The following reflect the findings of the Department of Health Services and Centers for Medicare and Medicaid Services (CMS) during the Annual Re-certification Survey on 2/05/06.

Representing CMS:
- Captain John Motter, RN
- Captain Eloise Beechinor, Nutrition/Dietary
- Patricia Frey, RN
- Ed Japitana, RN
- Gretchen Kane, RN
- Renie Soria, RN

Representing the Department of Health Services:
- Jean Solis, Health Facilities Evaluator Nurse
- Andrea Kubovick, Health Facilities Evaluator Nurse
- Arlene Jech, Health Facilities Evaluator Nurse
- Gregory Leung, Health Facilities Evaluator Nurse
- Buzz Gilbert, Health Facilities Evaluator
- Jean Ismail, Health Facilities Evaluator
- Mary Anne Hanthorn, Dietary Consultant
- Thomas Garrett, Medical Consultant

The total census at the time of the survey was 1013 residents.
The sample size was 96 residents.

The highest Scope and Severity was H-Substandard Quality of Care.

Complaints integrated with the Survey:
- Substantiated Complaints:
  53529 54233 55419 56836 57139 57978
  59947 61694 62182 62347 63404 63855
  63856 64445 64573 64943 65835 65897

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.

The facility must make the results available for examination and must post in a place readily accessible to residents and their representatives.
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

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

A. BUILDING

B. WING

02/21/2006

ID PREFIX TAG
F 167

ID PREFIX TAG
F 167

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 167 Continued From page 2
accessible to residents and must post a notice of their availability.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview with residents and the facility's Director of Quality Management, the facility failed to promote the residents right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility by posting the results in a place readily accessible to residents and posting a notice of their availability.

Findings:

The facility is composed of two large buildings far enough apart from each other that there is little co-mingling of residents. The only copy of the results of the most recent survey of the facility in the Clarendon Hall was posted in the old front entryway of building. Due to the construction currently underway, few residents use this access anymore. Sixteen cognitively alert residents attended either one of two Group Interviews conducted on 02/06/06. These interviews had residents representing each of Clarendon Hall’s three resident floors. Only three residents knew the current location of the most recent survey results. The majority of residents in both groups suggested bringing the survey results copy into the main first floor activity room along with notices on each of the three floors would greatly assist alert residents and their visitors of the availability of the report.
Continued From page 3

On 02/15/2006, at approximately 10:10 AM, the surveyor toured the general environment of Clarendon Hall with the facility's Director of Quality Management, Interim Director of Facilities Operations, General Services Manager and the Associate Administrator of Operations and pointed out the current isolated location of the copy of the State's latest survey results. The Director of Quality Management acknowledged the location as infrequently used since construction of a replacement facility started.

Sixteen cognitively alert residents attended either one of two Group Interviews conducted on 02/08/06. These interviews had residents representing each of Clarendon Hall's three resident floors. The residents in each Group Interview stated the facility does not distribute mail on Saturday. Residents stated if a letter is delivered to the facility on a Saturday, the

Findings:

Sixteen cognitively alert residents attended either one of two Group Interviews conducted on 02/08/06. These interviews had residents representing each of Clarendon Hall's three resident floors. The residents in each Group Interview stated the facility does not distribute mail on Saturday. Residents stated if a letter is delivered to the facility on a Saturday, the
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<tr>
<td>F 170</td>
<td>Continued From page 4 residents must wait until Monday to receive it. When asked, the facility's Assistant Administrator of Operations provided a copy of the facility's policy titled, &quot;Laguna Honda Hospital General Services Department-Mail Room Guidelines/Systems.&quot; This policy stated, &quot;Purpose: To provide guidance for LHH (Laguna Honda Hospital) mail systems and the handling of Resident mail/packages.&quot; Under the title of &quot;Days of Service&quot; was written, &quot;Services are provided five days per week, 8:30am-12am (Monday thru. Friday) except legal Holidays.&quot;</td>
<td>F 170</td>
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<td>F 174</td>
<td>483.10(k) TELEPHONE</td>
<td>F 174</td>
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<td>The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to ensure phone privacy and the resident's right to have reasonable access to the private use of a telephone for one of 96 sampled residents. (Resident 10) Findings: Resident 10 was admitted on 12/6/95 and re-admitted on 08/26/05 with diagnoses of: auto-immunodeficiency disease, failure to thrive, cerebral palsy (a disease characterized by a major disorder of motor function), and depression.</td>
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Continued From page 5

Record review on 02/05/06 of Resident 10's 12/01/05 Minimum Data Set (MDS), an assessment tool, documented that she had no cognitive problems, but needed total staff assistance for activities of daily living (ADL), including transfer by mechanical lift from her bed to a chair, grooming, dressing, and bathing because she had full loss of the voluntary movement of her arms, hands, legs, and feet.

Observation on 02/05/06 at 9:00 a.m. revealed Resident 10 sitting in her wheelchair next to her bed with a sad expression on her face. During an interview at the same time, Resident 10 stated she was not allowed to use her telephone for the 12 hours between 10:00 p.m. and 10:00 a.m. because her phone conversations bothered the other residents on the open ward. She stated she needed to talk to her son and boyfriend during those times that were home or before they went to work, and she was very upset about her lack of access to her private telephone.

During another interview on the same date and time, a nursing staff member acknowledged that Resident 10 was not allowed to use her cellular telephone from 10:00 p.m. to 10:00 a.m. The nurse stated Resident 10's telephone calls were heard by the other residents on the open ward, and the noise bothered them.

It was noted that the telephones in the staff offices or at nurses' stations did not meet the provisions of privacy of this requirement, and Resident 10 was not able to transfer outside of the open ward by herself to make telephone calls after she was placed in bed by the staff in the evenings.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLA Identification Number:** 555020  
**Multiple Construction:**  
A. Building  
B. Wing  
**Date Survey Completed:** 02/21/2006

**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

<table>
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<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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| F 174         | Continued From page 6  
Therefore, the facility failed to ensure telephone privacy for Resident 10 and her right to have reasonable access to the private use of a telephone. | F 174         |                                                                                                  |                |
| F 176         | 483.10(n) Self Administration of Drugs  
An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.  
This REQUIREMENT is not met as evidenced by:  
Based on observation, medical record review, and interview, the facility failed to assess one of 96 sampled residents for safe administration of her own medications. (Resident 55)  
Findings:  
Resident 55 was admitted to the facility on 12/17/91 with diagnoses of hemiplegia, seizure, and drug abuse. The Quarterly Minimum Data Set (MDS - assessment tool) dated 1/10/06 documented she was alert, oriented to people, place and time, and was verbally responsive.  
On 2/07/06 at 9:30 a.m. Resident 55 was observed in the dining room on the second floor at Clarendon Hall. Medication bottles were observed on her breakfast tray and she was seen opening the bottles with her teeth. The licensed nurse stood beside her during the process. While Resident 55 removed the medications from the containers, the licensed nurse explained what each medication was for to her. The surveyor | F 176         |                                                                                                  |                |
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER:**
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF  
375 LAGUNA HONDA BLVD.  
SAN FRANCISCO, CA 94116

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>asked the nurse if Resident 55 had been approved for self-administration of her medications. The nurse said: &quot;I train her to self-medicate. She had a brain injury so I have to explain the importance of the medications. We trained her many times to open the bottles with her right hand because her left hand is paralyzed, but she keeps using her mouth to open the bottles.&quot;</td>
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<td>F 221</td>
<td>483.13(a) PHYSICAL RERAINTS</td>
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<td>SS-D</td>
<td>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, 1 of 56 residents reported to be physically restrained on 2/6/2006, Resident 31, was not afforded her right to be free from a physical restraint imposed for the purposes of</td>
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<td>COMPLETION DATE</td>
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<td>F 221</td>
<td>Continued From page 8 convenience. The facility stated that they had placed Resident 31 in the restraint for safety purposes, but had not engaged in a systematic and gradual process toward reducing the &quot;Posey&quot; enclosed bed.</td>
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<td>Findings:</td>
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<td>Record review and staff interview revealed that Resident 31 was a 22 year old female admitted on 10/26/2004 with a history of cerebral palsy secondary to meningitis at the age of eight, S/P pulseless electrical activity, seizure disorder, hypothyroidism and adrenal insufficiency. Further clinical record review on 2/10/2006 revealed a neurology consultation dated 3/28/2005 which read: &quot;While apparently no recent, or certainly acute seizures were witnessed, it was felt that she may have suffered a seizure and possibly aspirated, becoming hypoxic and subsequently hypothermic and was transferred to Laguna Honda Hospital for ongoing care and rehabilitation at that time.&quot; Since that date, clinical record review revealed that there reportedly have been no clear seizures for Resident 31 at Laguna Honda Hospital, LHH.</td>
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<td>Resident 31 was observed approximately 11:00 A.M. on 2/09/2006 on her Unit E-3 to have a Posey brand name bed. Her &quot;Posey&quot; enclosed bed system was a canopy-like padded bed covered with nylon netting that can be zipped into place. At this time, staff stated that the bed was used to reduce falls from bed. Staff interview and record review revealed that Resident 31 was relocated to E-3 on 2/2/2006.</td>
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<td>Resident 31 was observed at 3:55 P.M. on 2/10/2006 in the presence of the Certified Nursing</td>
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<td>F 221</td>
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Assistant, CNA. Resident 31 appeared to be demonstrating significant psychomotor restlessness; moving the left side of her body voluntarily and flailing her left upper extremity. When asked at this time, the CNA who was assigned to work with her from 6-7 A.M. and 3-4:00 P.M. on 2/10/2006 stated that she: "Doesn't know what to do for her." "We are learning as we go." Staff went on to say, and record review revealed, that Resident 31 was relocated to E-3 on 2/2/2006 from another unit at LHH.

