD9) in the Marina Suite. Marina Suite was located on the sixth floor. When interviewed, the ES 1 confirmed the finding.	K 372		
K 541 SS=D	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and	K 541		

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K 541	Continued From page 41 protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on observation and interview, the facility failed to maintain the required protective separation features for the laundry chute. This was evidenced by a laundry chute door that failed to positive latch. This affected one of three buildings. This could result in the spread of fire and smoke in the event of a fire in the chute. NFPA 101, Life Safety Code, 2012 Edition. 19.5 Building Services. 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 19.5.1.2 Existing installations shall be permitted to be continued in service, provided that the systems do not present a serious hazard to life. 19.5.4 Rubbish Chutes, Incinerators, and Laundry Chutes. 19.5.4.1 Existing rubbish chutes or linen chutes, including pneumatic rubbish and linen systems, that open directly onto any corridor shall be sealed by fire-resistive construction to prevent further use or shall be provided with a fire door assembly having a minimum 1-hour fire protection rating. All new chutes shall comply with Section 9.5.	K 541		

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K 541	Continued From page 42 Findings: During a tour of the facility and interview with Staff, the laundry chute door was observed. North Building 1. On 1/6/20 at 12:15 p.m., the 1-hour fire rated door to the Laundry chute located in Room N1012 failed to latch when fully opened and released. The laundry chute door was tested two times. The room was located on the first floor. When interviewed, ES 1 confirmed the finding.	K 541		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover	K 741		

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K 741	Continued From page 43 devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on observation and interview, the facility failed to maintain the designated smoking area. This was evidenced by cigarette butts being disposed on the ground and by the failure to protect the safety-type smoke poles. This could result in the increased risk of fire, and affected the designated smoking area. Finding: During a tour of the facility and interview with staff, the designated smoking area was observed. Pavilion Building 1. On 1/8/20 at 12:50 p.m., there were approximately over 4 dozen cigarette butts observed on ground in the designated smoking area. The smoke poles provided had the covers removed leaving the smoke poles unprotected. The covers for the safety-type smoke poles were observed on the ground. The designated smoking area was located near the lobby in the Pavilion building. When interviewed, MS confirmed the finding.	K 741		
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited	K 753		

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K 753	Continued From page 44 unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on observation and interview, the facility failed to maintain their facility free of combustible decorations. This was evidenced by the failure to keep their facility free of combustible decoration. This could lead to an increased spread of fire and affected one of three buildings Findings: During a tour of the facility and interview with staff, the flammable decoration in the facility was observed. Pavilion Building 1. On 1/7/20 at 1:06 p.m. , there was an approximately 4 feet tall live Christmas tree in the Laboratory located in Room P1171. The pine needles were observed brittle, dried out, and falling off branches. When interviewed, ES 1 confirmed the finding.	K 753		

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K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation, document review, interview, the facility failed to maintain the fire doors. This was evidenced by the failure of the Won doors that failed to operate upon the activation of the fire alarm system and fire doors that failed the annual inspection. This affected two of three buildings and could result in the inability to contain smoke and/or fire. Findings: During fire alarm testing and interview with staff, the Won doors were observed and document reviewed. Pavilion 1. On 1/8/20 at 9:20 a.m., the 20-minute fire	K 761		

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K 761	Continued From page 46 rated Won door near Room P1132 failed to operate upon activation of the fire alarm system. When interviewed, ES 1 stated that the interior panel was broken and waiting for parts from the vendor. ES 1 further stated that the resident's wheelchair caused the damage to the Won door. 2. On 1/8/20 at 9:24 a.m., the 20-minute fire rated Won door near Room P1111 failed to operate upon activation of the fire alarm system. When interviewed, ES 1 stated that the interior panel is broken and waiting for parts from the vendor. ES 1 further stated that the resident's wheelchair caused the damage to the Won door. North Building 3. On 1/9/20 at 1:17 p.m., the annual inspection for the fire door assemblies were reviewed. The documentation, "Fire Doors Inspection Checklist", dated 2019 indicated there were three fire doors that failed the inspection. The failed fire doors are as follow: - Door Number, N1-FD4, Door by Cedar suite dining room N1033, failed, closer, ordered parts. - Door Number, N2-FD13, Main double door entrance towards Juniper Suites, failed, panic strike rubbing. - Door Number, NM-FD10, Main double doors by laundry heading towards loading dock, failed, coordinator, ordered parts. At 1:37 p.m., the ES2 was interviewed. He stated that he was not sure if the corrections/repairs were done. He contacted the MS and the MS stated that work orders were submitted for the failed fire doors. He stated that the	K 761		

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K 761	Continued From page 47 corrections/repairs are still pending.	K 761		
K 918 S&E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K 918		

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K 918	Continued From page 48 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on document review and interview, the facility failed to maintain their diesel generators. This was evidenced by the failure to complete an annual fuel quality test. This could result in a generator malfunction during an emergency. This affected three of three buildings. NFPA 101, Life Safety Code, 2012 Edition 19.6 Building Services. 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards. Findings: During document review and interview with Staff, the maintenance records for the two diesel generators were requested. 1. On 1/9/20 at 2:03 p.m., the facility failed to provide current documentation for the annual fuel quality test of two 2000 Kw diesel fuel powered generator upon request. The last annual fuel quality test was conducted on 12/14/18. When	K 918		

