PRINTED: 01/15/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A, BUILDING	LE CONSTRUCTION : 03	(X3) DATE SURVEY COMPLETED	۲
		555020	B, WING		01/09/202	20
	ROVIDER OR SUPPLIER HONDA HOSPITAL & RE	HABILITATION CTR D/P SNF		STREET ADDRESS, CITY, STATE. ZIP CO 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116	DDE	
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E 000	Initial Comments		€ 00	0		
	Department of Public Emergency Prepared The findings are in ac Federal Regulations (for Long Term Care (ness recertification survey, ecordance with 42 Code of (CFR) 483.73, Requirement LTC) Facilities.				
	Representing the Cal Health: 31203	ifornia Department of Public				
	The facility is not in at 42 CFR 483.73 for Lt Facilities.	ubstantial compliance with ong Term Care (LTC)				
	CENSUS: 753 Plan Based on All Ha CFR(s): 463,73(a)(1)	zards Risk Assessment -(2)	€ 00	96		
	and maintain an eme	The [facility] must develop rgency preparedness plan d, and updated at least every ust do the following:]	u			
	facility-based and cor	include a documented, mmunity-based risk an all-hazards approach,*				
	(2) Include strategies events identified by the	for addressing emergency ne risk assessment.				
	Plan. The LTC facility an emergency prepai reviewed, and update must do the following	§483.73(a)(1):] Emergency must develop and maintain redness plan that must be at least annually. The plan : include a documented,				
ABORATORY I	DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVĖ'S SIGNATU	RE	TITLE	(XB) DAYI	E

Any deficiency statement entiting with an astorisk (") 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.

Facility ID: CA220000512

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE.C A. BUILDING 83	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
555020	B. WING		01/09/20	20
rehabilitation CTR D/P SNF	375	LAGUNA HONDA BLVD.		
Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE COM	(XS) PLETION DATE
page 1 I community-based risk sing an all-hazards approach, residents. gies for addressing emergency by the risk assessment. §483,475(a)(1):] Emergency must develop and maintain an aredness plan that must be dated at least every 2 years. The following: and include a documented, I community-based risk sing an all-hazards approach, clients. gies for addressing emergency by the risk assessment. It §418,113(a)(2):] Emergency e must develop and maintain an aredness plan that must be dated at least every 2 years. The following; and include a documented, I community-based risk sing an all-hazards approach, gies for addressing emergency by the risk assessment, agement of the consequences natural disasters, and other awould effect the hospice's care. ENT is not met as evidenced ent review and interview, the saintain a complete written	E 008			
	S55020 REHABILITATION CTR D/P SNF EY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) Dage 1 I community-based risk ting an all-hazards approach, residents. Gies for addressing emergency by the risk assessment. S483,475(a)(1):] Emergency I must develop and maintain an ardness plan that must be dated at least every 2 years. The following: and include a documented, I community-based risk ting an all-hazards approach, clients. Gies for addressing emergency by the risk assessment. It \$418,113(a)(2):] Emergency I must develop and maintain an aredness plan that must be dated at least every 2 years. The following: and include a documented, I community-based risk ting an all-hazards approach, gies for addressing emergency by the risk assessment, hagement of the consequences matural disasters, and other I would effect the hospice's care. ENT is not met as evidenced	SENDED BY WING REHABILITATION CTR DIP SNF REPRESSOR RENCY MUST BE PRECEDED BY FULL REFIX REAG REPRESSOR REPRESSOR REFIX REAG REPRESSOR REFIX REAG REFIX RAG REFIX RAG REFIX RAG REFIX RAG REFIX RAG REHABILITATION CTR DIP SNF SA REHABILITATION CTR DIP SNF REFIX TAG REFIX TAG REPSIX TAG REPSIX TAG REPSIX TAG REFIX TAG REFIX TAG REF	SERVING STREET ADDRESS, CITY, STATE, ZIP CODE 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116 PROVIDER'S PLAN OF CORE SERVING MAN THE PRECEDED BY PULL OR LISC IDENTIFYING INFORMATION) DESCRIPTION OF CORE CROSS-REFERENCED TO THE AF DEFICIENCY) E 006 E 007 E 0	ERHABILITATION CTR DIP SNF A BUILDING 03 STREET ADDRESS, CITY, STATE, ZIP CODE 375 LAGUINA NONDA BLVD. SAN FRANCISCO, CA 94116 PROVIDER'S PLAN OF CORRECTION CAOSS-AFFERRACEDED SOF PULL CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CAOSS-AFFERRACEDED SOF PULL CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CAOSS-AFFERRACED TO THE APPROPRIATE CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CAOSS-AFFERRACED TO THE APPROPRIATE CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CAOSS-AFFERRACED TO THE APPROPRIATE CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CAOSS-AFFERRACED TO THE APPROPRIATE CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CAOSS-AFFERRACED TO THE APPROPRIATE CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CONS. PRANCISCO, CA 94116 PRESENT TAGS PROVIDER'S PLAN OF CORRECTION CONS. PROVIDER'S PLAN OF CORRECTION TAGS PROVIDER'S PLAN OF CORRECTION CONS. PROVIDER'S PLAN OF CORRECTION TAGS PROVIDER'S PLAN OF CORR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT: A, QUIL,DIN	IPLE CONSTRUCTION IG 03	(X3) DATE	SURVEY PLETED
		555020	B. WING_		01	09/2020
	rovider or supplier Honda Hospital & R	EHABILITATION CTR DIP SNF		STREET ADDRESS, CITY. STATE, ZIP CODE 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116		
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E 006	Continued From page	ge 2	 E0	006		
	affected 753 of 753	ity's risk assessment. This residents and could result in response in the event of an	;			
	Findings:					
	-	view and interview with staff gency preparedness manual				
	failed to include mis risk assessment. W and AS 3 confirmed	-	180	*		
E 015 SS=D	Subsistence Needs CFR(s): 483.73(b)(1	for Staff and Patients)	E	015		
	develop and implementations and proceeds and proceeds plan set forth in para assessment at para and the communicathis section. The pope to reviewed and up	produces. [Facilities] must hent emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of blicies and procedures must dicted every 2 years (annually num, the policies and lidress the following:	x-			
	and patients whether place, include, but a	subsistence needs for staff or they evacuate or shelter in are not limited to the following: medical and pharmaceutical		:*		
	(ii) Alternate so the following: (A) Tempe	urces of energy to maintain ratures to protect patient health he safe and sanitary storage			91	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING	E CONSTRUCTION 03		ATĘ SURVEY DMPLETED
		555020	B. WING			01/09/2020
	rovider or supplier Monda Hospital & Re	HABILITATION CTR D/P SNF		STREET ADDRESS, CITY. STATE. ZIP C 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	RECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		ION SHOULD BE THE APPROPRIATE	(K5) COMPLETION DATE
E 015	of provisions. (B) Emerge (C) Fire determination and procedu (B) The following are hospice-operated inpospice-operated inpospice and provision hospice employees a evacuate or shelter in limited to the following (A) Food, we pharmaceutical supp (B) Atternation the following (1) Termination the following (2) Emerge of provisions (2) Emerge of provisions (2) Emerge of provisions (2) Emerge of provisions (3) Fire alarm systems. (C) Sewage This REQUIREMENT by: Surveyor; 31203 Based on record revisions and procedu the fallure to provide	and waste disposal. The at §418.113(b)(6)(iii):] The at §418.113	E 01		,	
	safety and for the sa provisions and policy	ect residents health and fe and sanitary storage of r. emergency lighting, fire ing, and alarm systems, and			~	