At this time, the surveyor asked if Resident 31 had any activity materials or supplies that she could hold in her left hand. Staff told and showed the surveyor that Resident 31 had only one rattle; which was out of her reach. She had no activity supplies to hold in her hand, or to stimulate and interest the resident. She stated that the Activity Therapist does not come on the unit to work with Resident 31 on Friday afternoons. The CNA stated that Resident 31 is calmer with music, but Resident 31 was by her bed without music at 3:55 P.M. on 2/10/2006.

The E-3 Unit Nurse Manager was interviewed, the morning of 2/10/2006. She stated that the only member of Resident 31's interdisciplinary team who determined the bed was needed for safety, when initiated on 2/17/2005, was nursing. The nurse manager stated that after Resident 31 was found on 2/17/2005 at 4:35 P.M. on the floor with the bedside dresser partially on top of her trunk and legs, her head on top of the rail foam pad, her right hand holding a hair brush and her left hand on the drawer. By 6:45 P.M., on that day, Resident 31 was placed on what the
facility termed a "Vail" appearing bed. The record revealed a 2/18/05 note to put the resident in a "Vail" bed for safety until this was discussed with her family and other ways to prevent falls were discussed or explored.

Evidence was lacking that the interdisciplinary team ever tried any other alternatives, to the enclosed bed, or that they were using the least restrictive restraint, the enclosed bed, for the least amount of time. When asked on 2/10/2006, the E-3 Unit Nurse Manager stated that the facility was not trying to find or use any less restrictive alternatives for Resident 31's "Posey" enclosed bed. The Nurse Manager went on to state there was no ongoing patient evaluation and/or monitoring and that they did not ever intend to work towards removing Resident 31 from sleeping in the enclosed bed. She stated that neither a physical therapist, psychologist or behavioralist had evaluated Resident 31.

Record review on 2/10/06 revealed that Resident 31 had the following care plan problem dated 10/26/04: "Resistive during care - hitting and grabbing staff with her left hand with care - constant body movements such as rocking - moving her extremities especially upper extremities - putting objects she can reach to her mouth and removing her clothes." The care plan goal for this problem was for the resident: "to appear calm while care was being rendered and no injury to residents." The care plan's written intervention was to: "Assess the cause of her behavior due to developmental delay."

When the Nurse Manager and the charge nurses were asked on 2/10/2006 in the morning, and at approximately 4:00 P.M., and on 2/21/2006 at...
### Statement of Deficiencies and Plan of Correction

#### (X1) Provider/Supplier/Clinic Identification Number:

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<th>F 221</th>
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<th>(X3) Date Survey Completed</th>
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#### 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

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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced To The Appropriate Deficiency)</th>
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- **F 221**: Continued From page 11

  8:30 A.M. the facility could not produce any behavioral assessment documentation. There was no assessment as to the causes of the resistance to care or any data reflecting a review of the pattern, (no times of day and/or relationship to other precipitating factors had been recorded) intensity, or duration of this problem behavior.

  Further record review revealed, Resident 31 had a 2/1/2005 care planned problem for potential for social isolation. The written target date of 9/1/2005 read: Activities will make contact with Golden Gate Regional Center, GGRC, to determine nature and type of activities that resident participates in so that they can be duplicated or supplemented while this resident is at Laguna Honda Hospital. The care planned target date was changed to 12/1/2005: "Activities will coordinate with GGRC staff to develop activity program for resident's potential reintegration into the community, for example social and communication skill development, awareness of "others" and ability to follow simple directions."

  The activity therapist was interviewed by telephone on 2/13/2006 at 11:15 A.M. The surveyor asked her why there were no activity supplies at Resident 31's bedside. The activity therapist stated that she had barely just met Resident 31 on 2/8/2006 or 2/9/2006. The activity therapist stated that no activity or recreational program had been developed for her. The activity therapist stated that she was planning to visit Resident 31's school and learn what goals the school has for her so that the facility could coordinate and possibly carry over some recreation programs from her school.

  Resident 31 also had a care plan which stated:
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<td>F 221</td>
<td>Continued From page 12 &quot;Discharge Planning will require a Board and Care home placement when medically cleared.&quot; The goal was when the resident was medically stable the facility would transfer her to a lower level of care in the community. When asked, on 2/10/2006 the Nurse Manager stated to the surveyor that Resident 31 was currently medically stable. During a telephone at 11:15 A.M. on 2/13/2006 Resident 31's the social worker stated that Resident 31 had been ready for discharge since 1/28/2005. The social worker stated that Golden Gate Regional Center, GGRC, was handling Resident 31's discharge. GGRC had not found a place for Resident 31 to be discharged to live in the San Francisco area. Resident 31 had not been assessed for all the factors that put her at risk for physical restraint use including assessing possible reasons for problem or destructive behavior endangering herself and/or others, unmet psychosocial needs, such as the need for diversion activities and/or social interactions. Evidence was lacking as to whether or not the facility had determined previous interventions or approaches, both successful and unsuccessful, to avoid using the &quot;Posey&quot; enclosed bed as a physical restraint for Resident 31.</td>
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<tr>
<td>F 223</td>
<td>483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual,</td>
<td>F 223</td>
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NAME OF PROVIDER OR SUPPLIER: LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/IP SNF

STREET ADDRESS, CITY, STATE, ZIP CODE: 375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: 09ME11 Facility ID: CA220000512 If continuation sheet Page 13 of 274
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: 09ME11
Facility ID: CA22000512

F 223 Continued From page 13
or physical abuse, corporal punishment, or involuntary seclusion.

This REQUIREMENT is not met as evidenced by:

Based on observation, resident and staff interviews, and record review, the facility failed to ensure that 7 of 96 sampled residents were free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. (Residents 2, 27, 48, 49, 55, 68, and 76)

1. The facility failed to ensure that Resident 2 was free from involuntary seclusion.
2. The facility failed to ensure that Resident 48 was free from physical abuse.
3. The facility failed to intervene and to monitor Resident 49 to prevent verbal abuse.
4. The facility failed to ensure that Resident 68 was free from verbal and physical abuse.
5 & 6. The facility failed to ensure that Resident 27 had the right to be free from verbal abuse from Resident 79's relatives.
6. The facility failed to ensure that Resident 55 was free from sexual, verbal, and physical abuse, and involuntary seclusion.

Findings:

1. Record review during the survey on 02/05/06 of Resident 2 documented that Resident 2 was admitted on 03/02/05 and re-admitted on 12/04/05 with diagnoses including alcohol withdrawal, urinary tract infection, and failure to thrive. His 01/30/06 MDS (Minimum Data Set, an assessment tool) documented that he had no cognitive problem with daily decision-making. In addition, he could understand others and could make himself understood by the others. The MDS...
Continued From page 14
also documented that he had persistent anger with himself and others, and exhibited physically abusive behavior.

The Resident was observed lying in bed on 02/16/06 at 2:00 p.m. and he had facial grimace. During an interview on the same date and time, Resident 2 stated he had been restricted to his ward for over a month. He stated he was being punished after a resident-to-resident altercation a month ago, and that the facility had placed a wanderguard on his left wrist so, when he approached the ward doorway, an alarm sounded and a staff member took him back to his bed. His cigarettes were taken away, and he was not allowed to leave the ward to go to the smoking area. He was also not allowed to leave the ward to join any social activity, or to visit any other resident outside his ward. He stated that he had not agreed to this restriction, and he was very upset about the involuntary seclusion.