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K 918	Continued From page 49 interviewed, ES1 confirmed the finding.	K 918		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567 Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation, the facility failed to maintain their electrical wiring and equipment. This was evidenced by one faceplate cover that was cracked. This could result in an increased risk of an electrical fire and or electrical shock. This affected one of three buildings. NFPA 101, Life Safety Code, 2012 Edition 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. NFPA 101, Life Safety Code 2012 Edition 9.1.2 Electric Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, National Electrical Code, 2011 Edition 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner.	K 919		

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K 919	Continued From page 50 Informational Note: Accepted industry practices are described in ANSI/NECA 1-2006, Standard Practices for Good Workmanship in Electrical Contracting, and other ANSI-approved installation standards. (A) Unused Openings. Unused openings, other than those intended for the operation of equipment, those intended for mounting purposes, or those permitted as part of the design for listed equipment, shall be closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (1/4 in.) from the outer surface of the enclosure. 406.6 Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Receptacle faceplates mounted inside a box having a recess-mounted receptacle shall effectively close the opening and seat against the mounting surface. Findings: During a tour of the facility with Staff, the electrical wiring and equipment was observed. South Building 1. On 1/7/20 at 10:32 a.m., on the first floor, the faceplate cover in the Clean Utility room, S1012 was cracked. When interviewed, the ES1 confirmed the finding.	K 919		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		

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K 920	Continued From page 51 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on observation and interview, the facility failed to maintain the electrical equipment and connections. This was evidenced by the unapproved use of a non-UL rated relocatable power tap and extension cord. This affected two of three buildings, and could potentially result electrical shock or the ignition of an electrical fire. NFPA 101, Life Safety Code, 2012 Edition 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions	K 920		

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K 920	Continued From page 52 of section 9.1 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, National Electrical Code, 2011 Edition 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage Findings: During a tour of the facility and interview with staff, the electrical equipment were observed. North Building 1. On 1/6/20 at 12:40 p.m., a non-UL approved relocatable power tap was used to power an	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING 03 B. WING _____	01/09/2020

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
K 920	Continued From page 53 oxygen concentrator and electric wheelchair near Bed B in Room N114. Room N114 was located on the first floor. When interviewed, ES 1 confirmed the finding. South Tower 2. On 1/7/20 at 9:55 a.m.,, there was an extension cord observed with a DVD player near Bed B in Room S532. The extension cord was not plugged into the wall outlet. Room S532 was located on the fifth floor.	K 920		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING 03 B. WING	01/09/2020

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
K 923	Continued From page 54 each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION; OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 31203 Based on document review and interview, the facility failed to maintain the gas equipment storage. This was evidenced by the failure to include in their policy storage was planned so cylinders are used in order which they are received from the supplier. This affected three of three buildings and could result in the malfunction of the cylinders. NFPA 99, Health Care Facilities Code, 2012 Edition 11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. Findings:	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING 03 B. WING _____	01/09/2020

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
K 923	Continued From page 55 During document review and interview with staff, the oxygen storage policy was reviewed. North Building, South Building, and Pavilion Building 1. On 1/8/20 at 1:35 p.m., the policy and procedure for Oxygen was reviewed. The policy and procedure did not include storage was planned so that cylinders are used in order which cylinders are received from the supplier. When interviewed, the NM confirmed the finding and stated that it was not included in the policy.	K 923		

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

375 Laguna Honda Blvd., San Francisco, CA 94116-1411
Provider ID: 555020
Life Safety Code and Emergency Preparedness Survey
Date of Survey Completed 01/09/2020

Plan of Correction

E 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 January 9, 2020 and received by the facility on January 15, 2020 as part of the Life Safety Code and Emergency Preparedness Survey. 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.

Plan of Correction

E006
CFR: 483.73 Plan Based on All Hazards Risk Assessment
(a) Emergency Plan, the [facility] must develop and maintain an emergency preparedness plan that must be reviewed. and updated at least every 2 years. The plan must de the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
(2) Include strategies for addressing emergency events identified by the risk assessment.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain a complete written emergency preparedness plan. This was evidenced by the failure to include missing residents in the facility's risk assessment. This affected 753 of 753 residents and could result in a delay in adequate response in the event of an emergency.

Corrective Actions:

1. **The facility will update its policy and procedure LHHPP 70-01 B3 Resident Evacuation plan to include protocols on how to identify and locate missing residents during an emergency as part of the facility's risk assessment.**
   Responsible Person:
   Safety Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   The Emergency Preparedness Committee will review the emergency plan at a minimum annually. Policies and procedures will be reviewed at a minimum annually through the Emergency Preparedness Committee, Hospital Executive Committee (HEC), and the Joint Conference Committee (JCC), the Governing Body.

2. **All LHH staff will receive an in-service on updated Emergency Preparedness Plan (EPP). The Department of Education and Training will monitor staff compliance.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

E015
CFR: 483.73 Plan Based on All Hazards Risk Assessment
(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph {c) of this section. The policies and procedures must be reviewed end updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:

(i) Food, water. medical and pharmaceutical supplies

(ii) Alternate sources of energy to maintain the following:

(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.

(B) Emergency lighting.

(C) Fire detection, extinguishing, and alarm systems.

(D) Sewage and waste disposal.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to provide policy and procedures for alternate sources of energy to maintain temperatures to protect resident's health and safety and for the safe and sanitary storage of provisions and policy, emergency lighting, fire detection, extinguishing, and alarm systems, and for sewage arid waste disposal. This could result in the failure to protect 753 of 753 residents during a disaster.

Corrective Actions:

1. **The facility will obtain provisions for sewage disposal during an emergency and will make that part of the EPP.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   February 8, 2020 and ongoing.