	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0	CONSTRUCTION		TE SURVEY MPLETED
		565020	B, WING			1/09/2020
	ROVIDER OR SUPPLIER HONDA HOSPITAL & RE	ehabilitation ctr d/p snf	37	rreet address, city, state, zip code Ps Laguna Honda BLVD. An Francisco, ca 94118		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Tatement of deficiencies Cy must be preceded by full LSC identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIÊNCY)	SHOULD BE	COMPLETION DATE
E 015	for sewage and was	e 4 te disposal. This could result ct 753 of 753 residents	E 015			
-	on 1/9/20, the emerg 1. At 9:45 a.m., the provide policy and pro- sources of energy to protect residents her safe and sanitary sto- emergency lighting, if and alarm systems. confirmed the finding	fire detection, extinguishing, When interviewed, AS 2 a and stated that the facility tems were not listed on the			×	
	and procedures for s When interviewed, the confirmed the finding Procedures for Trace CFR(s): 483.73(b)(2 ((b) Policies and pro- develop and implem policies and procedu- plan set forth in para assessment at para and the communicat this section. The pol reviewed and update (annually for LTC).]	king of Staff and Patients	E 018			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.5%			ATE SURVEY
	556020	B. WING			01/09/2020
	REHABILITATION CTR D/P SNF	3	78 LAGU NA HONDA BLVD.		
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	IO PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
[(2) or (1)] A system on-duty staff and signal staff and sheltered the emergency, the specific name and or other location. *[For PRTFs at §4 ICF/IIDs at §483, 4 Policies and procelecation of on-duty the [PRTF's, LTC, and after an emergency, the [Pmust document the the receiving facility of the staff of the policies and procelecation of on-duty and procelecation of on-duty employees transportation; idealing the system to transportation; idealing the system to transportation with assistance. (v) A system to transportation on-duty employees on-duty employees relocated during the must document the receiving facility for CMHCs at §4 IFF or CMHCs at §4 IF	m to track the location of heltered patients in the ng an emergency. If on-duty patients are relocated during a [facility] must document the location of the receiving facility 41.184(b). LTC at §483,73(b), 75(b), PACE at §460,84(b):] dures. (2) A system to track the staff and sheltered residents in ICF/IID or PACE] care during gency. If on-duty staff and sare relocated during the RTF's, LTC, ICF/IID or PACE] as specific name and location of ty or other location. spice at §418,113(b)(6):] dures. In from the hospice, which ation of care and treatment is; staff responsibilities; intification of evacuation mary and alternate means of the external sources of the external sources of the external sources of the external sources of the emergency. If the ing an emergency, the hospice is specific name and location of ty or other location. 485.920(b):] Policies and	E 018			
	Summary (EACH DEFICIT REGULATORY) (EACH DEFICIT REGULATORY) ((2) or (1)) A system on-duty staff and s [facility's] care duri staff and sheltered the emergency, the specific name and or other location. "[For PRTFs at §4- Policies and proce- location of on-duty the [PRTF's, LTC, and after an emergency, the [Pmust document the the receiving facility "[For Inpatient Hos- Policies and proce- (ii) Safe evacuation includes considerated of evacuation includes considerated of evacuation includes considerated of evacuation includes considerated of evacuation assistance. (v) A system to tra employees' on-duty hospice's care duri on-duty employees relocated during the must document the the receiving facility "[For CMHCs at §- "[For CMHCs at §-	RONDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 evacues; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of	CORRECTION IDENTIFICATION NUMBER: 856920 8. WING ROYNDER OR SUPPLIER **SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 [(2) or (1)) A system to track the location of on-duly 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 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	ROWDER OR SUPPLIER RONDA HOSPITAL & REHABILITATION CTR DJP SNF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 5 [(2) or (1)] A system to track the location of on-duly staff and sheltered patients in the facility or other location of the receiving facility or other location. "[For PRTF's, LTC, ICF/III] or PACE] care during an emergency. If on-duly staff and sheltered residents in the location of on-duly staff and sheltered residents in the representation of the receiving facility or other location. "[For PRTF's, LTC, ICF/III] or PACE] care during and after an emergency. If on-duly staff and sheltered residents in the location of on-duly staff and sheltered residents in the location of on-duly staff and sheltered residents in the location and after an emergency. If on-duly staff and sheltered residents in the policies and procedures. (2) A system to track the location of on-duly staff and sheltered residents in the location of one-duly staff and sheltered residents in the policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacues; staff responsibilities; transportation, identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (iv) A system to track the location of hospice employees' on-duly and shaltered patients are relocated during the emergency, if the on-duly amployees or sheltered patients are relocated during the emergency, if the on-duly amployees or sheltered patients are relocated during the emergency, if the on-duly amployees or sheltered patients are relocated during the emergency, if the on-duly amployees or sheltered patients are relocated during the emergency, if the on-duly amployees or sheltered patients are relocated during the emergency. If the on-duly amployees or sheltered patients are relocated during the emergency. If the on-duly amployees or sheltered	SOME OF SUPPLIER SUMMARY STATEMENT OF DEFIGURNISS (EACH OFFICIENT) CONTINUED FROM PROPERTY OF STREETHING INFORMATION) SUMMARY STATEMENT OF DEFIGURNISS (EACH OFFICIENT) (EACH OFFICIENT) CONTINUED FROM PROPERTY OF LIST IN TACK THE INCOME. 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	rovider or supplier Honda Hospital & Re	HABILITATION CTR D/P SNF		STREET ADDRESS, CITY, STATE, ZIP 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full .sc identifying information)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
€ 018	evacuation location(s means of communica assistance. *[For OPOs at § 486. procedures. (2) A system documentation that p donor information, proposedures and maintain for the secures of the patients. This REQUIREMENT by: Surveyor: 31203 Based on document facility failed to maintain facility failed t	deration of care and vacuees; staff portation; identification of); and primary and alternate (ition with external sources of 360(b):] Policies and stem of medical reserves potential and actual otects confidentiality of lonor information, and is the availability of records. 62(b):] Policies and evacuation from the dialysis is staff responsibilities, and is not met as evidenced	EO	18		

RTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PLE CONSTRUCTION G 03		DATE SURVEY COMPLETED			
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,	rovider or supplier Honda Hospital & R	EHABILITATION CTR D/P SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116				
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E 018	Continued From pag	a 7	į E0	18				
	emergency. When it	nterviewed, AS 1, AS 2, and inding.	1		*			
E 020 SS=D		d Primary/Alt. Comm.)	EO	20				
	develop and implem policies and procedu plan set forth in para assessment at para and the communical this section. The pol reviewed and update (annually for LTC). and procedures mus [(3) or (1), (2), (6)] S [facility], which inclustreatment needs of eresponsibilities; transevacuation location(pedures. The [facilities] must ent emergency preparedness ares, based on the emergency graph (a) of this section, risk graph (a) (1) of this section, ion plan at paragraph (c) of icies and procedures must be ed at least every 2 years. At a minimum, the policies at address the following:] afe evacuation from the des consideration of care and evacuees; staff sportation; identification of s); and primary and alternate ation with external sources of						
	§416.54(b)(2):] Safe evacuation from includes the followin (i) Consideration of (ii) Staff responsibilit (iii) Transportation.	care needs of evacuees.						
	(v) Primary and alter							
	* [For CORFs at §48 Rehabilitation Agend §485.727(b)(1), and	cies, OPT/Spaech at						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 03	CONSTRUCTION	COMPLETED		
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	ROVIDER OR SUPPLIER HONDA HOSPITAL & F	EHABILITATION CTR DIP SNF	37	STREET ADDRESS, CITY, STATE. ZIP CODE 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 96116			
(Xd) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPI DEFICIENCY)	OULD BE COMPLETION		
E 020	Rehabilitation Agen Agencies as Provid Therapy and Speed Services; and ESRI staff responsibilities I For RHCs/FQHC evacuation from the appropriate placem responsibilities and This REQUIREMEN by: Surveyor: 31203 Based on record re failed to maintain th policies and proced the failure to provid safe evacuation the primary and alterna with external source result in the failure during a disaster. Findings: During document re on 1/9/20, the eme	m the (CORF; Clinics, cies, and Public Health ars of Outpatient Physical sh-Language Pathology D Facilities), which includes and needs of the patients. Is at §491.12(b)(1): J Safe RHC/FQHC, which includes ent of exit signs; staff needs of the patients. It is not met as evidenced wiew and interview, the facility are Emergency Preparedness tures. This was evidenced by a policy and procedure for at included transportation and the means of communication are of assistance. This could be protect 753 of 753 resident eview and interview with staff regency plan was reviewed.	E 02D				
	policy and procedu included transporta means of communi assistance. When and AS 3 confirmed	s for Sheltering in Place	E 022				

STATEMENT OF DEFICIENCIÉS AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED
		555020	B. WING			01/09/2020
, , , , , , , , , , , , , , , , , , , ,	ROVIDER OR SUPPLIER HONDA HOSPITAL &	REHABILITATION CTR DIP SNF		STREET ADDRESS, CITY, STATE, ZIP O 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116	CODE	
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PRÉFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
E 022	Continued From p	page 9	EO	22		
	develop and imple policies and proceplan set forth in p assessment at pa and the communithis section. The be reviewed and (annually for LTC and procedures of the facility). [(4) or (2),(3),(5),(for patients, staff, the [facility]. *[For Inpatient Hoand procedures. (6) The following hospice-operated The policies and following: (i) A means to shoppice employed this REQUIREM by: Surveyor: 31203 Based on docum facility failed to me Preparedness poevidenced by the procedure for shoresult in the failur during a disaster.	ent review and interview, the aintain the Emergency licies and procedures. This was failure to provide policy and eltering in place. This could a to protect 753 of 753 residents)#	
	Findings:	,				
	During document	review and interview with staff				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING 03	NSTRUCTION		TE SURVEY MPLETED
		. 565020	a wing		0	1/09/2020
	rovider or supplier Honda Hospital & Re	HABILITATION CTR DIP SNF	275 L	et address, city, state, zip codi Aguna Honda Blyd. Francisco, ca 84116	È	
(X4) ID PREFIX TAG	IEACH DEFICIENC	[ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 022	on 1/9/20, the emerg 1. At 10:20 a.m., the policy and procedure	ency plan was reviewed. facility failed to provide for a means to shelter in	€ 022			
E 026 SS=D	remain in the facility. 1, AS 2, and AS 3 co Roles Under a Waive	er Declared by Secretary	E 026			
H	develop and implement policies and procedure plan set forth in para assessment at paragrand the communication this section. The policy is reviewed and upon (annually for LTC).	cedures. The [facilities] must ent emergency preparedness res, based on the amergency graph (a) of this section, risk graph (a)(1) of this section, ion plan at paragraph (c) of licies and procedures must lated at least every 2 years At a minimum, the policies t address the following:]				
	(facility) under a waiv in accordance with s provision of care and), or (9)] The role of the ver declared by the Secretary, ection 1135 of the Act, in the it reatment at an alternate y emergency management				
	procedures. (8) The waiver declared by the with section 1135 of at an alternative can management official This REQUIREMEN by: Surveyor: 31203	3.748(b):) Policies and role of the RNHCI under a he Secretary, in accordance Act, in the provision of care e site identified by emergency s. T is not met as evidenced review and interview, the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/GUPPLIER/GLIA (DENTIFICATION NUMBER.	(X2) MULT A, BUILDIN	IPLE CONSTRUCTION NG 09	(X3) DATE SURVEY COMPLETED	
		656020	B. WING_		0	1/09/2020
	ROMDER OR SUPPLIER HONDA HOSPITAL & (REHABILITATION CTR D/P SNF		STREET ADDRESS, CITY, STATE, ZIP COD 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116	iE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
E 026	Preparedness police videnced by the faprocedure for the the waiver declared by with section 1135 of the failure to protect disaster. Findings: During document in on 1/9/20, the eme 1. At 10:40 a.m., the policy and procedure for resident which accordance with When interviewed, confirmed the finding Names and Contact CFR(s): 483.73(c)(1) [(c) The [facility multiple for the policy must be reviewed and must be reviewed to the policy must be reviewed to the policy must be reviewed that complies with and must be reviewed to the policy of the pol	Intain the Emergency Lies and procedures. This was allure to provide policy and the role of the facility under a the Secretary in accordance of the Act. This could result in the 753 of 753 residents during a eview and interview with staff regency plan was reviewed. The facility failed to provide the for how they would provide then they are at a different site, section 1135 of the Act. The AS 1, AS 2, and AS 3 The section plan the facility failed to provide then they are at a different site, section 1135 of the Act. The AS 1, AS 2, and AS 3 The section plan the facility failed to provide the As 1, AS 2, and AS 3 The section for the section plan federal, State and local laws and updated at least every the LTC). The communication all of the following: The third formation for the sections are provided to the section plan federal the following: The communication plan federal the following: The communication for the sections are provided to the following: The communication for the sections are provided to the following: The communication for the sections are provided to the following: The communication for the sections are provided to the following: The communication for the sections are provided to the following: The communication for the sections are provided to the following: The provided the following the follo	E	030		
	(v) Volunteers					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MUL A. SUILDI	TIPLE CONS ING 0 3	ETRUCTION		ATE SURVEY OMPLETED
		585020	B. WING				01/09/2020
	rovider or supplier Honda Hospital & Ri	EHABILITATION CTR D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 84116				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHONTO SE	(XG) COMPLETION DATE
E 030	"[For Hospitals at §4 §485.625(c)] The co- include all of the folk (1) Names and controllowing: (i) Staff. (ii) Entities provarrangement. (iii) Patients' phi (iv) Other (hospically) Volunteers. "[For RNHCIs at §40 communication plant following: (1) Names and controllowing: (i) Staff. (ii) Entities provarrangement. (iii) Next of kin, (iv) Other RNHI (v) Volunteers. "[For ASCs at §416. plan must include at (1) Names and controllowing: (i) Staff. (ii) Entities provarrangement. (iii) Patients' phi (iv) Volunteers. "[For Hospices at §- communication plant following: "[For Hospices at §- communication plant following:	82:15(c) and CAHs at mmunication plan must bying: act information for the diding services under sysicians itals and CAHs]. 03:748(c):] The must include all of the act information for the diding services under guardian, or custodian. Cls. 45(c):] The communication of the following: act information for the diding services under sysicians.		030			