Review of Resident 2's record on 02/05/06 documented that Resident 2 had a history of being restricted to his ward. Review of his 08/31/05 Physician's Progress Notes (five and a half months ago) documented that Resident 2's movement was restricted for a week after he was found with an empty bottle of liquor in his possession. There was no documented evidence of his consent to the restriction, a stated purpose/goal of the restriction, the specific behavior they are treating, or any evaluation of result of the restriction.

Review on 02/05/06 of the 12/07/05 Physician's Progress Notes documented that Resident 2 had "agitated demands to be allowed off-ward (bingo)" on the third day of another seven-day ward
Continued From page 15

Confined (started on 12/04/05). In addition, the Physician's Progress Notes documented that Resident 2 stated: "I feel like a prisoner." Review on 02/05/06 of the 01/14/06 Integrated Progress Notes documented that Resident 2 had been placed on ward restriction and grounded after he hit another resident on 01/14/06.

Review on 02/05/06 of the 01/14/06 Care Plan documented that Resident 2 had admitted hitting another resident on that day, and the care plan interventions included: "Ward Restriction for safety pending IDT (Inter-disciplinary Team) review." However, there was no documented evidence that the ward restriction was used only for a limited period of time as a therapeutic intervention. In fact, as revealed in a previous seven-day ward restriction started on 12/04/05, the ward restriction escalated Resident 2's agitation when he made "agitated demands" to be allowed off-ward to join a bingo activity. Again, there was no assessment and no evaluation for the use of the ward restriction.

During an interview on 2/16/06 at 3:00 p.m., an administrative nurse stated that Resident 2 had agreed to the restriction. She also stated that she had a copy of a "Treatment Agreement" for the ward restriction with Resident 2. However, she could only produce a copy of a "Treatment Agreement," dated 08/01/05. The "Treatment Agreement" documented that Resident 2 had agreed "to remain in the hospital without pass privileges for at least the first two weeks in order to allow time for me and the team to make plans for treatment."

There was no documented evidence to show that
Continued From page 16

Resident 2 had agreed to any other time for restriction, such as the ward restriction since 01/14/06 (a total of 34 days of involuntary seclusion from 01/14/06 to 02/16/06).

The facility was aware that Resident 2 was not cognitively impaired, and that he had a long history of physically abusive behavior. His care plan revealed that he was at risk for physical abuse with others, and the care plan interventions included ward restriction for safety.

However, it was not documented that the restriction was being used for a limited period of time as a therapeutic intervention to reduce agitation until staff could develop a plan of care to meet the resident's needs.

The ward restriction from 01/14/06 to 02/16/06 (34 days) was against the resident's will, and he had become agitated and upset by the restriction. The ward restriction on Resident 2 was used on 08/01/05, 12/04/05, and 01/14/05 with no documented evidence of least restrictive therapeutic intervention or a stated purpose. Therefore, the facility failed to ensure that Resident 2 was free from involuntary seclusion. (Cross reference F-324 & F 353.)

2. Record review on 02/07/06 of Resident 48 documented that Resident 48 was admitted on 10/09/97 and re-admitted on 07/15/99 with diagnoses including auto-immunodeficiency disease, seizure disorder, old stroke with right-side weakness, and depression.

A review of Resident 48’s clinical record on 02/07/06 documented that his 01/06/05 MDS noted that he had short and long-term memory...
Continued From page 17

problems, and needed extensive assistance from
the staff to transfer from his bed to a chair, and to
dress, groom, and bathe.

Review on 02/07/06 of his 07/11/05 Nursing
Assessment for Behavioral Risk revealed that the
facility was aware that Resident 48 had a "history
of victimization in the past year." There was a
care plan for Resident 48's risk for "altercations
with associated injury" with a date of 07/10/01 and
a revised date of 05/06/03, and it had a 08/31/05
care plan intervention, which documented that the
staff members were to "keep him away from
aggressors. Staff was instructed to monitor
activities and behavior." (This 07/10/01 care plan
was again revised on 01/17/06 for the risk of
aggression by others, and the care plan
interventions included, "Staff to keep resident
safe; to avoid other resident that would provoke
him to react aggressively; to attend a mandatory
anger management class; ward restriction for
safety for five days; if involved in another
altercation, will result in increased restriction; staff
will document behavior and report to IDT as
needed").

However, review on 02/07/06 of his 08/31/05
Integrated Progress Notes (five months ago from
08/31/05 to 02/07/06) at 1:00 p.m. indicated that
Resident 48 was hit in the stomach by another
resident when Resident 48 asked him to move;
instead, the other resident turned around and hit
him. Resident 48 became very "mad" about being
hit by the other resident.

Review on 02/07/06 of the 01/14/06 Integrated
Progress Notes at 2:30 p.m. documented that on
01/14/06 Resident 48 was hit on the right side of
his mouth without provocation by another resident
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 223</td>
<td>Continued From page 18 on the fifth floor &quot;breezeway.&quot; The Resident was observed on 02/07/06 at 10:00 a.m. lying in bed. During an interview on the same date and time, Resident 48 was alert and oriented to his name, time and place of residence; and was able to answer simple questions. He also stated that he was &quot;mad&quot; when the other resident hit him. The facility was aware that Resident 48 had a problem of victimization by other residents since 07/11/05, and the facility failed to ensure that Resident 48 was free from physical abuse by other residents on 08/31/05 and 01/14/06. (Cross reference F-324 &amp; F-353.) 3. Review on 02/10/06 of Resident 49's clinical record documented that Resident 49 was admitted on 11/17/94, and re-admitted on 08/31/05 with diagnoses including quadriplegia, and infection of right buttock, back and thigh. Review on 02/10/06 of Resident 49's 10/17/05 Nursing Assessment for behavioral Risk documented that he was at risk for aggressive behaviors. Review on 02/10/06 of the 08/31/05 Resident Care Plan documented that Resident 49 was taunting others, particularly the more frail and vulnerable residents. Review on 02/10/06 of the 11/01/05 Integrated Progress Notes documented that Resident 49 was calling another resident &quot;Mon-Mon: (meaning &quot;Gay&quot;), and &quot;I will have someone shut you off outside the hospital; your day will come,&quot; while he was trying to provoke a fight with another</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**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

**DATE SURVEY COMPLETED**

02/21/2006

**FORM APPROVED**

OMB NO. 0938-0391
Review on 02/10/06 of the 11/17/05 Integrated Progress Notes documented that on 11/16/05 at 3:30 p.m., Resident 49 was threatening a staff member.

The Resident was observed on 02/10/06 at 9:00 a.m. in his room. During an interview on the same date and time, Resident 49 stated that he was upset at times, and he did not like the "old people" around here.

The facility was aware that Resident 49 demonstrated aggressive behavior toward others, and that he made verbal threats. The facility failed to monitor and to intervene to prevent Resident 49's verbal abuse which resulted in verbal threats to another resident on 11/01/05 and to a staff member on 11/17/05. (Cross reference F-324.)

Review on 02/10/06 of Resident 68's clinical record documented that Resident 68 was admitted on 02/01/93 and re-admitted on 04/20/05 for heart problems, old stroke with right side weakness, seizure disorder, traumatic brain injury in 1987 after a motor vehicle accident, hypertension, and depression with visual hallucinations and suicidal ideation.

Review on 02/10/06 of Resident 68's 01/18/06 MDS documented that Resident 68 had short and long-term memory problems, poor decision-making skill; however, he was able to understand the others, and he usually able to make himself understood by the others. In addition, he had persistent anger with self and others, sad appearance, making repetitive anxious complaints, and he was physically
Continued From page 20

abusive. He also needed extensive assistance from the staff with transfers from his bed to chair, dressing, toilet use, grooming, and bath.

Review on 02/10/06 of the 08/31/05 Integrated Progress Notes documented at 2:00 p.m. that when Resident 68 was sitting in his wheelchair in the dining room and another resident asked him to move over, Resident 68 responded, "You F--ing Ni--er" and then he swing his right arm to hit the other resident on the stomach.

Review on 02/10/06 of the 09/17/05, 3:35 p.m. Integrated Progress Notes documented that on that day and at that time during the social activity, Resident 68 said "F—you" to another resident in a very loud voice, and threw a "Pokeno" chip at the resident. When the activities staff tried to intervene, Resident 68 yelled, "F--- bitch."

Review on 02/10/06 of the 09/21/05 Integrated Progress Notes documented at 10:55 a.m. that Resident 68 poured hot coffee on his own left hand. Ice was applied immediately to the left hand. "Skin abrasion" was reported.

Review on 02/10/06 of the 10/29/05 Integrated Progress Notes documented at 7:30 p.m. that when Resident 68 was passing-by another resident, they hit each other.