2. **The facility will update its policy and procedure LHHPP 70-01 A2 Emergency Preparedness to include alternate sources of energy to maintain temperatures to protect resident's health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, and alarm systems. The facility will obtain provisions for sewage disposal during an emergency and will make that part of the EPP.**
   Responsible Person:
   Safety Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   The Emergency Preparedness Committee will review the emergency plan at a minimum annually. Policies and procedures will be reviewed at a minimum annually through the Emergency Preparedness Committee, HEC, and the JCC, the Governing Body.

Plan of Correction

3. **All LHH staff will receive an in-service on updated EPP. The Department of Education and Training will monitor staff compliance.**

   Responsible Person:

   Nurse Educator.

   Completion Date:

   February 8, 2020 and ongoing.

   Monitoring:

   Compliance shall be reported quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

E018
CFR: 483.73 Procedures for Tracking of Staff and Patients
(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC). At a minimum, the policies· and procedures must address the following:

> [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility) must document the specific name and location of the receiving facility or other location.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain a complete written emergency preparedness plan. This was evidenced by the failure to provide policy and procedure that included a system to track the location of on-duty staff during and after an emergency. This could result in the failure to protect 753 of 753 residents during a disaster.

Corrective Actions:

1. **The facility will update its policy and procedure LHHPP 70-01 B1 Emergency Response Plan Appendix A to include a system to track the location of on-duty staff during and after an emergency.**
   Responsible Person:
   Safety Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   The Emergency Preparedness Committee will review the emergency plan at a minimum annually. Policies and procedures will be reviewed at a minimum annually through the Emergency Preparedness Committee, HEC, and the JCC, the Governing Body.

2. **All LHH staff will receive an in-service on updated EPP. The Department of Education and Training will monitor staff compliance.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

E020
CFR: 483.73 Policies for Evac. and Primary/Alt. Comm.
(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and update at least every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:

> [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the Emergency Preparedness policies and procedures. This was evidenced by the failure to provide policy and procedure for safe evacuation that included transportation and primary and alternate means of communication with external sources of assistance. This could result in the failure to protect 753 of 753 resident during a disaster.

Corrective Actions:

1. **The facility will update its policy and procedure LHHPP 70-01 B1 Emergency Response Plan to include safe evacuation that includes transportation and primary and alternate means of communication with external sources of assistance. LHH will coordinate with the San Francisco Department of Public Health (DPH) as per the Public Health Emergency Preparedness and Response (PHEPR) plan to obtain a copy of the reference coordination points.**
   Responsible Person:
   Safety Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   The Emergency Preparedness Committee will review the emergency plan at a minimum annually. Policies and procedures will be reviewed at a minimum annually through the Emergency Preparedness Committee, HEC, and the JCC, the Governing Body.

2. **The facility has updated its policy and procedure LHHPP 70-01 B3 Resident Evacuation Plan to include transportation of residents to alternate sites.**
   Responsible Person:
   Safety Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   The Emergency Preparedness Committee will review the emergency plan at a minimum annually. Policies and procedures will be reviewed at a minimum annually through the Emergency Preparedness Committee, HEC, and the JCC, the Governing Body.

Plan of Correction

3. **All LHH staff will receive an in-service on updated EPP. The Department of Education and Training will monitor staff compliance.**

   Responsible Person:

   Nurse Educator.

   Completion Date:

   February 8, 2020 and ongoing.

   Monitoring:

   Compliance shall be reported quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

E022
CFR: 483.73 Policies/Procedures for Sheltering in Place
(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:

[(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility).

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the Emergency Preparedness policies and procedures. This was evidenced by the failure to provide policy and procedure for sheltering in place. This could result in the failure to protect 753 of 753 residents during a disaster.

Corrective Actions:

1. **The facility will update its policy and procedure LHHPP 70-01 B1 Emergency Response Plan to include sheltering in place for residents', staff, and volunteers who remain in the facility.**
   Responsible Person:
   Safety Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   The Emergency Preparedness Committee will review the emergency plan at a minimum annually. Policies and procedures will be reviewed at a minimum annually through the Emergency Preparedness Committee, HEC, and the JCC, the Governing Body.

2. **All LHH staff will receive an in-service on updated EPP. The Department of Education and Training will monitor staff compliance.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

E026
CFR: 483.73 Policies/Procedures for Sheltering in Place
(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:

[(8) ((6), (6){C)(iv), (7), or (9}] The role of the (facility) under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the i provision of care and treatment at an alternate care site identified by emergency management officials.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the Emergency Preparedness policies and procedures. This was evidenced by the failure to provide policy and procedure for the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act. This could result in the failure to protect 753 of 753 residents during a disaster.

Corrective Actions:

1. **The facility will update its policy and procedure LHHPP 70-01 B1 Emergency Response Plan to include the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act. More specifically, how LHH will provide care for residents when transferred to a different site, in accordance with section 1135 of the Act.**
   Responsible Person:
   Safety Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   The Emergency Preparedness Committee will review the emergency plan at a minimum annually. Policies and procedures will be reviewed at a minimum annually through the Emergency Preparedness Committee, HEC, and the JCC, the Governing Body.

2. **All LHH staff will receive an in-service on updated EPP. The Department of Education and Training will monitor staff compliance.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

E030
CFR: 483.73 Names and Contact Information
(c) The [facility must develop and maintain an **emergency preparedness communication plan** that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC). The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians
(iv) Other [facilities].
(v) Volunteers.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain an emergency communication plan. This was evidenced by the failure to include the contact information for entities providing services under arrangement and other (Facilities). This affected 753 of 753 residents and could result in a delayed response to an emergency situation.