	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V BRITZING	E CONSTRUCTION 03		ATE SURVEY PMPLETED
		555020	B. WING	<u>p</u>		1/09/2020
	ROVIDER OR SUPPLIFR HONDA HOSPITAL &	REHABILITATION CTR D/P SNF		RTREET ADDRESS, CITY, STATE, ZIP CODE 375 LAGUNA HONDA BLYD. SAN FRANCISCO, CA 94116	•	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (GROSS-REFERENCED TO THE A DEFICIENCY)	SKOULD BE	(X5) COMPLETION DATE
E 030	arrangement, (iii) Patients'; (iv) Other hos *[For HHAs at §48 plan must include (1) Names and co following: (i) Staff, (ii) Entitles pr arrangement. (iii) Patients' (iv) Volunteer *[For OPOs at §4] plan must include (2) Names and co following: (i) Staff, (ii) Entitles pr arrangement. (iii) Volunteer (iv) Other OP (v) Transplan OPO's Donation S This REQUIREMI by: Surveyor: 31203 Based on docume facility failed to m communication pl failure to Include t entities providing and other (Facilities)	inployees. oviding services under chysicians. spices. 34.102(c):] The communication all of the following: intact information for the aviding services under chysicians. s. 36.360(c):] The communication all of the following: intact information for the aviding services under s. Os. It and donor hospitals in the Service Area (DSA). ENT is not met as evidenced ent review and interview, the aintain an emergency an. This was evidenced by the the contact information for services under arrangement ans. This affected 753 of 753 and result in a delayed response	€ 03			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING 03	JULTIPLE CONSTRUCTIÓN LIDING 93		(X3) DATE SURVEY COMPLETED	
		555020	B. WING	V.	` c	1/09/2020	
	Rovider or supplier Honda Hospital & Re	HABILITATION CTR DIP SNF	375	EET ADDRESS, CITY, STATE, ZIP COD LAGUNA HONDA BLVD. N FRANCISCO, CA 94116	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	CXS) COMPLETION CATE	
E 030	Continued From page	e 14	€ 030				
	Findings:					ļ	
		iew and interview with staff ency communication plan			6		
	communication plan of information for entitie arrangement and oth	emergency preparedness did not include the contact as providing services under er (Facilities). When AS 2, and AS 3 confirmed					
		ring Plan with Patients	E 035				
	must develop and ma preparedness commit with Federal, State a reviewed and update	3.475(c):] [(c) The ICF/IID aintain an emergency unication plan that complies no local laws and must be d at least every 2 years.] blan must include all of the					
	facility must develop preparedness commi with Federal, State a reviewed and update	t §483.73(c):] ((c) The LTC and maintein an emergency unication plan that complies no focal laws and must be at least annually.] The must include all of the		Stark.			
	emergency plan, that is appropriate, with re families or represent	ring information from the the facility has determined esidents [or clients] and their atives. T is not met as evidenced					

	INT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NO CORRECTION IDENTIFICATION NUMBER: A, BUILDING 83				TE SURVEY MPLETED	
		555020	8. WING	· · · · · · · · · · · · · · · · · · ·		1/09/2020
	ROVIDER OR SUPPLIER HONDA HOSPITAL & RE	HABILITATION CTR D/P SNF		STREET ADDRESS, CITY, STATE, ZIP COI 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116	DE	
(XA) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 035	facility failed to maint communication plan, failure to include a m from the emergency determined was appropriate families or repre- communication plan.	review and interview, the tain an emergency This was evidenced by the ethod for sharing information plan that the facility has repriate with residents and esentatives in the This affected 753 of 753 result in a delayed response	E 03	95		
€ 039 SS=D	on 1/9/20, the emerg was reviewed. 1. At 11:00 a.m., the communication plan sharing information f the facility has determined the facility has determined the finding EP Testing Requiren CFR(s): 463.73(d)(2) *[For RNCHi at §403.44.102, ("Organizations" und §485.920, RHC/FQF Facilities at §494.62" (2) Testing. The [facto test the emergence must do all of the followers.	nents 3.748, ASCs at §416.54, CORFs at §485.68, OPO, er §485.727, CMHC at HC at §491.12, ESRD 3. (lity) must conduct exercises by plan annually. The [facility]	E 0	39		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(XS) MULTIPLE CO	(X3) DATE SURVEY COMPLETED			
		555020	B. WING		01/09/2020		
	ROVIDER OR SUPPLIFIR	REHABILITATION CTR D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FUI,I. OR USC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION		
E 039	community-based (A) Wher not accessible, core exercise every 2 (B) If the natural or man-ma activation of the er is exempt from en community-based functional the actual event. (ii) Conduct al every 2 years, opp functional exercise this section is connot limited to the for (A) A sec community-based functional exercise (B) A mo (C) A tab is led by a facilitate discussion using a clinically-relevise of problem sta prepared question emergency plan. (iii) Analy maintain documer exercises, and em revise the [facility) *[For Hospices at (2) Testing for hospatient's home. T exercises to test to annually. The hos	every 2 years; or a community-based exercise is induct a facility-based functional years; or [facility] experiences an actual de emergency that requires inergency plan, the [facility] gaging in its next required or individual, facility-based if exercise following the onset of additional exercise at least resite the year the full-scale or sunder paragraph (d)(2)(i) of ducted, that may include, but is collowing: ond full-scale exercise that is or individual, facility-based er; or ck disaster drill; or letop exercise or workshop that or and includes a group in narrated, vant emergency scenario, and a tements, directed messages, or s designed to challenge an exe the [facility's] response to and station of all drills, tabletop ergency events, and elemergency plan, as needed.	€ 039				

	of deficiencies correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IFLE CONSTRUCTION NG 03	(XS	ODATE SURVEY
		655020	B, WING			01/09/2020
	ROVIDER OR SUPPLIER HONDA HOSPITAL & (REHABILITATION CTR D/P SNF		STREET AJDRESS, CITY, ST 275 LAGUNA HONDA BLVI SAN FRANCISCO, CA 9	в.	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREI CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	not accessible, corbased functional exempt from engages cale community-b facility-based the onset of the emergency period of the emergency period of the emergency period of the emergency period of the emergency plan. (ii) Conduct a years, opposite the functional exercise this section is conducted in the formal exercise of the emergency plan. (iii) Conduct a years, opposite the functional exercise this section is conducted in the formal exercise of (A) A section of the formal exercise; or (B) A monoid of the emergency plan.	a community based exercise is adduct an individual facility kercise every 2 years; or mospice experiences a natural regency that requires activation blan, the hospital is ging in its next required full ased exercise or individual diffunctional exercise following hergency event. In additional exercise every 2 eyear the full-scale or under paragraph (d) (2)(i) of flucted, that may include, but is allowing; and full-scale exercise that is or a facility based functional exercise or workshop that for and includes a group narrated, ant emergency scenario, and a mements, directed messages, or designed to challenge an olices that provide inpatient hospice must conduct	E	039		
	exercises to test the year. The hospice (i) Participate that is community-(A) When not accessible, confacility-based functions.	ne emergency plan twice per must do the following: in an annual full-scale exercise based; or a community-based exercise is induct an annual individual		·		•

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G 03	(X3) DATE SURVEY COMPLETED	
		556020	B. WING_			1/09/2020
	ROVIDER OR SUPPI,IER HONDA HOSPITAL &	REHABILITATION CTR D/P SNF		STREET ADDRESS, CITY, STATE, ZIP CODI 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116	CODE	
(X4) ID FREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CÓI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
€ 039	or man-made eme of the emergency exempt from engage full-scale community for the emergency (ii) Conduct at that may include, it following: (A) A second community-based exercise; or (B) A moderate of the emergency census at the emergency scenarious at the emergency plan. (iii) Analyze the emergency plan. (iii) PRFTs at §4 §482.15(d), CAHs (2) Testing. The [Fonduct exercises twice per year. The following: (i) Participate that is community. (A) When not accessible, confacility-based functions are consisted to the following: (B) If the	rgency that requires activation plan, the hospice is ging in its next required fity based or facility-based exercise following the onset event. In additional annual exercise tout is not limited to the cond full-scale exercise that is or a facility based functional oct disaster drill; or clietop exercise or workshop led includes a group discussion clinically-relevant fit, and a set of problem ed messages, or prepared designed to challenge an the hospice's response to and station of all drills, tabletop ergency events and revise regency plan, as needed. 41.184(d), Hospitals at at §485.625(d):} PRTF, Hospital, CAH] must to test the emergency plan he [PRTF, Hospital, CAH] must in a nanual full-scale exercise based; or a community-based exercise is induct an annual individual,	EO	39		
	unpullettere all at			i		