Review on 02/10/06 of the 11/09/05, 2:45 p.m. Integrated Progress Notes documented that during a therapy session, Resident 68 stated to a therapy staff member, "I'm going to beat you up and that's a threat." He then aggressively wheeled toward the staff. Another staff member had to physically stop him.
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During an interview on 02/10/06 at 9:00 a.m., Resident 68 stated that he sometimes become upset and he could not control himself. He also stated that he hit other people when he became "mad."

During an interview on 02/10/06 at 10:00 a.m., a licensed nursing staff stated that they were unable to monitor and to supervise Resident 68 at "all times", especially when he left the unit to join the social activities and/or was smoking in the smoking area. There was no documented evidence that Resident 68 had any supervision and/or monitoring of his behavior when he was outside the ward.

The facility was aware of Resident 68's behavior of verbal and physical abuse to others and himself, and the facility failed to ensure that Resident 68 was free from verbal and physical abuse, resulting in multiple resident-to-resident altercations, physical abuse to himself, and verbal and physical abuse to the staff. (Cross reference F-353.)

5. A review of the facility's self-reported incident revealed that on 08/14/05 Resident 27 had a verbal altercation with Resident 76's teenage daughter.

The facility staff and Sheriff's Institutional Police (IP) separated the two parties involved and they were counseled. The investigation report conducted by the nurse supervisor dated 8/14/05 concluded that verbal abuse by visitor towards Resident 27 was substantiated.

The facility's self-report letter dated 8/15/05 stated, "The interdisciplinary team (IDT) is
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
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**STREET ADDRESS, CITY, STATE, ZIP CODE**
375 LAGUNA HONDA BLVD.
SAN FRANCISCO, CA 94116

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F 223 Continued From page 22

meeting regarding this incident to revise the plan of care with the goal of preventing further incidents."

a.) Resident 27, a 42-year old female was re-admitted on 11/22/05 with diagnoses of cerebrovascular accident (CVA), left hemiparesis, insulin dependent diabetes mellitus (IDDM), hypertension, and end-stage renal disease (ESRD). The minimum data set (MDS) dated 11/29/05 revealed the resident has moderately impaired cognitive skills in decision-making.

The Integrated Progress Notes dated 8/14/05 at 5:30 p.m. revealed the resident reported that daughter of Resident 76 called her "bitch" when she told her not to talk to her mother in such a disrespectful manner. Resident 27 exchanged few words with the teenage daughter and then stayed away.

The Sheriff report dated 8/14/05 confirmed that a verbal argument developed among Resident 27, Resident 76 and teenage daughter. At one point the sheriff heard the daughter of Resident 76 to say that she was going to tell her sister about Resident 27, and have her sister come to the facility and beat up Resident 27. The nurse supervisor's report indicated that Resident 27 and daughter of Resident 76 admitted calling each others names.

On 2/9/06 9:30 a.m., Resident 27 was observed awake in bed, alert, and able to communicate with slight communication difficulty due to recent stroke. At 10:30 a.m., the resident was observed outside of L5 unit talking to other residents in the hallway. The resident was independently able to maneuver the electric wheelchair.

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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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The Sheriff report dated 8/14/05 confirmed that a verbal argument developed among Resident 27, Resident 76 and teenage daughter. At one point the sheriff heard the daughter of Resident 76 to say that she was going to tell her sister about Resident 27, and have her sister come to the facility and beat up Resident 27. The nurse supervisor's report indicated that Resident 27 and daughter of Resident 76 admitted calling each others names.

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On 2/16/06, at 10 a.m., Resident 27 stated that she no longer sees the teenage daughter of Resident 76 in the facility. She also stated that she does not fear any of the relatives of Resident 76 will get back at her and beat her up.

A review of the resident’s medical record with the social worker on 2/15/06 and with the nurse manager on 2/14/05 showed no evidence that the IDT met regarding this incident. There were no changes in the care plan to protect Resident 27 from verbal abuse and potential physical abuse from Resident 76’s relatives.

b.) Resident 76, a 43-year old female was admitted on 5/10/2001 with diagnosis of subarachnoid hemorrhage secondary to aneurysm. The MDS dated 12/09/2005 revealed the resident has short and long term memory problems. There were no identified mood and behavior problems.

On 2/17/05 at 10:00 a.m. Resident 76 was observed alert, pleasant, and able to answer questions with yes or no responses.

Resident 76’s Integrated Progress Notes dated 8/14/05 at 5 p.m. revealed that “visiting daughter called another resident (27) ‘bitch,’ when said resident told her not to talk to her mother (Resident 76) in such a disrespectful manner. Daughter still very loud and cursing in the hallway even when told to calm down and other residents are being bothered. IP was called ...”

The social services progress notes dated 8/15/05 at 10:30 a.m. showed that the social worker met with Resident 76 regarding the verbal altercation
### Summary Statement of Deficiencies

Continued from page 24 incident. With the use of questions answerable by "yes" or "no" the social worker confirmed with Resident 76 that her daughter has been "loud and had used swear words" and had asked her for money. The resident pulled $5.00 from her purse and when the social worker asked her if she wanted to give the money to her daughter, the resident said, "no." The resident was very mad and saddened by her daughter's behavior. After discussion with the resident, the social worker called the resident's ex-husband to speak to the daughters and not to ask money from Resident 76 who receives a small amount of money each month for personal use. The ex-husband was very angry and claimed the facility staff always blamed his children.

The social worker's semi-annual assessment dated 9/19/05 revealed that Resident's daughters visited regularly and the resident felt that the incident that occurred with her daughter had been resolved. She expressed her desire for her daughters to visit and she indicated that she is aware that she can go to the staff for help any problems that arise. The resident continues to enjoy her private room where she moved in February, 2005.

On 2/15/06 at 11:25 a.m. interview with the social worker revealed that she spoke with both residents involved in the above incident and showed her documentation. She also stated that she monitors the daughters' visits by asking Resident 76 how the visit went and reassured her that facility staff will be available if there are problems during the visit.

During the above interview, the social worker also informed the surveyor that a couple of years ago,
On 2/9/06 at 12:15 p.m., the charge nurse stated that he has not seen the daughters visit in the morning shift. He also stated that he was not aware of a change in the care plan of care after the above incident. The social worker earlier in the interview indicated that the daughters were reprimanded to visit in the morning because the school principal has informed the father that they were skipping classes. The social worker also confirmed that there were times that the doors were closed when daughters visit Resident 76.

There was no evidence in the record that the interdisciplinary team met and developed a plan of care to protect Resident 76 from potential verbally abusive behavior of her daughters and potentially taking the resident's money without her consent.

On 2/16/06 at 2:50 p.m. the Chief Nurse Officer was informed of the above finding. She confirmed after reviewing the records that the IDT documentation was not present in the residents' medical records. There were no supervised family visits conducted after the incident. The plans of care were not revised as indicated in the action plan to protect both residents from abuse.

6. Resident 55 was admitted to the facility on 12/17/01 with diagnoses of hemiplegia, seizure, and drug abuse. The 1/10/06 Quarterly Minimum
### Statement of Deficiencies and Plan of Correction

**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

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<td>F 223</td>
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<td>Data Set (MDS-assessment tool) documented that she was alert, oriented to people, place, and time, and was verbally responsive. She was identified as making negative statements, calling out, had repetitive physical movements and disruptive behavior.</td>
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<td>Review of the medical record on 2/9/06 revealed that Resident 55 had a history of verbal and physical aggression with residents and nursing staff; used alcohol and illegal substances, was an unsafe smoker; and had unsafe sex with another Resident.</td>
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<td>The 6/9/05 nursing notes at 4:30 p.m. documented that Resident 55 threw a cup of coffee at a male Resident while he was weeding the plants outside in the smoking area. Two security officers brought Resident 55 back to South 200 at Clarendon Hall (CH). Resident 55 told the nursing staff that the other Resident was killing the plants that he had planted, and that the other Resident &quot;had no respect for nature.&quot; The nursing staff told Resident 55 that her assaultive behavior was wrong and that she needed to be restricted to the second floor for 24 hours. Her cigarettes and lighter were taken away. The nursing notes indicated that Resident 55 was upset and said, &quot;I did not do anything wrong.&quot;</td>
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<td>The 7/28/05 nursing notes at 7:10 p.m. documented that staff heard a commotion and witnessed Resident 55 punching Resident 60 on his back as he was going into the elevator on the first floor. The Residents were screaming at each other, and nursing staff intervened. Resident 55 said Resident 60 grabbed the cigarette from her mouth. There were no injuries noted on either Resident.</td>
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<td>(Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</td>
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**Continuation Sheet Page 27 of 274**
The IDT discussed the incident on 7/29/05 and agreed to restrict Resident 55 to the Unit for 24 hours and have her cigarettes taken away. She was offered a nicotine patch. At 10:30 a.m. Resident 55 was "caught smoking in violation of her restriction. Extension of her restriction until tomorrow 7/30/05 at 10:30 a.m. will be imposed. Refused nicotine patch." The Social Service notes on 7/29/05 documented: "Resident agitated & angry about being restricted to the ward, feeling she was being treated unfairly even though she acknowledges physical conflict with the other Resident."