Corrective Actions:

1. **The facility will update its policy and procedure LHHPP 70-01 B1 Emergency Response Plan under section Communication Plan to include contact information of entities providing services under prior arrangement, as well as contact information for key personnel during an emergency situation.**
   Responsible Person:
   Safety Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   The Emergency Preparedness Committee will review the emergency plan at a minimum annually. Policies and procedures will be reviewed at a minimum annually through the Emergency Preparedness Committee, HEC, and the JCC, the Governing Body.

2. **All LHH staff will receive an in-service on updated EPP. The Department of Education and Training will monitor staff compliance.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

E035
CFR: 483.73 LTC and ICF/IID Sharing Plan with Patients
[For ICF/IIDs at §483.475(c)]: (c) The ICF/110 must develop and maintain an **emergency preparedness communication plan** that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:
[For LTC Facilities at §483,73(c)]: (c) The LTC facility must develop and maintain an **emergency preparedness communication plan** that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents (or clients) and their families or representatives.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain an emergency communication plan. This was evidenced by the failure to include a method for sharing information from the emergency plan that the facility has determined was appropriate with residents and their families or representatives in the communication plan. This affected 753 of 753 residents and could result in a delayed response to an emergency situation.

Corrective Actions:

1. **The facility will update its policy and procedure LHHPP 70-01 B1 Emergency Response Plan under section Communication Plan to include information that will be provided to the residents and their families or representatives of the facility's response to an emergency situation.**
   Responsible Person:
   Safety Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   The Emergency Preparedness Committee will review the emergency plan at a minimum annually. Policies and procedures will be reviewed at a minimum annually through the Emergency Preparedness Committee, HEC, and the JCC, the Governing Body.

2. **Information from the emergency plan deemed appropriate by LHH will be shared with residents during Community Meetings on all neighborhoods; to their families or representatives during Resident Care Conferences; and to new residents and families or representatives during admission.**
   Responsible Person:
   Safety Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

3. **All LHH staff will receive an in-service on updated EPP. The Department of Education and Training will monitor staff compliance.**

   Responsible Person:

   Nurse Educator.

   Completion Date:

   February 8, 2020 and ongoing.

   Monitoring:

   Compliance shall be reported quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

E039
CFR: 483.73 EP Testing Requirements
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/11D) must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility based functional exercise.

(B) If the [LTC facility) facility experiences an actual natural or man-made emergency that requires activation of the emergency plan. The LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following;

(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise: or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility) facility's emergency plan as needed.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain an emergency preparedness training and testing program. This was evidenced by the failure to provide document to show that the facility participated in a community based disaster drill. This could result in the failure to protect 753 of 753 residents in the event of a disaster.

Corrective Action:

1. **LHH experienced an actual activation of HICS during a community-based disaster (an extreme heat event in June 11, 2019). The facility will review the HICS documentation and develop an after-action report.**
   Responsible Person:
   Safety Officer.
   Completion Date:
   February 8, 2020.

2. **The Emergency Preparedness Committee will develop and maintain a calendar of scheduled exercises to test the emergency plan at a minimum twice a year, of which one is a full-scale exercise.**
   Responsible Person:
   Safety Officer.
   Completion Date:
   February 8, 2020 and ongoing.

Plan of Correction

K 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 January 9, 2020 and received by the facility on January 15, 2020 as part of the Life Safety Code and Emergency Preparedness Survey. 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.

Plan of Correction

K345
CFR: NFPA 101 Fire Alarm System - Testing and Maintenance
Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code. and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the fire alarm system (FAS). This was evidenced by a trouble signal noted on the Fire Alarm Control Panel (FACP), by an alarm silence noted on the annunciators, and by the failure to provide documentation for a semi-annual fire alarm system inspection. This could result in a delay in communication in the event of a fire. This affected three of three buildings.

Corrective Actions:

1. **The facility has contacted the fire alarm vendor on 01/09/20 for confirmation that the trouble shown on the system is due to an addition to the FAS as part of a current project under the jurisdiction of OSHPD. The vendor arrived on-site at LHH on 01/30/20 and located the bad addressable relay module on the roof controlling EF2. The vendor replaced the FAS module with the new SIGA-CR module and checked that the fire panel had returned to normal.**
    a. **Attachment One: Common Trouble Reset printout from the fire alarm panel indicating common trouble reset.**
    b. **Attachment Two: Image of the Main Fire Alarm Panel indicating a clear panel with no alarms or troubles.**
    c. **Attachment Three: Email confirmation from the vendor indicating the issue has been resolved.**

    Responsible Person:
    Director of Facility Services.
    Completion Date:
    January 30, 2020

2. **The semi-annual fire alarm system inspections will be scheduled in the Facilities Preventative Maintenance (PM) program. The Safety Engineer will review the fire alarm system inspection reports semi-annually for completion.**
    Responsible Person:
    Director of Facility Services.
    Completion Date:
    February 8, 2020 and ongoing.
    Monitoring:
    The Senior Stationary Engineer and Chief Stationary Engineer are responsible for monitoring compliance with fire alarm system inspections on a semi-annual basis. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

3. **The Safety Engineer has amended the annual test and inspection report of the fire alarm system to include the semi-annual visual inspection of the initiating devices.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   February 8, 2020.