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IQENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03			(X3) DATE SURVEY COMPLETED	
		\$55020	B. WING				01/09/2020
	ROVIDER OR SUPPLIER HONDA HOSPITAL & I	REHABILITATION CTR D/P SNF		376 LA	raddregs, city, state, zip code guna honda blyd. Rancisco, ca 94116	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	statement of deficiencies NCY Must be preceded by full R LSC IOENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	40ULD BE	(X5) COMPLETION DATE
E 039	emergency that recemergency plan, the engaging in its next based or functional exercise emergency event. (ii) Conduct an and that may include tollowing: (A) A sect community-based of functional exercise (B) A moderational exercise of problem state prepared questions emergency plan. (iii) Analyze the maintain document exercises, and emit the [facility's] emergency proceed (C) The [LTC facilities the emergency proceed (C) Participate that is community—(A) When not accessible, confacility-based functions (B) If the	quires activation of the le [facility] is exempt from the required full-scale community individual, facility-based following the onset of the leaditional] annual exercise or de, but is not limited to the lond full-scale exercise that is per individual, a facility-based in or and includes a group in arrated, and emergency scenario, and a sements, directed messages, or designed to challenge an elegacility's response to and tation of all drills, tabletop ergency events and revise gency plan, as needed. Seat §483.73(d): sy must conduct exercises to be plan at least twice per year, inced staff drills using the lures. The [LTC facility, the following; in an annual full-scale exercise based; or a community-based exercise is oduct an annual individual,	E	039			

AND DI AN OF CONDECTION		A. BUILDIN	PLE CONSTRUCTION G 03		(K2) DATE SURVEY COMPLETED	
	•	555020	B. WING_			01/09/2020
	RONDER OR SUPPLIER HONDA HOSPITAL &	REHABILITATION CTR DIP SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116			(*)
(X4) IÚ PRFFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(XE) COMPLETION DATE
E 039	required a full-scal individual, fact following the onse (ii) Conduct at that may include, I following: (A) A ser community-based functional exercise (B) A mo (C) A tat is led by a facilitat using a narrated, emergency scena statements, direct questions emergency plan. (iii) Analyze (response to and modills, tabletop exercise avents, and revise emergency plan. *[For ICF/IIDs at § (2) Testing. The IC to test the emergency plan is community (A) When not accessible, confacility-based functions (B) If the	of the emargency plan, exempt from engaging its next le community-based or lility-based functional exercise it of the emergency event. In additional annual exercise out is not limited to the cond full-scale exercise that is or an individual, facility based or conditional exercise or workshop that or includes a group discussion, clinically-relevant rio, and a set of problem led messages, or prepared designed to challenge an the [LTC facility] facility's naintain documentation of all process, and emergency of the [LTC facility] facility's as needed. 2483.475(d)]: CF/IID must conduct exercises and plan at least twice per year, do the following: in an annual full-scale exercise based; or in a community-based exercise is induct an annual individual,	EO	39		
	activation of the e					

PRINTED: 01/15/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG 03	(XS) DATE SURVEY COMPLETED		
		555020	e. WNG			01/09/2020	
	ROVIDER OR SUPPLIER HONDA HÖSPITAL &	REHABILITATION CTR D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF I IEACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(XS) COMPLETION DATE	
E 039	Continued From p	age 21	EC	39			
	full-scale communicated by a facilitate discussion, using emergency plan. (ii) Conduct a may include, but is (A) A second community-based functional exercises functional exercises of problem states of problem states prepared question emergency plan. (iii) Analyze the maintain document exercises, and emitted the ICF/IID's emergency plan. (iii) Conduct a or workshop at least led by a facilitate discussion, using emergency scena statements, questions designed plan. If the OPO eor man-made emergency engaging in its neafollowing the onsefollowing t	ity-based or individual, facility- nal exercise following the onset event, n additional annual exercise that a not limited to the following: cond full-scale exercise that is or an individual, facility-based a; or ck disaster drill; or letop exercise or workshop that or and includes a group a narrated, vant emergency scenario, and a tements, directed messages, or a designed to challenge an le ICF/IID's response to and station of all drills, tabletop ergency events, and revise gency plan, as needed. 36.360] a OPO must conduct exercises ency plan. The OPO must do the paper-based, tabletop exercise est annually. A tabletop exercise					

Facility ID: CA220000512

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING 83			(X3) DATE SURVEY COMPLETED	
		555020	g. WING		01	/09/2020
	ROVIDER OR SUPPLIER HONDA HOSPITAL & RE	Habilitation CTR D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116			
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERÊNCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
E 039	and emergency ever and OPO's] emerger This REQUIREMEN' by: Surveyor: 31203 Based on record revi failed to maintain an training and testing p by the failure to provi the facility participate disaster drill. This of	tion of all tabletop exercises, lts, and revise the [RNHCl's	E 039			
K 000	on 1/9/20, the emerg reviewed. 1. At 1:35 p.m., ther at time of survey to s participated in a com The facility provided exercises. When int and AS 3 confirmed INITIAL COMMENTS Surveyor: 31201 K3 BUILDING: 01 K6 PLAN APPROVA K7 SURVEY UNDER	munity based disaster drill. documents for two table top erviewed, the AS 1, AS 2, the finding. S	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		565020	B. WING		01	/09/2020
	rovider or supplier Honda Hospital & Re	HABILITATION CTR D/P SNF	375 L	et address, city, ŝtate, zip codf Aguna Honda Blyd. Francisco; ca 94116		
(X4) iD PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y Must Be preceded by full LSC identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X3) COMPLETION DATE
K 000	Continued From page	23	K 000			
	Department of Public Life Safety Code rece findings are in accord Federal Regulations National Fire Protecti Life Safety Code, 20' Health Care Facilities	Building ding the findings of the California Health, during an annual ertification survey. The fance with 42 Code of (CFR) §483.90(a)(b)(c)(j), on Association (NFPA) 101 - 12 Edition, and NFPA 99 -			*	
	31201 31203 The facility is not in s	ubstantial compliance with Long Term Care Facilities.				
,	Staff Identifier ES1 - Chief Engineer ES2 - Engineer Staff AS1 - Chief Operatin AS2 - Director of Fac AS3 - Manager, Adm MS - Maintenance SI NM - Nurse Manager	g Officer cility Services cinistration				
K 345 SS=D	Fire Alarm System - CFR(s): NFPA 101 Fire Alarm System - A fire alarm system is	Testing and Maintenance Testing and Maintenance s tested and maintained in approved program complying	K 345			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING 03	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		555020	B. WING		01/09/2020
	rovider ör supplier Honda Hospital &	REHABILITATION CTR DIP SNF	37	reet address, city, state, zip code 5 Laguna Honda BLVD. N Francisco, ca 94116	
(X4) ID FREFIX TAG	(EACH DEFIC)	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR I.SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
K 345	with the requirement Electric Code, and and Signafing Code captance, main available. 9.6.1.3, 9.6.1.5, No This REQUIREMENT by: Surveyor: 31201 Based on docume facility failed to make facility failed to provided with accordance with accordance with accordance with accordance with the failed facility failed to be constalled. 9.6.1.3 A fire alam shall be installed, accordance with the permitted to be constalled. 9.6.1.4 All system approved for the permitted to be constalled. 9.6.1.5 To ensure alam system shall maintenance and the applicable reconstalled.	ents of NFPA 70, National of NFPA 72, National Fire Alarm de. Records of system tenance and testing are readily stenance and testing stenance stenance and testing stenance st	K 345		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING 03	INSTRUCTION		TE SURVEY MPLETED
		555020	B. WING		0	1/09/2020
	rovider ör Supplier H onda Hospital & R e	HABILITATION CTR D/P SNF	375 (ET ADDRESS, CITY, STATE, ZIP CODE LAGUNA HONDA BLVD. I FRANCISCO, CA 94116		
(X4) fÜ PRFFIX TAG	(EACH DEFICIENC	ATEMIENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
К 345	2010 Edition 10.4.3 Inspection, Te Personnel, (SIGTMS 10.4.3.1" Service per experienced in the in maintenance of syste scope of this Code. (Include, but not be lift following: (1)"Personnel who at certified for the spect being serviced (2)"Personnel who at recognized certification to the authority havin (3)"Personnel who at certified by a state or service on systems at this Code (4) Personnel who at an organization listed testing laboratory for within the scope of the of qualifications shall having jurisdiction up 10.12 Trouble Signa 10.12.1 Trouble sign normal shall be indic the locations identified 10.12.2 Indication of signals transmitted to be delayed in accord 10.12.3 If an intermit	code. The Alarm and Signating Code. It is and Maintenance The Specific of Specific of Specific of Specific of Specific of Specific of the Specific of S	K 345			

		(X1) PROVIDER/SUPPLIER/CI, IA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03		(X3) DATE SURVEY COMPLETED	
**		555020	B, WING		01/09/2020	
	rovider ör supplier Honda Hospital &	REHABILITATION CTR D/P SNF	37	reet address, city, state, zip cot is laguna honda blvd. An Francisco, ca 94116	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	n should be Appropriate	(X5) COMPLETION DATE
K 345	10.12.4 A single at permitted to annur 10.12.5 The troubl where it is likely to 10.12.6 Visible and visible indication of shall be indicated (1) Fire alarm confurance systems (2) Building fire confire emergency vois systems (3) Central station systems installed in 10.18.3 Records. 10.18.3.1 A comploperations of each next test and for 1 10.18.3.2 The records test and systems in the records can be requested. 10.18.3.3 If off-prerecords of all significant in the records of all sin	udible trouble signal shall be uciate multiple fault conditions. e signal(s) shall be in an area be heard. d audible trouble signals and if their restoration to normal at the following locations: rol unit for protected premises mmand center for in-building ce/alarm communications or remote station location for n compliance with Chapter 26 lete record of the tests and a system shall be kept until the year thereafter. For dishall be available for if required, reported to the risdiction. Archiving of records all be permitted if hard copies of a provided promptly when lemises monitoring is provided, als, tests, and operations pervising station shall be	K 345			
	of systems, their in notification applian requirements of the 14.1.2 The inspect of single and multi- alarms and house	tion, testing, and maintenance nitiating devices, and nees shall comply with the sis chapter. Ition, testing, and maintenance iple-station smoke and heat hold fire alarm systems shall equirements of this chapter.				