On 9/23/05 at 3:50 p.m., the nursing notes documented that a Resident went into the elevator and triggered the alarm. Resident 55 told him to get out but the other Resident did not listen. He later exited from the elevator and Resident 55 hit him on the face. He hit her back three times. The nursing staff separated both Residents. Both Residents were assessed by the licensed nursing staff and there were no injuries noted. The incident was discussed with the Interdisciplinary Team (IDT) and Resident 55 was restricted to the second floor for 24 hours. According to the nursing notes Resident 55 was cooperative with her restriction but she refused to use a nicotine patch. On 7/26/05, Resident 55 attended Substance Abuse Training Services (SATS) Program.

The 9/27/05 nursing notes documented that the housekeeping supervisor reported that a porter witnessed a male resident from South 300 touching Resident 55's breasts in the day room on the first floor. "According to the report Resident 55 said this has been happening"
everyday in the dayroom while playing the computer. Asked if she wants to press charges & she said "no". "I just want him to stop." No injuries noted. Encourage resident to report if it happens again." The nursing notes also indicated that Resident 55 did not want to press charges and just wanted the male Resident to stop. She stated she was embarrassed about the incident but she did not want to lose his friendship.

The 10/19/05 nursing notes documented: "At around 12:15 p.m., LV (Licensed vocational nurse) had seen Resident 55 and (a) Resident having intimate position on CH West ramp 1st floor. (The) Resident was seen sitting on (the) lap of Resident 55 (and) facing each other (while) in front of the public."

According to the Nurse Manager's documentation she discussed with Resident 55 the fact that the other Resident had a diagnosis of HIV and Resident 55 said she was aware of it. She was offered by the staff the availability of condoms and the use of a private room if needed. On 10/23/05 Resident 55 went out on pass with the boyfriend and they both returned to the facility at 1:50 p.m. smelling of alcohol. The facility did a toxicology test on both residents.

Resident 55 was observed during the survey wheeling herself constantly from the Unit to the hallways. She appeared alert, oriented, verbally responsive, and kept wheeling herself back and forth while talking to the Surveyor and to the staff. On 2/8/06 at 11:00 a.m. this Surveyor attempted to interview Resident 55. When asked how she felt about being confined in the Unit several times she responded, "I hate it. They think I could be punished but they don't know what I can do."
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<td>wheeled herself from the Unit into the hallway.</td>
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<td>In an interview on 2/15/06 at 10:50 a.m. the licensed staff stated Resident 55 had brain injury and was very impulsive. She also stated Resident 55 calms down everytime she was reminded by the staff that she would be restricted to the Unit. The Nurse manager said, &quot;The care plan is revised for every incident. The best intervention according to the IDT is confinement on the second floor. This intervention works best because the Resident does not like being confined.&quot;</td>
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<td>According to the record, the Resident was not compliant with the interventions and even though her cigarettes were taken away, she was able to get cigarettes from other Residents.</td>
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<td>The Resident was angry about being confined everytime she had altercations with other Residents. She told the Social Service staff she felt she was not treated fairly.</td>
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<td>Therefore, the facility's behavioral interventions with Resident 55 were not effective and did not therapeutically deal with the Resident's behavior. The Resident was placed on involuntary seclusion without consent and she was angry about it. (Cross reference F-224, F-250, &amp; F-353.)</td>
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<td>F 224</td>
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<td>483.13(c) STAFF TREATMENT OF RESIDENTS</td>
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<td>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

**STREET ADDRESS, CITY, STATE, ZIP CODE**
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This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement their written policies and procedures that prohibit mistreatment, neglect and abuse of residents when they failed to provide services to seven of 96 sampled residents identified with behavior problems in order to prevent physical and mental harm to all the residents. (Residents 65, 66, 84, 26, 58, 8, & 55.)

1. The facility failed to protect Resident 84, diagnosed with subdural hematoma, from being repeatedly struck in the head and face by several other residents on K-6.
2. The facility failed to protect three residents from Resident 65's assaults on K-6.
3. The facility failed to protect three residents from Resident 66's assaults on K-6.
4. The facility failed to protect Resident 26 from other residents' assaults on L-6.
5. Resident 58, readmitted to the facility for the third time, had to be transferred on an involuntary hold after threatening staff and residents.
6. Resident 8 had repeated episodes of aggressive behavior with an identified need for increased supervision which the facility failed to provide.
7. The facility failed to protect Resident 55 from being inappropriately touched by a resident in the presence of other residents.

**Findings:**

1. Resident 84 was originally admitted to the facility on 1/20/93 and readmitted on 2/1/01 with diagnoses including subdural hematoma, seizure disorder, and altered mental status. His 11/28/05
Continued From page 31

MDS indicated he had short and long-term memory problems, severely impaired decision-making ability, and was not oriented to person, place or time. He was rarely able to make himself understood, and sometimes understood what others said to him. He had the behavioral symptoms of daily wandering not easily altered, verbally abusiveness several days a week that was easily altered, socially inappropriate/disruptive behavior, and resisted care daily. He needed only supervision to get out of bed, walk, eat, and use the toilet, and required extensive assistance with dressing and bathing. He was continent of bowel and bladder.

Review of his Integrated Progress Notes revealed that on 9/18/05 at 6:45 am: "Resident was punched in the chest by resident (Resident 66)- sustained skin redness on the chest." The RN Assessment on 9/18/05 at 8 am stated: "Resident is at risk for being injured by others related to his sudden outburst of yelling, verbally abusive using "F" word and using obscene hand gesture which provoke other residents. Resident is advised to stop such behavior so he won't get hurt." Review of his care plan revealed that he was "at risk for injury by others," he had "episodes of shouting, yelling, screaming," and "in dining area he should sit by self to prevent altercations." His care plan contained no interventions aimed at protecting him from the assaults of other residents such as by supervising, intervening and redirecting him when he was verbally abusive.

Review of Resident 84's Integrated Progress Notes on 10/15/05 at 6:20 am revealed: "Heard that resident saying the word "fuck you" to resident (Resident 65) and returned incident (sic) resident (Resident 65) put his hands on his
### Statement of Deficiencies and Plan of Correction

**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

**Date Survey Completed:** 02/21/2006

#### Summary Statement of Deficiencies

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<td>F 224</td>
<td>Continued From page 32</td>
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(Resident 84's) neck and slapped him on his left cheek. The RN Assessment of the incident at 7:20 PM stated: "Resident has a history of being verbally abusive." Neither the assessment nor the care plan contained interventions aimed at protecting Resident 84 from the assaults of others by supervising and redirecting him away from other residents when he was verbally abusive.

Review of Resident 84's Integrated Progress Notes revealed that on 12/17/05 at 5:50 PM, Resident 84 "was struck by resident (Resident 65) on his face/punches with an open hand (after) he made an obscene gesture and cursed this resident." The RN Assessment included: "Residents were separated and closely watched...Has history of being loud and verbally abusive." Two hours later, on 12/17/05 at 7:55 am, the notes stated: "Staff heard loud voices at the back ward. When checked CNA saw resident (Resident 65) hitting Resident 84 on his (L) temporal area (the left side of his head) 1x with a fist and 1x with an open hand. Resident 84 was sitting on his own bed at the time." The RN Assessment stated: "Resident unable to give report of what happened related to dementia." Neither the assessment nor the care plan contained any plan or intervention aimed at supervising Resident 84 and redirecting him when he was verbally abusive in order to protect him from repeated physical abuse and victimization by other residents.

Review of the record revealed that only on 1/9/06, after Resident 84 had been assaulted four times (9/18/05, 10/15/05, and twice on 12/17/05) by two different residents over a period of four months, did the facility develop a care plan for: "At risk for injury from others due to his shouting obscenities.
STATEMENT OF DEFIENCIES AND PLAN OF CORRECTION

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| F 224 | Continued From page 33 and intrusive behavior R/T (related to) internal stimuli (S/P head trauma)." The care plan interventions were: "Observe resident pacing and redirect him to others activities," and "hang signs 'no cursing, hitting here' where resident can observe them," and "if resident shouts, yells, speak in a very low, soft voice," and "also bring him to sign and say: 'this is a rule, no cursing, no hitting.'"