4. **LHH will create a multi-disciplinary group Environment of Care (EOC) Committee which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care. The EOC Committee shall conduct scheduled EOC rounds throughout LHH on a continuous basis to identify potential risks and test EOC-related staff knowledge and skills.**
   Responsible Person:
   Chief Operating Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported monthly to the Environment of Care Committee (EOC), quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

ATTACHMENT ONE

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-OPERATOR COMMAND-  18:23:23  01/29/2020 P:10 C:00 D:00 LCD Level:0
ACTIVATE PNL SILENCE
P:FFFFFFFFFFFFFFFF C:00 D:0000

SUPERVISORY RST  ::  00:45:51 01/30/2020  P:01  C:03  D:0150
Existing Hospital Supervisory  MXL Panel

COMMON TRBL ACT  ::  09:25:27 01/30/2020  P:03  C:04  D:0143
South Roof E1A Shunt Relay

-OPERATOR COMMAND-  09:25:37  01/30/2020 P:02 C:00 D:00 LCD Level:0
ACTIVATE PNL SILENCE
P:FFFFFFFFFFFFFFFF C:00 D:0000

COMMON TRBL RST  ::  09:25:53 01/30/2020  P:03  C:04  D:0143
South Roof E1A Shunt Relay

LOCAL TRBL ACT  ::  09:26:07 01/30/2020  P:03  C:04  D:0676
03040676Unprogrammed Device DataCard1

-OPERATOR COMMAND-  09:26:12  01/30/2020 P:02 C:00 D:00 LCD Level:0
ACTIVATE PNL SILENCE
P:FFFFFFFFFFFFFFFF C:00 D:0000

LOCAL MNTR ACT  ::  09:26:44 01/30/2020  P:03  C:04  D:0673
03040673Mapping In   Progress DataCard1

-OPERATOR COMMAND-  09:26:52  01/30/2020 P:02 C:00 D:00 LCD Level:0
ACTIVATE PNL SILENCE
P:FFFFFFFFFFFFFFFF C:00 D:0000

-OPERATOR COMMAND-  09:26:53  01/30/2020 P:02 C:00 D:00 LCD Level:0
ACTIVATE PNL SILENCE
P:FFFFFFFFFFFFFFFF C:00 D:0000

COMMON TRBL RST  ::  09:27:15 01/30/2020  P:03  C:04  D:0144
South Roof E2A Shunt Relay

LOCAL TRBL RST  ::  09:27:15 01/30/2020  P:03  C:04  D:0676
03040676Unprogrammed Device DataCard1

LOCAL MNTR RST  ::  09:27:15 01/30/2020  P:03  C:04  D:0673
03040673Mapping In   Progress DataCard1

SWITCH ACTIVE  ::  10:15:31 01/30/2020  P:02  C:35  D:0001
South Building       System Bypass