	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
*		566020	B, WING	- f+	0	1/09/2020
	rovider or supplier Honda Hospital & R	REHABILITATION CTR D/P SNF	375	EET ADDRESS, CITY, STATE. 21P ÇODE LAGUNA HONDA BLVD. N FRANCISCO, CA 94116		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST RE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 345	Continued From pa	ge 27	K 345			
	operational integrity inspection, testing, 14.2.1.2 Impairmen 14.2.1.2.1 The requishall be applicable 14.2.1.2.2 System (be corrected). 14.2.1.2.3 If a defer corrected at the corrected at the corrected at the corrected of the imphours. 14.3 Inspection. 14.3.1 Unless other visual inspections accordance with the more often if requiry jurisdiction. 9, Initiating devices (b) Duct detectors (e) Manual fire alar (f) Heat detectors (h) Smoke detector 14.3.1 Unless other visual inspections accordance with the more often if requiry jurisdiction. Table 14.3.1 Visual 3, Batteries (d) Sealed lead-aci 14.4.5 Testing Frepermitted by other shall be performed	when a system is impaired, defects and malfunctions shall of or malfunction is not inclusion of system inspection, ance, the system owner or the difference of the difference				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	nstruction		te survey Mpleted
		555020	B. WING		0	1/09/2020
	ROVIDER OR SUPPLIER HONDA HOSPITAL & RI	EHABILITATION CTR D/P SNF	376 L	et address, city, state, zip code aguna honda blvd. Francisco. Ca 94116		
(X4) ID PREFIX TAG	(EACH DEFIGIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XG) COMPLETION DATE
K 345	Table 14.4.5 Testing 6. Batteries-fire alarm (d) Sealed lead-acid	ority having jurisdiction. Frequencies n systems type place battery within 5 years more frequently as 0 minutes)-annuelly	K 345	•		
	interview with Staff. documentation review 1. On 1/6/20, at 12: panel silence signal The trouble, 0001 Componence, 0001 Compo	facility, document review, and the FAS was observed, w, and staff interviewed. 44 p.m., a trouble and a were observed on the FACP anel Indicated "Selected non Trole Act, Acknowledge of E2A Shunt Relay." When alted that he did not know nal on the panel started. He as five main FACP and they sected, all FACP have the .m., ES1 was interviewed. vendor was scheduled to be 20 to troubleshoot the issue. ouble on the FACP will not our activating during the .m., the annunciators were alter on the Annunciators e Alarm Silence was lit and				

CENTER	S FOIT MILDIONITE OF	MICHOUND OFILINGE	_		The second secon
	OF DEFICIENCIES FEORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 03	(X3) DATE SURVEY COMPLETED
		555020	B. WING		01/09/2020
	Rovider or Supplier H onda Hospital & Re	HABILITATION CTR DIP SNF		STREET ADDRESS, CITY, STATE, ZIP COD 376 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116	Æ
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PRÉFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD SE COMPLETION EAPPROPRIATE DATE
K 345	why the alarm silence Annunciators - 12 loc 12 located in the Sou Pavilion Building. On 1/8/20, between alarm testing was co smoke detectors, put tamper all activated of signals received by to was observed during silence on the Annunciators.	e was lit. The was a total 25 cated in the North Building; and one in the 9:20 a.m. to 9:57 a.m., inducted. The devices: Il stations, water flows and during alarm testing and the monitoring company. It is alarm testing that the alarm inciators were not lit.	K 34	5	
	interviewed. ES2 state FACP could not reso on the FACP. ES1 s proprietary system a diagnostic testing us their vendor will have vendor for the diagnoscheduled as soon a			±	
K 353 SS=0	provide a semi-annuat the time of survey confirmed that the se inspection was not c	14 a.m., the facility failed to all fire alarm inspection report . When interviewed, the ES2 emi-annual fire alarm onducted. Maintenance and Testing	K 34	53	
	Automatic sprinkler of inspected, tested, are with NFPA 25, Stand Testing, and Maintain	faintenance and Testing and standpipe systems are and maintained in accordance lard for the Inspection, ning of Water-based Fire Records of system design, and testing are			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION		TE SURVEY MPLETED
		555020	B. WING			1/09/2020
	rovider or supplier Honda Hospital & R	EHABILITATION CTR D/P SNF	37	reet address, city, state, zip code 6 Laguna Honda Blyd. An Francisco, ca 94116		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FUI.L R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
K 353	maintained in a sector available. a) Date sprinkler site of the provided in REMARK any non-required or system. 9.7.5, 9.7.7, 9.7.8, a This REQUIREMENT by: Surveyor; 31203 Based on observation falled to maintain the This was evidenced sprinkler system could be operation of the result in delay in extra affected one of three NFPA 101, Life Safe	ure location and readily ystem last checked ystem last upply source (S information on coverage for partial automatic sprinkler and NFPA 25 IT is not met as evidenced on and interview, the facility e automatic sprinkler system. by the failure to maintain imponent. This could affect sprinkler system that could tinguishing a fire. This e buildings.	K 353			
	be protected throug supervised automat	ontaining nursing homes shall hout by an approved, ic sprinkler system In ction 9.7, unless otherwise 5.				
	required by another in accordance with (1) NFPA 13, Stand Sprinkler Systems (2) NFPA 13D, Stan	natic sprinkler system section of this Code shall be one of the following: ard for the Installation of adard for the Installation of n One- and Two-Family ufactured Homes				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTI	RUCTION		ATE SURVEY OMPLETED
		555020	B. WING				01/09/2020
	rovider or supplier Honda Hospital & R	EHABILITATION CTR DIP SNF		375 LAG	ADDRESS. CITY, STATE, ZIP CODE LINA HONDA BLVD, ANCISCO, CA 94115		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ITATEMENT OF DEFICIENCIES CY MUST BE FRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 353	(3) NFPA 13R, Stan Sprinkler Systems is to and Including Four 9.7.7 Documentation regarding the design and the procedures and testing of the firmaintained at an apthe life of the fire procedures. Standard Systems, 2010 Edit 6.2.7 Escutcheons 6.2.7.1 Plates, escuted to cover the arround a sprinkler. 6.2.7.2° Escutcheon.	dard for the Installation of a Residential Occupancies up ar Stories in Height In. All required documentation of the fire protection system for maintenance, inspection, e protection system shall be proved, secured location for otection system. If the Installation of Sprinkler ion and Cover Plates. It the one of the devices included sprinkler is seed with recessed, alled sprinklers shall be part of	K	353			
		facility and interview with the ystem component was					
	sprinkler head in the kitchen was not flus escutcheon droppe	d approximately 1 inch from hterviewed, the ES 1				,	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MUI.T A. BUILDII	IPLE CONSTRUCTIÓN NG 03		DATE SURVEY COMPLETED
		555020	B. WING_			01/09/2020
1,0,0,1-	ROMDER OR SUPPLIER HONDA HOSPITAL & R	EHABILITATION CTR D/P SNF		STREET ADDRESS, CITY, STATE. ZIP C 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94118	ODE .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TAYEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF K (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
K 355 SS=D	CFR(s): NFPA 101 Portable Fire Exting Portable fire extinguinspected, and mair NFPA 10, Standard Extinguishers. 18.3.5.12, 19.3.5.12 This REQUIREMENT by: Surveyor: 31201 Based on observatifailed to maintain the evidenced by missing portable fire extinguisher that waresult in a malfunctifextinguisher. This is NFPA 101, Life Safi 19.3.5.12 Portable provided in all healt accordance with 9,7.4.1* Where requancher section of textinguishers shall inspected, and main NFPA 10, Standard Extinguishers. NFPA 10, Standard 2010 Edition 7.2 Inspection. 7.2.1.1* Fire exting inspected when init 7.2.1.2* Fire extinguishers extinguishers in the section of the	uishers aishers are selected, installed, atained in accordance with for Portable Fire 2. NFPA 10 IT is not met as evidenced on and interview, the facility e fire extingulshers. This was ng monthly inspections for one aisher and a portable fire as obstructed. This could on of the portable fire affected of three buildings. ety Code, 2012 Edition fire extinguishers shall be th care occupancies in 7.4.1. uired by the provisions of this Code, portable fire be selected, installed, atained in accordance with	K	355		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING D3	(X3) DATE SURVEY COMPLETED	
		555020	555020 D. WNG		01/09/2020
	ROVIDER OR SUPPLIER HONDA HOSPITAL &	REHABILITATION CTR D/P SNF	3761	EET ADDRESS, CITY, STATE, ZIF CODE LAGUNA HONDA BLVD. I FRANCISCO, CA 94116	,
(X4) ID PREFIX YAG	FACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION 8 CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLET
К 355	monitoring devices intervals. 7.2.2 Procedures electronic monitorinclude a check of (1) Location in de (2) No obstructior (3) Pressure gaus operable range or (4) Fullness deterfor self-expelling-tocartridge-operated (5) Condition of tinozzle for wheeler (6) Indicator for nusing push-to-test 7.3* Maintenance 7.3.1 Frequency. 7.3.1.1 All Fire Extransintenance at Infat the time of hydrindicated by an innotification. 7.3.1.1.2 Fire extination. 7.3.1.1.1 Fire extination. 7.3.1.1.1 Fire extination. 7.3.1.1.1 Fire extination. 7.3.1.1.2 Fire extinexamined at intenspecified in Table Findings:	Periodic inspection or ing of fire extinguishers shall at least the following items: signated place to access or visibility ge reading or indicator in the position mined by weighing or hefting ype extinguishers, and pump tanks res, wheels, carriage, hose, and dextinguishers on-rechargeable extinguishers pressure indicators tinguishers shall be subjected to tervals of not more than 1 year, rostatic test, or when specifically spection or electronic inguishers shall be internally vals not exceeding those 7.3.1.1.2.	K 355		
	During a tour of the Staff, the fire extire interviewed. South Building	ne facility and interview with nguisher was observed and staff	• • • • • • • • • • • • • • • • • • • •		