In an interview on 2/10/06 at 11:30 am, a supervisory nurse stated that Resident 84 provokes the other residents by yelling the F word and makes gestures," but offered no explanation for why staff did not monitor and intervene when Resident 84 began verbally abusing other residents to prevent other residents from him assaulting him.

Observation on 2/16/06 at 2 PM revealed Resident 84, a frail man, sitting on the edge of his bed near the window. His shoulders were slumped, and he shrunk back when approached by the surveyor. He had trouble answering when asked how he was, mumbling something unintelligible in almost a whisper.

In another interview on 2/17/06 at 8:15 am, a staff nurse stated: "Sometimes it's just not possible to prevent them from hitting each other. Things happen and they can be so quick." She stated that the CNAs can't watch them all the time because they are busy giving care, or have to go to in-service. She said having another staff person would help.

Review on 2/10/06 of the facility's Policy and Procedure, File:20-13 Revised 7/29/05, Abuse Prevention, Identification, Investigation and...
Continued From page 34

Response revealed: "Laguna Honda Hospital (LHH) shall promote an environment that enhances resident well-being and protects residents from abuse and neglect. Policies: #1. It is the responsibility of all LHH employees and volunteers to protect all residents from physical, psychological, fiduciary and verbal abuse and neglect."

The facility failed to implement their own P&P to protect Resident 84, with his diagnoses of subdural hematoma (accumulation of blood in the brain usually caused by injury to the head) and seizure disorder, from the physical abuse of being struck in the face, hit in the head with a fist, slapped in the face, struck on the back of the head, and otherwise repeatedly assaulted by other residents on his unit. The facility failed to develop a care plan to address the problem of assaults on him due to his shouting obscenities until he had been assaulted four times (9/18/05, 10/15/05, and twice on 12/17/05) by two different residents over a period of four months. When they finally did address it, the care plan intervention of hanging signs that said "no cursing, hitting here" where resident could observe them" were clearly inadequate for a resident with memory problems and severely impaired thought processes. And, with the exception of redirecting the resident when he was pacing, the care plans only addressed ameliorating the problem of Resident 84's behavior of shouting obscenities. The facility did not develop strategies to monitor and intervene to prevent other residents from victimizing and assaulting him, and they failed to protect Resident 84 from other residents' physical and psychological abuse. (Cross reference F-279 & 353.)
F 224  Continued From page 35

2. Closed record review on 2/8/06 revealed that Resident 65 was admitted to the facility on 6/8/05 with diagnoses of traumatic brain injury secondary to motor vehicle accident, diabetes, cataracts and glaucoma. His 9/5/05 MDS indicated he had short and long-term memory problems, moderately impaired decision-making ability, and was not oriented to person, place or time. He was easily distracted, had altered perceptions, restlessness, and repetitive physical movements. He required limited assistance to get out of bed, walk, and use the toilet, and extensive assistance to bathe and dress. He had 9/7/05 physician's orders for Depakote 500 mg at bedtime for agitation, Trazodone 200 mg at bedtime for sleep, and Ativan 0.5 mg every 3 hours whenever necessary (prn) for agitation at night after Trazodone given.

Record review on 2/8/06 revealed that Resident 65 had a care plan, dated 9/10/05, for: "At risk for aggressive behavior toward others related to resistiveness to care, agitation, restlessness, being verbally loud, kicking, punching staff during care." On 10/15/05 the care plan included "altercation with other resident with the above behavior." The interventions included: "staff will separate Resident 65 from resident (Resident 84) related to resident's (Resident 84's) verbally abusive behavior which provokes Resident 65 to hurting him." On 12/12/05 the care plan included monitoring the other resident, and "direct resident to the front away from other residents."

Review of the nurses' notes on 2/8/06 revealed that Resident 65 attempted to strike a CNA in the head with a piece of marble on 11/25/05 and was...
Continued From page 36

subdued by two CNAs. On 12/17/05 at 5:50 PM, Resident 65 struck Resident 84 in the face. Two hours later at 7:55 PM on 12/17/05, he went to Resident 84's bedside and hit him in the head with his fist and again with his open hand. His December 2005 Medication Administration Record (MAR) documented that on 12/18/05 he required Ativan 0.5 mg at 3:40 PM, Seroquel 25 mg at 4:30 PM, Seroquel 25 mg at 6:30 PM, Seroquel 25 mg at 9:50 PM, all by mouth (P.O.). On 12/19/05 he received Seroquel 50 mg P.O. at 5 PM, and Seroquel 25 mg at 11:40 PM for "attempting to hit when redirected." On 12/20/05 5:55 PM, his nurses notes stated he "was coming out of the 2nd bathroom with a sitter behind him when, without provocation, he elbowed another resident who was coming into the bathroom...then attempted to hit resident (a third resident) who was motioning for him to get out of his bed. Was subdued by CNA to prevent him from hitting resident." The RN Assessment of the incident stated: "Resident with increased agitation for past few days. Seroquel added to medical regime to control behavior, 1:1 care was provided but resident was very unpredictable." He received Seroquel 25 mg P.O. at 6 PM for "agitation, undirectable to his bed." On 12/20/05 at 8:15 PM he was seen by the psychiatrist and involuntarily transferred (5150'd) to the hospital Psychiatric Emergency Service (PES.)

In an interview on 2/8/06 at 2:45 PM, a licensed nurse stated that Resident 65 had broken the glass window in the bathroom door on 11/25/05 after a staff person redirected him away from banging on the back door and was subdued by two CNAs.

In an interview on 2/17/06 at 8:15 am, another...
F 224 Continued From page 37

licensed nurse stated: "Sometimes it's just not possible to prevent them (the residents on the ward) from hitting one another. They can be so quick. We try but things happen. We can't always be there because staff might be busy giving care to residents, or they have to go to in-service. We could use one more person."

Review on 2/10/06 of the facility's Policy and Procedure, File:20-13 Revised 7/29/05, Abuse Prevention, Identification, Investigation and Response revealed: "Laguna Honda Hospital (LHH) shall promote an environment that enhances resident well-being and protects residents from abuse and neglect. Policies: #1. It is the responsibility of all LHH employees and volunteers to protect all residents from physical, psychological, fiduciary and verbal abuse and neglect."

The facility failed to implement their own P&P to protect all residents from physical and psychological abuse when they neglected to protect three residents from Resident 65's assaults. (Cross reference F-353.)

3. Resident 66 was originally admitted to the facility on 3/11/98, and readmitted on 7/5/05 with diagnoses of dementia, diabetes, and seizure disorder. His 11/27/05 MDS indicated he had short and long-term memory problems, moderately impaired decision-making skills, and was not oriented to person, place or time. He wandered daily, and resisted care. He needed supervision to get out of bed, walk, eat, use the toilet, and dress, and needed extensive assistance to bathe. He had a 7/6/05 physician's order for Ativan (an antianxiety medication) 0.5 mg every six hours for anxiety, and restlessness.
Record review on 2/10/06 revealed that Resident 66's 7/5/05 care plan stated he had the "potential for restlessness, agitation, aggressive behavior, may hit others, territorial, intolerable of residents who may be loud, talking, pacing." The goal was, "will not hit others." The interventions were: "Staff will report any signs of restlessness. When noted to be restless, agitated, staff will redirect from others, or others away from resident to prevent possible altercation," and "staff will immediately redirect other residents away from his space (Ex. bedside) or other residents who may be loud or pacing."

Record review on 2/10/06 of Resident 66's Integrated Progress Notes revealed that on 9/18/05 at 6:45 am, "resident punched (Resident 84) in the chest." (The same resident struck by Resident 65.) When asked why he hit Resident 84, Resident 66 stated: "he called me "funk." That's why I hit him. Resident was advised not to hit anyone, to call the staff if someone irritates him."

Record review on 2/10/06 of Resident 66's Integrated Progress Notes revealed that on 12/19/05 at 9 am, "Resident got very upset when (Resident 84) turned to him, was verbally abusive to him, yelling at him, using his middle finger. Resident 66 angrily reacted to this, stood up, approached him, ran after him after (Resident 84) tried to get away. He hit him at the back of his head. He was provoked by (Resident 84) to do it." The notes stated the incident was witnessed by a CNA who "was not able to break (sic) the fight related to his distance."