SWITCH ACTIVE  ::  10:15:32 01/30/2020  P:02  C:36  D:0001
North Building       System Bypass
```

Plan of Correction

ATTACHMENT TWO

Plan of Correction

ATTACHMENT THREE

From: Cantor, Mark (DPH)
To: Talai, Nawzaneen (DPH)
Subject: FW: Laguna Honda Hospital
Date: Friday, January 31, 2020 9:42:14 AM

Here is Email from Service Technician that completed work yesterday.
Thanks,

From: Ray Gallagher [mailto:raymond@gallagheralarm.com]
Sent: Friday, January 31, 2020 9:39 AM
To: Cantor, Mark (DPH) <mark.cantor@sfdph.org>
Subject: Laguna Honda Hospital

> This message is from outside the City email system. Do not open links or attachments from untrusted sources.

Mark,

Service work completed yesterday:

Troubleshoot EF2 relay trouble on Fire Panel - Located bad addressable relay module on roof controlling EF2, replaced with new SIGA-CR module and checked fire panel had returned to normal.

Thanks

Ray

Plan of Correction

K353
CFR: NFPA 101 Sprinkler System – Maintenance and Testing
Sprinkler System. Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available:

a) Date sprinkler system last cheeked
b) Who provided system test
c) Water system supply source

Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the automatic sprinkler system. This was evidenced by the failure to maintain: sprinkler system component. This could affect the operation of the sprinkler system that could result in delay in extinguishing a fire. This affected one of three buildings.

Immediate Corrective Action:

1. **Facility Services staff has adjusted the escutcheon on the sprinkler head back to its correct position.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   January 7, 2020.

Corrective Action:

2. **LHH will create a multi-disciplinary group EOC Committee which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care. The EOC Committee shall conduct scheduled EOC rounds throughout LHH on a continuous basis to identify potential risks and test EOC-related staff knowledge and skills.**
   Responsible Person:
   Chief Operating Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

3. **Annual visual inspections of the sprinkler system in accordance with NFPA 25, 5.2 will be incorporated into the EOC rounds. The Safety Engineer is responsible for monitoring completion of inspections and any needed repair work.**

   Responsible Person:

   Director of Facility Services.

   Completion Date:

   February 8, 2020 and ongoing.

   Monitoring:

   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

K355
CFR: NFPA 101 Portable Fire Extinguishers
Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the fire extinguishers. This was evidenced by missing monthly inspections for one portable fire extinguisher and a portable fire extinguisher that was obstructed. This could result in a malfunction of the portable fire extinguisher. This affected of three buildings.

Immediate Corrective Action:

1. **The vital sign machine and medication cart were moved from obstructing the portable fire extinguisher by room 334 on South 3.**
   Responsible Person:
   Unit Nurse Manager.
   Completion Date:
   January 7, 2020.

Corrective Actions:

2. **The portable fire extinguisher on the second floor of the Pavilion Building located on the roof near the chillers was inspected and received its annual service.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   January 16, 2020.

3. **The portable fire extinguisher on the second floor of the Pavilion Building in the corridor near Room 2111 was inspected and received its annual service.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   January 16, 2020.

4. **LHH will create a multi-disciplinary group EOC Committee which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care. The EOC Committee shall conduct scheduled EOC rounds throughout LHH on a continuous basis to identify potential risks and test EOC-related staff knowledge and skills.**
   Responsible Person:
   Chief Operating Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

5. **Monthly visual inspections of all fire extinguishers will be conducted by Facilities staff. The Safety Engineer is responsible for monitoring completion of inspections and any needed repair work.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

6. **All LHH staff will receive an in-service regarding the use of portable fire extinguishers and the importance of ensuring that there are no obstructions to access or visibility of portable fire extinguishers.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

K363
CFR: NFPA 101 Corridor - Doors
Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware, Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted, Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted, Door frames shall be labeled and made of steel or other I materials in compliance with 8,3, unless the I smoke compartment Is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the corridor doors. This was evidenced by a corridor door that was obstructed and corridor doors that failed to latch. This affected three of three buildings and could result' in the passage smoke and flames in the event of a fire.

Immediate Corrective Action:

1. **The stool blocking the Laundry Room door to N2013 was immediately removed.**
   Responsible Person:
   Unit Nurse Manager.
   Completion Date:
   January 6, 2020.

2. **Facility Services staff adjusted the door to N6046 to latch when self-closed.**
3. **Facility Services staff adjusted the door to N4046 to latch when self-closed.**
4. **Facility Services staff adjusted the door to N4051 to latch when self-closed.**
5. **Facility Services staff adjusted the door to NM046 to latch when self-closed.**
6. **Facility Services staff adjusted the air flow in the gift shop and the door to latch when self-closed.**
7. **Facility Services staff adjusted the door to S526 to latch when manually closed.**
8. **Facility Services staff adjusted the door to S425 to latch when manually closed.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   January 7, 2020.

Plan of Correction

Corrective Actions:

9. **All LHH staff will receive an in-service on policy and procedure LHHPP 70-01 C1 Fire Response Plan.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported monthly to the Nursing Quality Improvement Committee (NQIC), quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

10. **LHH will create a multi-disciplinary group EOC Committee which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care. The EOC Committee shall conduct scheduled EOC rounds throughout LHH on a continuous basis to identify potential risks and test EOC-related staff knowledge and skills.**
    Responsible Person:
    Chief Operating Officer.
    Completion Date:
    February 8, 2020 and ongoing.
    Monitoring:
    Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

11. **Facility Services staff will conduct semi-annual inspections of all self-closing and manually closing doors as part of the EOC rounds to ensure proper closing and latching. The Chief Engineer and Maintenance Supervisor are responsible for monitoring compliance with the completion of any generated work orders.**
    Responsible Person:
    Director of Facility Services.
    Completion Date:
    February 8, 2020 and ongoing.
    Monitoring:
    Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

K372
CFR: NFPA 101 Subdivision of Building Spaces – Smoke Barriers
Smoke barriers shall be constructed to a 112-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the smoke integrity of the smoke barrier walls. This was evidenced by unsealed penetrations in the smoke barrier walls. This could result in the spread of smoke and fire in the event of a fire. This affected two of three buildings.

Immediate Corrective Actions:

1. **The penetration in the smoke barrier wall in N1, elevator lobby west wall towards the Pavilion building has been caulked and sealed by Facility Services staff.**
2. **The penetration in the smoke barrier wall on NM in the Cedar Suite has been caulked and sealed by Facility Services staff.**
3. **The penetration in the smoke barrier wall on N1 in the Redwood Suite has been caulked and sealed by Facility Services staff.**
4. **The penetration in the smoke barrier wall on S6 in the Marina Suite has been caulked and sealed by Facility Services staff.**

   Responsible Person:

   Director of Facility Services.

   Completion Date:

   January 8, 2020.