NAME OF PROVIDER OR SUPPLIER LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF (X4) 10 PREFIX TAG CONTINUED From page 34 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		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIN	PLE CONSTRUCTION IG 02		E SURVEY IPLETED
LAGUNA HONDA HOSPITAL & REHABILITATION CTR DIP SNF (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) K 355 Continued From page 34 portable fire extinguisher was obstructed from immediate access. The portable fire extinguisher 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			555020	B. WING_		0.	/09/2020
REGULATORY OR LSC IDENTIFYING INFORMATION) K 365 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		•	EHABILITATION CTR DIP SNF		375 LAGUNA HONDA BLVD.	DE	
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	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X3) COMPLETION DATE
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 363 SS=E CFR(s): NFPA 101 Carridor - Doors Corridor - Doors Corridor - Ocors 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	K 363	portable fire extingu immediate access. was between a vital medication cart by F confirmed by ES2. Pavilion Building 2. On 1/7/20, at 12: the portable fire exti by the Chiller machi inspections for the n December 2019. We that he was not awainspections. The arron 1/16/19. 3. On 1/7/20, at 12: the portable fire exti Room 2111 was mis inspection. The find The annual service Corridor - Doors CFR(s): NFPA 101 Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting co required enclosures hazardous areas reand are made of 1.3 wood or other mate at least 20 minutes, smoke compartment the passage of smot to rooms containing materials have positions.	isher was obstructed from The portable fire extinguisher sign machine and a Room 334. The finding was 34 p.m., on the second floor, inguisher located on the roof ines were missing monthly months of November and iften interviewed, ES2 stated are of the missing monthly mual service was conducted 35 p.m., on the second floor, inguisher in the corridor near esing December 2019 monthly ding was confirmed by ES2, was conducted on 1/16/19. Tridor openings in other than a of vertical openings, exits, or sist the passage of smoke 3/4 inch solid-bonded core rial capable of resisting fire for Doors in fully sprinklered ats are only required to resist oke. Corridor doors and doors of flammable or combustible titive latching hardware. Roller				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO. PI.AN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING 03	DISTRUCTION		DATE SURVEY .		
•		656020	B. WING			01/09/2020		
	ROVIDER OR SUPPLIER KONDA HOSPITAL &	REHABILITATION CTR D/P SNF	376	STREET ADDRESS, CITY, STATE, ZIP CODE 376 LAGUNA HONDA BLVO. SAN FRANCISCO, CA 94116				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION}	ND PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE:	CTION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE		
K 363	Clearance betwee covering is not ex complying with 7.3 with a device cape when a force of 5 impediment to the devices that relea pulled are permitted heigh meeting 19.3.6.3. shall be labeled a materials in comparation window assemblic sprinklered comparations in area frames in window 19.3.6.3, 42 CFR and 485 Show in REMARI protection ratings etc. This REQUIREMING: Surveyor: 31201 Based on observifailed to maintain evidenced by a cand corridor door affected three of feet of the control of the c	mmable or combustible material. en bottom of door and floor ceeding 1 inch. Powered doors 2.1.9 are permissible if provided able of keeping the door closed libit is applied. There is no a closing of the doors. Hold open se when the door is pushed or ed, Nonrated protective plates at are permitted. Dutch doors are permitted. Door frames nd made of steel or other fliance with 8.3, unless the ent is sprinklered. Fixed fire es are allowed per 8.3. In artments there are no a or fire resistance of glass or	K 363					
	Findings: During a tour of the	he facility and interview with	and the second delication of the second delica					

		MEDICAID SCRAIGES					
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03		(X3) DATE SURVEY COMPLETED	
		555020	8, WING			01/09/2020	
	ROVIDER OR SUPPLIER HONDA HOSPITAL & RE	HABILITATION CTR DIP SNF		376 L	et address, city, state, zip code aguna honda blvd. Francisco, ca 94116		
(X4) ID Prefix TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 363	Staff, the corridor dod North Building 1. On 1/6/20, at 11:1 door to the Telecom is equipped with a self-failed to latch when a interviewed, ES2 comequipped with a self-failed to latch when a interviewed, ES2 comequipped with a self-failed to latch when a interviewed, ES2 comequipped with a self-failed to latch when a interviewed, ES2 comequipped with a self-failed to latch when a interviewed, ES2 comequipped with a self-failed to latch when a interviewed, ES2 comequipped with a self-failed to latch when a interviewed, ES2 compavilion Building 5. On 1/7/20, at 1:04	5 a.m., on the 6th floor, the Room (Room N6046) was closing device. The door allowed to self-close. When affirmed the finding. 13 p.m., on the 4th floor, the Room (Room N4046) was closing device. The door allowed to self-close. When affirmed the finding. 15 p.m., on the 4th floor, the m (Room 4051) was closing device. The door allowed to self-close. When affirmed the finding. 13 p.m., Mezzanine floor, the Room (Room NM046) was closing device. The door allowed to self-close. When affirmed the finding.	K	363			
	self-closing device. When interviewed, A	ift Shop was equipped with a The right door failed to latch. IS2 confirmed the finding and essure prevented the right ch.		· The state of the			

CENTER	OT OIL MEDICALITE OF	MEDIO, UD OFICATOR	1		
	OF DEFICIENCIES CORRECTIÓN	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING 03	NOITOURTRUCTION	(X3) DATE SURVEY COMPLETED
		555020	B. WING	etward -	01/09/2020
	rovider or supplier Honda Hospital & Re	HABILITATION CTR D/P SNF	375	RET ADDRESS, CITY, STATE, ZIP CODE LAGUNA HONDA BLVD. 1 FRANCISCO, CA 94116	
(X4) 10 Prefix Tag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED-BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
K 363	6. On 1/6/20 at 11:43 the Laundry room (Rivith a self-closing de open by a stool. The The room was locate When interviewed, the finding. South Building 7. On 1/7/20 at 10:04	3 a.m., the corridor door to com N2013) was equipped vice. The door was held room was left unattended. d on the second floor. e ES 1 confirmed the	K 363		
K 372 \$\$=E	on the fifth floor. Whe that the door will nee 8. On 1/7/20 at 10:31 resident Room S425 manually closed by son the fourth floor. We confirmed the finding Subdivision of Buildin CFR(s): NFPA 101 Subdivision of Buildin Construction 2012 EXISTING Smoke barriers shall fire resistance rating	taff, The room was located an interviewed, ES 1 stated d adjustment. 3 a.m., the corridor to failed to latch when taff. The room was located when interviewed, ES 1	K 372		
	Smoke dampers are penetrations in fully of an approved sprinkle smoke compartment barrier. 19.3,7.3, 8.6.7.1(1)				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03			(X3) DATE SURVEY COMPLETED	
		565020	B WING			01	/09/2020	
,, .= .	ROVIDER OR SUPPLIER HONDA HOSPITAL & RE	HABILITATION CTR D/P SNF		375 L	et address, city, state, zip code Aguna Honda Blvd. Francisco, ca 94116			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE	
K 372	by: Surveyor; 31201 Based on observation falled to maintain the smoke barrier walls, unsealed penetration. This could result in the event of a fire, buildings. NAPA 101, Life Safet 19.3.7.3 Any required constructed in according the smoke barriers of the smoke barriers shall have a minimum rating, unless otherwice following: (1) This requirement atrium is used, and balso shall apply: (a) Smoke barriers stat an atrium wall con 8,6.7(1)(ac). (B) Not less than two compartments shall I (2) Smoke dampers penetrations of smok heating, ventilating, where an approved, sprinkler system in a been provided for smoke barrier. 8,5.6.2 Penetrations conduits, pipes, tube items to accommodal.	n and interview, the facility smoke integrity of the This was evidenced by is in the smoke barrier walls, he spread of smoke and fire This affected two of three Ismoke barrier shall be dance with Section 8.5 and in 1/2-hour fire resistance is permitted by one of the shall not apply where an both of the following criteria thall be permitted to terminate structed in accordance with a separate smoke be provided on each floor, shall not be required in duct the barriers in fully ducted and air-conditioning systems supervised automatic accordance with 19.3.5.8 has noke compartments adjacent for cables, cable trays, as yents, wires, and similar the electrical, mechanical, nunications systems that	K	372				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/SULA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0	CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		555020	B. WING	-	01/09/2020	
	ROVIDER OR SUPPLIER HONDA HOSPITAL & F	REHABILITATION CTR D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 376 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116			
(X4) ID PREFIX TAG	(EACH DEFICIEN	Statement of Deficiencies NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
K 372	through the ceiling of a smoke barrier of smoke. by a system or mate transfer of smoke. 6.5.6.3 Where a sm constructed as a fin shall be protected in requirements of 8.3 a time period equal the assembly and 6 smoke, unless the met. Findings: During a tour of the	ed as a smoke barrier, or membrane of the root/ceiling assembly, shall be protected erial capable of restricting the	K 372		•	
	North Building 1. On 1/7/20, at 12 wall in North 1, electhe Pavilion building penetrations. One approximately ½-in pipe and the other ½- inch around flex interviewed, the AS Surveyor: 31203 North Building 2. On 1/6/20 at 1: approximately 1 incaround an electrica wall above the cross	:47 p.m., the smoke barrier vator lobby west wall towards g was observed with three penetration measured ch top right of a flex conduit two measured approximately conduit pipes. When it confirmed the finding.				

STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CO A. BUILDING 03	ONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		555020	B. WING		01/09/	2020		
	rovider or supplier Honda Hospital & Re	Habilitation CTR DIP SNF	375	eet address, city. State, zip code Laguna Honda Blvd. I Francisco, ca 94116				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	PROVIDER'S PLAN OF CORRE .(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OUI,D BE C	(KS) OMPLETION DATE
K 372	Mezzanine floor. Wh confirmed the finding. 3. On 1/6/20 at 1:11 approximately 1/2 incaround a network cat above the cross corrigion.	en interviewed, the ES 1 p.m., there was an the unsealed penetration le in the smoke barrier wall dor doors (N1-FD15) in the twood Suite was located on	K 372					
K 541 SS=D	the smoke barrier wa doors (S6-FD9) in the was located on the si the ES 1 confirmed the Rubbish Chutes, Incir	a.m. , there was an th unseated penetration in Il above the cross corridor Marina Suite . Marina Suite xth floor. When interviewed,	K 541					
	Chutes 2012 EXISTING (1) Any existing linen pneumatic rubbish ar directly onto any corr resistive construction shall be provided with a fire protection rating shall comply with 9,5 (2) Any rubbish chute pneumatic rubbish ar provided with automatin accordance with 9, (3) Any trash chute s	e or linen chute, including nd'linen systems, shall be atic extinguishing protection		·				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA - IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING (COMPLETED	
		556020	B, WING		0.	1/09/2020
	ROVIDER OR SUPPLIER HONDA HOSPITAL & RE	HABILITATION CTR D/P SNF	1	itreet address, city, state, zip code 175 Laguna Honda BLVD. 3AN FRANCISCO, CA 94116		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 541	iaundry chutes permit room are protected by accordance with 19.3 (4) Existing fuel-fed in by fire resistive construse. 19.5.4, 9.5, 8.4, NFP. This REQUIREMENT by: Surveyor: 31203 Based on observation failed to maintain the separation features for was evidenced by a little to positive latch. This buildings. This could and smoke in the even NFPA 101, Life Safet 19.5 Building Service 19.5, 1 Utilities. 19.5.1.1 Utilities. 19.5.1.2 Existing institute be continued in se systems do not present to be continued in se systems do not present 19.5.4.1 Existing rubincluding pneumatic that open directly ont sealed by fire-resisting further use or shall be assembly having a market open.	nce with 8.4. (Existing teed to discharge into same y automatic sprinklers in 1.5.9 or 19.3.5.7.) Incinerators shall be sealed ruction to prevent further A 82 If is not met as evidenced in and interview, the facility required protective or the laundry chute. This aundry chute door that failed a affected one of three result in the spread of fire ent of a fire in the chute. By Code, 2012 Edition. Comply with the provisions allations shall be permitted ryice, provided that the ent a serious hazard to life. The serious hazard to life.	K 541			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING 03	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555020	8. WING		0	1/09/2020
	rovider or supplier Honda Hospital & R	EHABILITATION CTR DJP SNF	376 L	ETADDRESS, CITY, STATE, ZIP CODE AGUNA HONDA BLVD. FRANCISCO, CA 94116		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(AS) COMPLETION DATE
K 741 SS=D	Staff, the laundry of North Building 1. On 1/6/20 at 12 door to the Laundry N1012 failed to late released. The launtimes. The room w. When interviewed, is moking Regulation CFR(s): NFPA 101 Smoking Regulation Smoking regulation include not less tha (1) Smoking shall be ward, or compartme combustible gases, and in any other ha area shall be poster SMOKING or shall international symbol (2) In health care of	facility and interview with nute door was observed. 15 p.m., the 1-hour fire rated chute located in Room h when fully opened and dry chute door was tested two as located on the first floor. ES 1 confirmed the finding. In section of the following provisions: In a prohibited in any room, and where flammable liquids, or oxygen is used or stored zardous location, and such deposited with signs that read NO be posted with the	K 741	,		
	that prohibits smoki (3) Smoking by pati responsible shall be (4) The requirement where the patient is (5) Ashtrays of non design shall be pro- smoking is permitte	t of 18.7.4(3) shall not apply under direct supervision. combustible material and sale vided in all areas where				

	IF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 03	A. BUILDING 03		
		.565020	B. WING		01/09/2020	
NAME OF PE	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIF CODE		
LAGUNA I	10NDA HOSPITAL & RE	EHABILITATION CTR D/P SNF	34	aguna Honda Blvd. Francisco, ca 94115		
	CI IMMADY ET	TATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTION	1 (X5)	
(X4) IĎ PREFIX TAG	(EACH DEFICIENC	LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
K 741	Continued From pag	e 43	K 741			
	devices into which as	shtrays can be emptied shall	ı			
	permitted. 18.7.4, 19.7.4	o all areas where smoking is				
	by: .	T is not met as evidenced				
120	Surveyor: 31203 Based on observatio	n and interview, the facility			1	
	failed to maintain the	e designated smoking area. by cigarette butts being				
	disposed on the grou	and and by the failure to				
¥	protect the safety-ty result in the increase the designated smok	pe smoke poles. This could ad risk of fire, and affected king area.			:	
	Finding:		!			
		facility and interview with I smoking area was observed.	Î			
	Pavilion Building	•				
	1. On 1/8/20 at 12:					
	observed on ground	4 dozen cigarette butts I in the designated smoking				
	area. The smoke po	oles provided had the covers smoke poles unprotected.			1	
	The covers for the s	afety-type smoke poles were		· · · · · · · · · · · · · · · · · · ·		
	observed on the gro	ound. The designated ocated near the lobby in the				
	Pavilion building. W	hen interviewed, MS				
V 760	confirmed the finding		K 753			
	CFR(s): NFPA 101	Sf. At 142				
	Combustible Decora					
	Combustible decora	itions shall be prohibited				

\$TAYFMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IMPAIRING ATION AND INCOME.		MULTIPLE CONSTRUCTION UILDING 93		(X3) DATE SURVEY COMPLETED		
		565020	8. WNG			1/09/2020		
	rovider or supplier Honda Hospital & I	REHABILITATION CTR D/P SNF	3751	STREET ADDRESS, CITY, STATE, ZIP CODE 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST RE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(KS) COMPLETION DATE		
K 753	Continued From pa	age 44	K 753					
	unless one of the final of the	ollowing is met: Int or treated with approved and that is listed and labeled for leet NFPA 701. In which heat release less than cordance with NFPA 289. In which as photographs, paintings attached to the walls, ceilings doors in accordance with .5.6(4). In a in existing occupancies are notitles that a hazard of fire read is not present. In the interview, the facility heir facility free of combustible was evidenced by the failure to ree of combustible decoration, an increased spread of fire and						

statement of deficiencies and plan of correction		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03		
		866020	B. WING		0	1/09/2020
	ROVIDER OR SUPPLIER HONDA HOSPITAL (REHABILITATION CTR D/P SNF	375	EET ADORESS, CITY, STATE, ZIP CODE LAGUNA HONDA BLYD. N FRANCISCO, CA 94116		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 761 S\$=D	CFR(s); NFPA 10 Maintenance, Ins	pection & Testing - Doors pection & Testing - Doors blies are inspected and tested	K 761			
	annually in accor for Fire Doors an Non-rated doors, patient rooms an routinely inspected maintenance products and possess with the demonstrate Written records of maintained and a 19.7.6, 8.3.3.1 (L. 5.2, 5.2.3 (2010 I. This REQUIREM by: Surveyor: 31201 Based on observinterview, the fact doors. This was Won doors that factivation of the that failed the antwo of three builds.	dance with NFPA 80, Standard of Other Opening Protectives. including corridor doors to dismoke barrier doors, are ed as part of the facility gram. In the door inspections and knowledge, training or experience is ability. If inspection and testing are are available for review, SC) NFPA 80) ENT is not met as evidenced				
	Findings: During fire alarm the Won doors wereviewed. Pavilion	testing and interview with staff, were observed and document				
		9:20 a.m., the 20-minute fire				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A, BUILDING 03	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555020	B. WING			1/09/2020
	ROVIDER OR SUPPLIER HONDA HOSPITAL & RI	EHABILITATION CTR D/P SNF	375 i	RT ADDRESS, CITY, STATE, ZIP CODE AGUNA HONDA BLVD. FRANCISCO, CA 94116		
(X4) IĎ PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 761	operate upon activat When interviewed, E panel was broken ar vendor. ES 1 further wheelchair caused to 2. On 1/8/20 at 9:24 rated Won door near operate upon activat When interviewed, E panel is broken and vendor. ES 1 further	re 46 r Room P1132 failed to the fire alarm system. S 1 stated that the interior and waiting for parts from the restated that the resident's the damage to the Won door. I a.m., the 20-minute fire recom P1111 failed to the fire alarm system. S 1 stated that the interior waiting for parts from the restated that the resident's the damage to the Won door.	K 761			
	for the fire door asset documentation, "Fire dated 2019 indicated that failed the inspect as follow: - Door Number, N1-I dining room N1033, - Door Number. N2-I entrance towards Justrike rubbing Door Number, NM-I aundry heading fow coordinator, ordered At 1:37 p.m., the ES	p.m., the annual inspection amblies were reviewed. The about Inspection Checklist', there were three fire doors are action. The falled fire doors by action for the falled, panic actions actions action for the falled for the corrections/repairs				

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D FI, AN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO. A. BIJILDING D3	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555020	9. WING		0	1/09/2020
	ROVIDER OR SUPFLIER HONDA HOSPITAL & R	EHABILITATION CTR DIP SNF	375 L	et address, city, state. Zip cod Aguna Honda Blvd. Francisco, ca 94116	E	
(X4) ID PREFIX TAG	Summary statement of deficiencies (Each deficiency must be preceded by full regulatory or LSC (Dentifying Information)		PREFIX TAG	PROVIDER'S PLAN OF CO (EACH GORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 761 K 918 S6=E	CFR(s): NFPA 101 Electrical Systems - Maintenanca and Te The generator or of and associated equi- service within 10 se criterion is not met of	are still pending. Essential Electric Syste Essential Electric System	K 761 K 918		ē	
	capability for the life Maintenance and te transfer switches ar with NFPA 110. Generator sets are under load 30 minul day intervals, and e months for 4 continuader load conditions imulated cold start transfer of all EES is competent personn stored energy power accordance with NF circuit breakers are	e safety and critical branches. Isting of the generator and the performed in accordance inspected weekly, exercised thes 12 times a year in 20-40 exercised once every 36 uous hours. Scheduled test this include a complete the and automatic or manual toads, and are conducted by the left of the conducted of the co				Ų.
	program for periodic components is esta manufacturer requiremaintenance and to readily available. El circuits are marked separate from normathe possibility of da source is a design of installations.	cally exercising the ablished according to rements. Written records of easting are maintained and ES electrical panels and readily identifiable, and hall power circuits. Minimizing mage of the emergency power consideration for new				