Record review on 2/10/06 of Resident 66's
Integrated Progress Notes revealed that on 1/4/06 at 5 am, Resident 66 "got upset and irritated with (another) resident, went to his bed and pushed him on his (L) shoulder. Resident apparently was irritated when (the other) resident kept moving around his (own) bed and fixing it." At 11 am the same day, the notes stated Resident 66: "remains confused and disoriented except his name." Review of the record revealed a 1/5/06 physician's order for Seroquel (an antipsychotic medication) 25 mg at bedtime (HS), and an updated care plan to "give Seroquel as ordered." On 1/17/06 the care plan was updated to read: "Will choose a resident that is more quiet and one who does not have early-morning wake-up schedule to prevent resident from startling out of sleep and hitting that person," and "will introduce the potential resident that will be next to his bed."

Record review on 2/10/06 of Resident 66's Integrated Progress Notes revealed that on 1/29/06 at 6 PM, "he (Resident 66) try (sic) to hit (a third resident) in his face that he deflected it and it landed on his shoulder." When he was interviewed the next day, Resident 66 denied the incident and indicated he did not hit/push anyone. The record showed that Resident 66's 1/5/06 25 mg Seroquel order was increased to Seroquel 50 mg at HS for agitation, and Seroquel 25 mg every 6 hours whenever necessary for agitation added." On 2/8/06 during the survey, the care plan was also updated to read: "Continue to leave additional space by his bed area."

In an interview on 2/10/06 11:30 am, a supervisory nurse stated: "He's provoked for all episodes. He's very territorial. If someone passes by his area, he gets upset. We decided not to put
Observation on 2/10/06 at 12 PM revealed Resident 66, a tall man dressed in blue sweat-shirt and sweat-pants sitting in a chair at his bedside. His bed was in the far corner of the ward, and the bed that would have been near it had been removed. A CD player was on his night-stand but it was not plugged in. He answered simple questions with "yes" or "no." But when asked if he listened to music from his CD player, he appeared confused, seemed unable to formulate an answer, and his face took on an irritated, threatening expression.

In an interview on 2/17/06 at 8:15 am, a staff person stated: "Sometimes it (Resident 66's assault) happens very quick. He's very territorial. We moved beds away. We tried to move a very quiet resident next to him but he hit him too. We have one CNA in front and one CNA in back (of the ward), but the CNAs have to do patient care, and then there's only the licensed staff to watch. And today we have in-service and 2 CNAs have to go. If (only) we had another staff person it would help. Sometimes it's just not possible to prevent them from hitting other residents. We try, but unfortunately things happen."

Review on 2/10/06 of the facility's Policy and Procedure, File:20-13 Revised 7/29/05, Abuse Prevention, Identification, Investigation and Response revealed: "Laguna Honda Hospital (LHH) shall promote an environment that enhances resident well-being and protects residents from abuse and neglect. Policies: #1. It is the responsibility of all LHH employees and volunteers to protect all residents from physical,
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| F 224    |        |     | Continued From page 41 psychological, fiduciary and verbal abuse and neglect."
|          |        |     | The facility failed to implement their own P&P to protect all residents from physical and psychological abuse when they neglected to protect three residents from Resident 66's assaults. (Cross reference F-353.) |
| F 224    |        |     | 4. Resident 26 was originally admitted to the facility on 1/10/05 and readmitted on 4/29/05 with diagnoses including dementia, congestive heart failure and hypotension. Her 1/10/06 MDS indicated she had short and long-term memory and severely impaired cognitive (reasoning) problems. She had mood and behavior problems of restlessness, wandering, physical abusiveness, and resisting care. She was able to get out of bed, walk and eat, but needed extensive assistance to dress and bathe. She had physician's orders for Risperdal .25 mg every evening, and Trazodone 25 mg every 12 hours whenever necessary for agitation. |
|          |        |     | She had a 7/26/05 care plan for: "At risk for being a target of others' aggression as evidenced by wandering into other resident's physical space, handling other resident's belongings without their permission." One of the interventions was for staff to: "Maintain line-of-sight by staff." |
| Review of the Integrated Progress Notes, dated 7/28/05 at 6 am, revealed: "Resident got hit by other resident (as she was) walking on the ward. Resident 26 came in her way and a new resident started hitting her." On 8/15/05 at 5 PM, She was found to have a: "Bruise noted on the right forehead measuring 2" x 2". Cause unknown." The RN assessment stated: "Resident has the
F 224 Continued From page 42

habit of bending down under tables and chairs and beds collecting shoes, pillows, etc and might have bumped her forehead." On 10/24/05 at 8:30 PM, the notes stated: "Res. was lying on her bed when another resident went to her and was heard by CNA talking and arguing and both were tugging along the comforter. Both of them were separated. Resident 26 stayed at her bed with her privacy curtains drawn while the other resident was redirected to her bed. After approx. 5 minutes, CNA heard both residents arguing again. This time Resident 26 was sitting on the floor 2 ft. to (sic) her bed while the other resident was standing next to her holding the comforter. Resident 26 was found with a bump on her (L) jaw with 2 superficial cuts about 0.5 cm each with minimal bleeding. She also sustained a bruise with purplish discoloration on her forehead 3 x 2 cm and a bump at the back of her head 4 x 5 cm with purplish discoloration. Resident was pointing at her left jaw and grimacing."

Observation on 2/7/06 at 11:45 am revealed Resident 26 sitting in a chair beside the bed of another resident and another resident sitting in a chair near a TV. They were speaking together in a non-English language. Resident 26 looked up and smiled and nodded at the surveyor and continued speaking in the non-English language. She was neatly dressed in slacks and shirt and seemed alert.

In an interview on 2/15/06 at 4 PM, a licensed nurse was asked about Resident 26's altercation with another resident on 10/24/05 at 8:30 PM when Resident 26 sustained bruises on her jaw and back of her head. The nurse stated: "No-one witnessed it. Staff were putting residents to bed. Staff heard something and found the resident on
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| F 224 | Continued From page 43 | the floor with the curtain pulled around." | | | | | Review on 2/10/06 of the facility's Policy and Procedure, File:20-13 Revised 7/29/05, Abuse Prevention, Identification, Investigation and Response revealed: "Laguna Honda Hospital (LHH) shall promote an environment that enhances resident well-being and protects residents from abuse and neglect. Policies: #1. It is the responsibility of all LHH employees and volunteers to protect all residents from physical, psychological, fiduciary and verbal abuse and neglect."

The facility failed to implement their own P&P to prevent physical and psychological abuse when they failed to maintain line-of-sight supervision of Resident 26 and intervene to protect her from other residents' assaults, causing her to have a bruised right forehead on 7/28/05, and a bumped and bleeding left jaw, a purple bruise on her forehead, and a bruise on the back of her head on 10/24/05. (Cross reference F-353.)

5. Resident 58, a 51 year old male, was admitted to Ward M-6 on 2/1/05 with diagnosis of impulse disorder with explosive personality. Review of his 2/28/05 admission Minimum Data Set (MDS) documented that he had a mental health history, no memory problems, independent decision making skills, highly impaired hearing, a sad, pained, worried facial expression, required supervision for locomotion off the unit, and needed set up help with eating and bathing. The 7/28/05 quarterly MDS documented that the resident had a mental health history, no memory problems, independent decision making skills, a sad, pained, worried facial expression, independence in all activities of daily living, and

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Review of the 9/9/05 Discharge Summary revealed that this was Resident 58's second admission to the facility. The resident was described as having a long history of behavior problems, alcoholism, homelessness and recent deafness. He was originally admitted to the facility on 10/27/04. "He was bitterly unhappy," displayed acting out and menacing behavior, and required an involuntary transfer to the general acute care hospital on 11/3/04. After some time at the acute "as there was no ideal ward for him," the resident agreed to try an unlocked ward at this facility, and "special arrangements were made for this despite the fact that he had no skilled nursing needs."

The documented plan was: "we will attempt to keep this patient calm, happy and nonfrustrated on M-6."

The discharge summary also documented that the resident was evaluated by orthopedics for a long standing complaint of left shoulder pain. Occupational therapy evaluated the resident on 3/21/05. Therapy was recommended but the resident would not comply with exercises. The medical record documented a variety pain management regimes based on resident complaints. Medication Administration Records document that the resident was most consistently receiving two tablets of Vicodin every four to six hours. A psychiatric progress note, dated 8/1/05, documented: "he's been here 6 mos (months) now & (and) apparently gets demanding esp. (especially) of pain meds, sometimes yelling/screaming 1-2X/wk (one to two times per
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| | | Social Services Note/Quarterly Assessment dated 5/11/05 documented that Resident 58 did well on M-6 this quarter. He was cooperative with care, pleasant and not verbally abusive. It also documented: "he does not need SNF (skilled nursing facility) level of care. Res (resident) desires discharge. Goal is to discharge to a B & C (Board and Care). Goal this quarter is for resident to visit a B & C with MSW (social worker)."
| | | Nurses notes, dated 6/23/05, documented that the resident was banging his door and bedside table when told his Vicodin was given just two hours ago, and he was told that such aggressive behavior was not acceptable.
| | | On 5/31/05 Resident 58 was seen for neuropsychological evaluation to assess Board and Care placement. The report documented that the neuropsychology service: "support TCM (Targeted Case Manager) and the IDT's (Interdisciplinary Team) plan of discharge to a Board and Care facility..." A "Focused Progress Note," dated 7/22/05, documented that the resident had gone out to smoke, and propped the door open with an orange cone. When Security attempted to explain that he could not do that, the resident was heard yelling: "stop pushing me, stop hitting me." There was an allegation that the security officer struck the resident in the thigh. Resident 58 went out on pass with his family for the day.
| | | Activities note, dated 7/27/05, documented the resident was angry at the lunch time bus trip "because the food we ordered at Burger King was..."
Continued From page 46

not enough for him" and "Res (resident) cheeseburger was not to his liking & (and) threw it in the garbage."