Corrective Actions:

5. **LHH will create a multi-disciplinary group EOC Committee which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care. The EOC Committee shall conduct scheduled EOC rounds throughout LHH on a continuous basis to identify potential risks and test EOC-related staff knowledge and skills.**

   Responsible Person:

   Chief Operating Officer.

   Completion Date:

   February 8, 2020 and ongoing.

   Monitoring:

   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

6. **Facility Services staff performs a semi-annual inspection of the smoke barrier walls above the ceiling to check for any penetrations. The Safety engineer will review the inspection reports for completion. The Chief Engineer and Maintenance Supervisor are responsible for monitoring compliance with the completion of any generated work orders.**

   Responsible Person:

   Director of Facility Services.

   Completion Date:

   February 8, 2020 and ongoing.

   Monitoring:

   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

K541

CFR: NFPA 101 Rubbish Chutes, Incinerators, and laundry Chutes

(1) Any existing linen and trash chute. including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour, all new chutes shall comply with 9.5.

(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.

(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.)

(4) Existing fuel-fed incinerator shall be sealed by fire resistive construction to prevent further use.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the required protective separation features for the laundry chute. This was evidenced by a laundry chute door that failed to positive latch. This affected one of three buildings. This could result in the spread of fire and smoke in the event of a fire in the chute.

Immediate Corrective Action:

1. **The latch on the laundry chute door in room N1012 was repaired by Facility Services staff.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   January 6, 2020.

Corrective Actions:

2. **LHH will create a multi-disciplinary group EOC Committee which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care. The EOC Committee shall conduct scheduled EOC rounds throughout LHH on a continuous basis to identify potential risks and test EOC-related staff knowledge and skills.**
   Responsible Person:
   Chief Operating Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

3. **Facility Services staff will conduct semi-annual inspections of the laundry chute doors as part of the EOC rounds. The Safety Engineer is responsible for monitoring completion of inspections and any needed repair work.**

   Responsible Person:

   Director of Facility Services.

   Completion Date:

   February 8, 2020 and ongoing.

   Monitoring:

   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.
   February 8, 2020 and ongoing.

Plan of Correction

K741
CFR: NFPA 101 Smoking Regulations
Smoking regulations shall be adopted and shall include not less than the following provisions:

(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
(2) In health care occupancies where smoking is, prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.
(3) Smoking by patients classified as not responsible shall be prohibited.
(4) The requirement of 18. 7,4(3) shall not apply where the patient is under direct supervision.
(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.
(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the designated smoking area. This was evidenced by cigarette butts being disposed on the ground and by the failure to protect the safety-type smoke poles. This could result in the increased risk of fire, and affected the designated smoking area.

Immediate Corrective Action:

1. **The four dozen cigarette butts were removed from the ground of the designated smoking area. The covers of the safety-type smoke polls were replaced.**
   Responsible Person:
   Director of Environmental Services.
   Completion Date:
   January 8, 2020.

Corrective Actions:

2. **Cleaning of the designated smoking area will occur at a minimum three times per Day and PM shift. The smoke patrol staff shall inform the Environmental Services Department if additional cleaning of the designated smoking area is needed based on daily activity.**
   Responsible Person:
   Director of Environmental Services.
   Completion Date:
   February 8, 2020 and ongoing.

3. **Residents will receive reminders of the ground rules when utilizing the designated smoking area as part of the neighborhood Community Meetings.**
   Responsible Person:
   Director of Therapeutic Activities and Wellness.
   Completion Date:
   February 8, 2020 and ongoing.

Plan of Correction

4. **Signage will be developed and posted in the designated smoking area indicating the ground rules.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   February 8, 2020 and ongoing.

5. **LHH will create a multi-disciplinary group EOC Committee which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care. The EOC Committee shall conduct scheduled EOC rounds throughout LHH on a continuous basis to identify potential risks and test EOC-related staff knowledge and skills.**
   Responsible Person:
   Chief Operating Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

K753
CFR: NFPA 101 Combustible Decorations
Combustible decorations shall be prohibited unless one of the following is met:

- Flame retardant or treated with approved j tire-retardant coating that is listed and labeled for product.
- Decorations meet NFPA 701.
- Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.
- Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-tire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).
- The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain their facility free of combustible decorations. This was evidenced by the failure to keep their facility free of combustible decoration. This could lead to an increased spread of fire and affected one of three buildings.

Immediate Corrective Action:

1. **The combustible decoration was removed from the Laboratory located in room P1171.**
   Responsible Person:
   Clinical Support Services Manager.
   Completion Date:
   January 7, 2020.

Corrective Actions:

2. **A memo was given to the Clinical Laboratory Department explaining no combustible decorations are permitted at LHH. Each Medical Evaluation Assistance was requested to sign in acknowledgement of the memo.**
   Responsible Person:
   Clinical Support Services Manager.
   Completion Date:
   January 24, 2020.

3. **All LHH staff will receive an in-service on policy and procedure LHHPP 71-06 Facility Decorations.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported monthly to NQIC, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

4. **LHH management and supervisors will receive reminders of LHH policy and procedure LHHPP 71-06 Facility Decorations stating cut trees or any flammable decorations are prohibited at LHH. Reminders will be provided during the months of October to December as part of the announcement section in Leadership Forum.**
   Responsible Person:
   Manager of Administration.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

5. **Residents will receive reminders of LHH policy and procedure LHHPP 71-06 Facility Decorations stating cut trees or any flammable decorations are prohibited at LHH. Reminders will be provided during the months of October to December as part of the neighborhood Community Meetings.**
   Responsible Person:
   Director of Therapeutic Activities and Wellness.
   Completion Date:
   February 8, 2020 and ongoing.

Plan of Correction

K761
CFR: NFPA 101 Maintenance, Inspection & Testing - Doors
Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the fire doors. This was evidenced by the failure of the Won doors that failed to operate upon the activation of the fire alarm system and fire doors that failed the annual inspection. This affected two of three buildings and could result in the inability to contain smoke and/or fire.

Corrective Actions:

1. **Corrections/repairs have been completed by Facility Services staff for fire doors:**
   a. **Door Number N1-FD4 by the Cedar Suite Dining Room N1033;**
   b. **Door Number N2-FD13, entrance door towards Juniper Suites; and**
   c. **Door Number, NM-FD10, main door by laundry loading docks.**

   Responsible Person:
   Director of Facility Services.
   Completion Date:
   January 14, 2020.
   Monitoring:
   All fire doors are labeled for identification, and annual inspections will be conducted by Facilities Staff to identify fire doors that do not fully latch when closed upon activation of the fire alarm system and to adjust the door and the door latching mechanism to positively latch when closed. The Maintenance Supervisor is responsible for monitoring compliance with the fire door inspections and completion of any generated work orders.

2. **Parts have been ordered to repair the WON door near P1132. The vendor will perform the repairs and place the door back in service as soon as parts arrive.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   February 8, 2020.
   Monitoring:
   All WON doors are inspected for proper operation during quarterly fire drills. The Safety Engineer is responsible for initiating immediate repairs of any doors not operating correctly and shall notify the Chief Engineer of such repairs. The Chief Engineer is responsible for monitoring the status of all repairs to the WON doors.

Plan of Correction

3. **Parts have been ordered to repair the WON door near P1111. The vendor will perform the repairs and place the door back in service as soon as parts arrive.**

   Responsible Person:

   Director of Facility Services.

   Completion Date:

   February 8, 2020.

   Monitoring:

   All WON doors are inspected for proper operation during quarterly fire drills. The Safety Engineer is responsible for initiating immediate repairs of any doors not operating correctly and shall notify the Chief Engineer of such repairs. The Chief Engineer is responsible for monitoring the status of all repairs to the WON doors.

4. **LHH will create a multi-disciplinary group EOC Committee which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care. The EOC Committee shall conduct scheduled EOC rounds throughout LHH on a continuous basis to identify potential risks and test EOC-related staff knowledge and skills.**

   Responsible Person:

   Chief Operating Officer.

   Completion Date:

   February 8, 2020 and ongoing.

   Monitoring:

   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

K918

CFR: NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing

The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds, If the 10-second criterion is not met during the monthly test. a process shall be provided to annually confirm this capability for the life safety and critical branches, Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.

Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 38 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain their diesel generators. This was evidenced by the failure to complete an annual fuel quality test. This could result in a generator malfunction during an emergency. This affected three of three buildings.

Corrective Action:

1. **The annual fuel quality test was performed by the qualified vendor once the PO was issued. The report is still pending.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   January 15, 2020.

2. **The Senior Stationary Engineer is responsible for monitoring compliance with NFPA 110 Testing. Monthly test reports will be submitted to the Chief Stationary Engineer every month for follow-up as necessary.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Documentation of monthly inspections, monthly generator test results, and timely follow-up will be evaluated quarterly and compliance reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

K919
CFR: NFPA 101 Electrical Equipment - Other
List in the REMARKS section any NFPA 99 Chapter 1O, Electrical Equipment requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99).

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain their electrical wiring and equipment. This was evidenced by one faceplate cover that was cracked, This could result in an increased risk of an electrical fire and or electrical shock. This affected one of three buildings.

Immediate Corrective Action:

1. **Facility Services staff replaced the cracked faceplate cover in S1012.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   January 7, 2020.

Corrective Actions:

2. **LHH will create a multi-disciplinary group EOC Committee which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care. The EOC Committee shall conduct scheduled EOC rounds throughout LHH on a continuous basis to identify potential risks and test EOC-related staff knowledge and skills.**
   Responsible Person:
   Chief Operating Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

3. **Facility Services staff will conduct semi-annual inspections of electrical outlets, light switches and coverplates as part of the EOC rounds. The Safety Engineer and Senior Safety Engineer are responsible for completion of inspections.**
   Responsible Person:
   Director of Facility Services.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.
   February 8, 2020 and ongoing.

Plan of Correction

K920

CFR: NFPA 101 Electrical Equipment – Power Cords and Extension Cords

Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the electrical equipment and connections. This was evidenced by the unapproved use of a non-UL rated relocatable power tap and extension cord. This affected two of three buildings, and could potentially result electrical shock or the ignition of an electrical fire.

Immediate Corrective Actions:

1. **The unapproved non-UL rated relocatable power tap was removed from N114B. The Unit Nurse Manager conducted environmental care rounds to inspect and ensure no other unapproved non-UL rated relocatable power tap were being used on the unit.**
   Responsible Person:
   Unit Nurse Manager.
   Completion Date:
   January 7, 2020.

2. **The unapproved extension cord was removed from S532B. The Unit Nurse Manager conducted environmental care rounds to inspect and ensure no other unapproved non-UL rated relocatable power tap were being used on the unit.**
   Responsible Person:
   Unit Nurse Manager.
   Completion Date:
   January 7, 2020.

Corrective Actions:

3. **Residents will receive information on the proper power strips to be utilized in patient care rooms to ensure they meet UL 1364 as part of the neighborhood Community Meetings.**
   Responsible Person:
   Director of Therapeutic Activities and Wellness.
   Completion Date:
   February 8, 2020 and ongoing.

Plan of Correction

4. **All LHH staff will receive an in-service on the proper power strips to be utilized in patient care areas and non-patient rooms.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

5. **LHH will create a multi-disciplinary group EOC Committee which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care. The EOC Committee shall conduct scheduled EOC rounds throughout LHH on a continuous basis to identify potential risks and test EOC-related staff knowledge and skills.**
   Responsible Person:
   Chief Operating Officer.
   Completion Date:
   February 8, 2020 and ongoing.
   Monitoring:
   Compliance shall be reported monthly to the EOC Committee, quarterly to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

K923
CFR: NFPA 101 Gas Equipment - Cylinder and Container Storage
Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.
>300 but <3,000 cubic feet
Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum, 1/2 hr fire protection rating.

Less than or equal to 300 cubic feet
In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2, A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION; OXIDIZING GAS{ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with Integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the gas equipment storage. This was evidenced by the failure to include in their policy storage was planned so cylinders are used in order which they are received from the supplier. This affected three of three buildings and could result in the malfunction or the cylinders,

Corrective Actions:

1. **The Central Processing Department policy and procedure B3 Oxygen and Compressed Air was revised to include, “cylinders are used in order which they are received from the supplier.”**
   Responsible Person:
   Director of Materials Management.
   Completion Date:
   February 8, 2020 and ongoing.

2. **All Central Processing Department staff will receive an in-service on the revisions of the policy and procedure B3 Oxygen and Compressed Air.**
   Responsible Person:
   Director of Materials Management.
   Completion Date:
   February 8, 2020.