Event ID; X4I921

APILIPINAL AND MEDIANISM OF PA		A TOTAL DISTORTED CONTINUES			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A, BUILDING 03	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		555020	B. WING		01/09/2020
	ROVIDER OR SUPPLIER HONDA HOSPITAL & R	EHABILITATION CTR DIP SNF	375 L	et address, city, state, zip code Aguna Honda Elvd. Francisco, ca 94116	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIÉS ICY MUST BE PRÉCEDED BY FULL R LSC IDÉNTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
K 918	by: Surveyor: 31201 Based on document facility failed to main This was evidenced annual fuel quality to generator malfunction. This affected three NFPA 101, Life Safe 19.5 Building Service 19.5.1 Utilities. 19.5.1.1 Utilities should be suffered by the service of Section 9.1. 9.1.3.1 Emergency power systems shamaintained in accordant for Emergency power systems. NFPA 110, Standar Power Systems. NFPA 110, Standar Power Systems, 20.8.3.8 A fuel quality least annually using standards. Findings: During document of the maintenance regenerators were resulted to the provide current document doc	It is not met as evidenced It review and interview, the Intain their diesel generators. It by the failure to complete an I est. This could result in a I on during an emergency. I of three buildings. I ety Code, 2012 Edition I ess. I comply with the provisions I generators and standby I be installed, tested, and I dance with NFPA 110, I gency and Standby Power I of or Emergency and Standby I O Edition I test shall be performed at I g tests approved by ASTM I eview and interview with Staff, I evords for the two diesel	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTIÓN 183	(X3) DATE SURVEY . COMPLETED	
		656020	R, WING		01/09/2020	
NAME OF PROVIDER OR SUPPLIER LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF				STREET ADDRESS, CITY, STATE, ZIP CODE 375 LAGUNA HONDA BLYD. SAN FRANCISCO, CA 94116		
(X4) IQ PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
K 918 K 919 SS=D	Continued From page interviewed, ES1 con Electrical Equipment CFR(s): NFPA 101 Electrical Equipment List in the REMARKS Chapter 10, Electrica that are not addressed but are deficient. This applicable Life Safety citation, should be incompared to the continuation of	a 49 firmed the finding. Other Other Equipment, requirements of by the provided K-Tags, a information, along with the Code or NFPA standard cluded on Form CMS-2567. I) is not met as evidenced on, the facility failed to eal wiring and equipment, by one faceplate cover that could result in an increased or electrical shock, three buildings. I comply with the provisions of the code code code code code code code cod	K 91	DEFICIENCY)	NATE	
	National Electrical Co are approved existing permitted to be conti NFPA 70, National E 110.12 Mechanical E	ectrical Code, 2011 Edition xecution of Work. Electrical astalled in a neat and			٠	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		z) MULTIPLE CONSTRUCTION BUILDING 03		DATE SURVEY COMPLETED
		565020	8, WING			01/09/2020
	OVIDER OR SUPPLIER	REHABILITATION CTR D/P SNF	5	STREET ADDRESS, CITY, STAT 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94		.1
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE SED TO THE APPROPRIATE SPICIENCY)	(X\$) GOMPLETION DATE
K 919	are described in Al Practices for Good Workmanshi other ANSI-approv Unused Openings those intended for those intended for permitted as part of equipment, shall be substantially equipment. Where used with nonmeta recessed at least 6 surface of the encircle faceptacle Receptacle faceptacle Receptacle faceptacle faceptacle shall efficiently cover the mounting surfamounted inside a traceptacle shall efficiently surfamounted inside a t	Accepted industry practices NSI/NECA 1-2006, Standard p in Electrical Contracting, and ed installation standards. (A) Unused openings, other than the operation of equipment, mounting purposes, or those of the design for listed e closed to afford protection elent to the wall of the metallic plugs or plates are altic enclosures, they shall be of mm (1/4 in.) from the outer osure. Faceplates (Cover Plates), eles shall be installed so as to one opening and seat against oce. Receptacle faceplates box having a recess-mounted fectively close the opening and ounting surface.	KS	119		
4 000	South Building 1. On 1/7/20 at 1 faceplate cover in was cracked. Who confirmed the find		K	920		
SS=D	CFR(s): NFPA 10	nt - Power Cords and Extens				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA : IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03		(X2) DATE SURVEY COMPLETED	
		555020	B. WING_			01/09/2020	
NAME OF PROVIDER OR SUPPLIER LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116				
(X4) ID PREFIX TAG	' (EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(XI) COMPLETION DATE	
K 920	Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assembly qualified person 10.2.3.6. Power amay not be used electronics), excer may not be used electronics, excer rooms that do not person power that do not person power than the power to the power tap and exceptions. Extension cords to immediately upon which it was instanced in the power tap and exceptions. This REQUIREM by: Surveyor: 31203 Based on observice failed to maintain connections. This unapproved used power tap and exceptions are power tap and exceptions.	patient care vicinity are only ents of movable ed electrical equipment eles that have been assembled entering in the patient care vicinity for non-PCREE (e.g., personal pt in long-term care resident use PCREE. Power strips for 1363A or UL 60601-1. Power REE in the patient care rooms e) meet UL 1363, in non-patient er strips meet other UL wer strips are used with general ension cords are not used as a d wiring of a structure. used temporarily are removed a completion of the purpose for elled and meets the conditions of e), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 ENT is not met as evidenced	K9	20			
	19.5.1 Utilities.	afety Code, 2012 Edition		i			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION . BUILDING 03		(X3) DATE SURVEY COMPLETED	
	555020		B. WING	E, WING		01/09/2020	
NAME OF PROVIDER OR SUPPLIER LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF			STREET ADDRESS, CITY, STATE, ZIF CODE 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116				
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X3) COMPLETION DATE	
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.		K 92	0			
	400.8 Uses Not Perpermitted in 400.7, not be used for the (1) As a substitute structure (2) Where run throceilings, suspender floors (3) Where run throsimilar openings (4) Where attacher Exception to (4): Fermitted to be attaccordance with the (5) Where conceal or located above services (6) Where installed otherwise permitted to the exception to (4): Fermitted to be attaccordance with the (5) Where conceal or located above services (6) Where installed otherwise permitted.	for the fixed wiring of a ugh holes in walls, structural d ceilings, dropped ceilings, or ugh doorways, windows, or d to building surfaces lexible cord and cable shall be ached to building surfaces in ne provisions of 368.56(B) led by walls, floors, or ceilings uspended or dropped ceilings d in raceways, except as					
	Findings:	of all the same to have been able					
¥		e facility and interview with equipment were observed.		,			
	North Building						
		2:40 p.m., a non-UL approved tap was used to power an		*			

NAME OF PROVIDER OR SUPPLIER 555020 B. WING	9/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF SAN FRANCISCO, CA 94116	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG 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 17720 at 9:55 a.m., there was an extension cord observed with a DVD player near Bed B in Room S582. The extension cord was not plugged into the wall outlet. Room S532 was located on the fifth floor. K 923 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage Iocations 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 Iocations 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, individuel cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet so no requal to 300 cubic feet so no requal to 300 cubic feet so no requal to 300 cubic feet in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03		(X3) DATE SURVEY COMPLETED	
		565020	8. WNG		01/09/2020	
	Rovider or Supplier Honda Hosfital & Re	HABILITATION CTR DIP SNF	375 L	et address, city, state. Zip code Aguna Honda Blyd. Francisco, ca 94116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by fuli, LSC identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETI	
K 923	where the sign include minimum "CAUTION: STORED WITHIN NO Storage is planned so of which they are recognitives. When facilintegral pressure gauconsidered empty is are marked to avoid in the open are prote 11.3.1, 11.3.2, 11.3.3. This REQUIREMENT by: Surveyor: 31203 Based on document facility failed to maint storage. This was evinclude in their policy cylinders are used in received from the sur	a cylinder storage room, es the wording as a COXIDIZING GAS(ES) COMOKING." Cocylinders are used in order eived from the supplier. segregated from full lity employs cylinders with uge, a threshold pressure established. Empty cylinders confusion. Cylinders stored	K 923			
*	Edition	re Facilities Code, 2012 outions - Storage of Cylinders				
100	11,6.5.1 Storage sha cylinders can be use are received from the	all be planned so that d in the order in which they e supplier.				
	Findings:			ije.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03		(X3) OATE SURVEY COMPLETED	
		555020	B. WING			1/09/2020	
		REHABILITATION CTR DIP SNF		STREET ADDRESS, CITY, STATE, 2 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116	IP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
K 923	EX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			923			
					P.		



375 Laguna Honda Blvd., San Francisco, CA 94116-1411

<u>Provider</u> 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.



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.



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.



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:



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:

 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:

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:

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.



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:



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:

 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:



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:

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:



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:

 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:



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:



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:



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:

 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 afteraction 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.



375 Laguna Honda Blvd., San Francisco, CA 94116-1411

<u>Provider</u> ID: 555020

Life Safety Code and Emergency Preparedness Survey

Date of Survey Completed 01/09/2020

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.



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.



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.



ATTACHMENT ONE

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

LOCAL MNTR ACT :: 09:26:44 01/30/2020 P:03 D: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:FFFFFFFFFFFFF 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



ATTACHMENT TWO



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



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:



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:



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:



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:



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.

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:



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:



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:



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:



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:

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.



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:

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:



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.



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.



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:



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 followup 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.



K919

CFR: 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).

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:



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.



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:



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.