Nursing Note, dated 7/27/05, documented that Resident 58 was "agitated," he informed the day nurse "he thinks his Vicodins for pain are Bayer ASA (aspirin)," and was "in his room and door slamming."

Nurses notes, dated 8/21/05 at 4:15 P.M., documented that the resident: "had physical aggression banging and hitting the door going to the first ward when told that his Morphine SO4 (sulfate) was just given at 3pm." At 6:40 P.M.: "screaming-come to nurses station threw his jacket yelling that he broke an egg that someone had put in his pocket in his jacket that he wears to go out to smoke." "Yelling and noisy...I'm going to kill that son of the bitch." The note went on to document that he continued yelling, cursing, and banging doors. Resident told staff he was the one who put the egg in his pocket. When staff informed the resident that the doctor would be called if kept up the unpredictable behaviors of yelling, bumping and kicking doors, the resident told staff "he did not do wrong."

Nurses note, dated 8/24/05, documented that Resident 58 was mad, banging & (and) slamming the door because he was asking for his pain pills. When the licensed staff offered him the Vicodin "he was so mad, he stated that he already talked to the MD (doctor) to change it."

Another note, dated 8/24/05 at 11am, documented that the resident's family was informed that there has been several documented incidents indicating escalated and agitated
behavior around demands with medications. The family apparently stated that his history of pain medication dependency was an issue that created an aggressive and agitated situation.

Nurses notes, dated 8/25/05 at 12:50am, documented that the resident walked to the nurses station and asked for his pain medication. When informed it was too soon, he started yelling, screaming, and threatening staff. He then went back to his room, banging the door.

A Focused Progress Note, dated 8/26/05, documented that the resident wanted his medication, and when he could not get it he got mad, yelling, "struck staff with his fist," gestured, "I'll hit you and I'll see you all in court with my lawyer." The Sheriff was called. Resident 58 was calm when talking with the Sheriff.

Nurses note, dated 8/31/05, documented that the resident became verbally abusive, threatening resident- "I'll beat you too," talking and yelling loudly. Resident left the ward before staff could speak with him about his behavior. Nurses note, dated 9/1/05, documented that the staff heard a noise, went to his room and found a dinner tray scattered at the entrance of his room door.

Nurses note, dated 9/2/05, documented resident with inappropriate behavior cursing, yelling, banging the door. Nurses note, dated 9/4/05, documented staff attempted to collect urine for a drug screen, but the resident refused twice.

Nurses note, dated 9/4/05, (Monthly Summary) documented he continued with his inappropriate behavior. "He gets demanding especially of pain meds (medication) yelling, screaming, sometimes refusing care"; "has menacing behavior when
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER:** LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

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<td>Continued From page 48 Staff is busy and cannot immediately meet his request; he will yell, slam doors, threaten staff, and also noted accusing other people of stealing his things. The note went on to document that, with the care plan of having the Sheriff make rounds on the ward at 5pm, Resident 58 had not had aggressive behavior since 9/2/05. Nurses note, dated 9/5 and 9/6/05, documented episodes of yelling, screaming and demanding his pain medications. On 9/6/05, Resident 58 went out on pass by himself, did not return at the designated time, and was discharged from the facility. A day later, on 9/7/05, the facility admitted him for the third time. He became very upset because he thought someone had moved or taken his belongings. Staff reported he was yelling, slamming doors, and threatening to kill people. At 3:30 pm, Resident 58 was placed on an involuntary hold as being a danger to others, and transported to the general acute care hospital. The facility's &quot;ADMISSION TO LHH AND RELOCATION&quot; Policy, File: 20-03 Revised November 22, 2005, documented that LHH will accept and care for only those San Francisco residents who meet skilled nursing facility (SNF) or acute care criteria, and for whom they are able to provide care. The facility's Policy and Procedure, File:20-13 Revised 7/29/05, Abuse Prevention, Identification, Investigation and Response documented that &quot;Laguna Honda Hospital (LHH) shall promote an environment that enhances resident well-being and protects residents from abuse and neglect. Policies: #1. It is the responsibility of all LHH employees and volunteers to protect all residents from physical, psychological, fiduciary and verbal abuse and...</td>
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**STREET ADDRESS, CITY, STATE, ZIP CODE:** 375 LAGUNA HONDA BLVD.
SAN FRANCISCO, CA 94116

**ID NUMBER:** 555020

**NAME OF PROVIDER OR SUPPLIER:** LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 375 LAGUNA HONDA BLVD.
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**ID NUMBER:** 555020
F 224 Continued From page 49
neglect." The facility failed to follow their own P&P when they failed to protect the other residents from Resident 58's physical, psychological and verbal abuse after the facility admitted him for the third time.

6. Resident 8 was readmitted to the facility on 10/3/05 following a near death drowning on Ward E-6 on 9/26/05. Prior to that date, the resident had lived at the facility since 1995. He was last admitted to the acute care facility in 2001 after a similar near death drowning incident at the facility. The resident's diagnoses included mental retardation with agitation.

The discharge summary documented that Resident 8 was stable until around the middle of the year (2005) when the resident began to be more invasive with particular patients. Interview with licensed staff on 2/7/06 revealed that Ward E-6 residents had been relocated for renovations to Ward E-3, and during this time the resident's behavior escalated. "Right outside of the ward was an area where a lot of other residents hung out; people teased (Resident) and he didn't know how to react."

The discharge summary, dictated by the primary care doctor, also documented: "we had many, many meetings and discussions about how to manage this patient. At this point I recommended a sitter from 5 p.m. to 9 p.m. to prevent problems; however, this was unable to be arranged."

The Quarterly Activity Progress note, dated 2/2/05, documented that, because of his mental retardation, his social isolation with other residents has been limited, and at times he has gotten into arguments.
## SUMMARY STATEMENT OF DEFICIENCIES

### EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION

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**Nurses notes, dated 3/23/05, document that there was a complaint about the resident's behavior from a volunteer in the library, that the resident "again is causing problems...tearing up magazines, books...and throwing them into the garbage can." "According to the volunteer, he apparently had stopped the behavior for about 6 months but now he is doing it again."**

**Nurses note, dated 3/30/05 at 7pm, documented that IP (Institutional Police) reported that the resident "has been assaulting and sexually exposing himself to female cadet."** Nurses note, dated 4/7/05 at 5:10pm, documented that the female cadet came to the ward asking staff to help get the resident out in the hall; the resident was coming into the ward and was verbally loud, pointing fingers at the female cadet. Medication was administered for agitation. Resident continued to be aggressively resistive when the cadet was attempting to leave the ward. The Sheriff came and attempted to bring the resident off the hallway so the cadet could leave, "but the resident continue to get physically aggressively resistive."

**Nurses note, dated 4/8/05 at 3:15pm, documented that the Senior Deputy stated: "a police report will be filed on (Resident) because of the threat for the safety of the female cadet..."** Nurses note, dated 4/12/05 at 8:35am, documented that the resident was witnessed to slap another resident on his right arm. The other resident hit Resident 8 on the back on his left shoulder. A nurses note, dated 4/12/05 at 7:30pm, documented that the nursing office called the ward to have staff go to the fifth floor because the resident, "was very loud, pointing his
Nurses note, dated 6/15/05 at 10AM, documented that the resident's doctor and Interdisciplinary Team met on this date and a "sitter will be assigned to (Resident) on days that the cadet is on." Nurses note, dated 6/16/05 at 4pm, documented that "sitter will be provided for 5pm-9pm." Nurses note, dated 6/16/05 at 6pm, documented that, "sitter order discontinued by Dr. (Medical Director)."

MSW (Social Service) Note, dated 6/25/05, documented that a meeting was held on 6/22/05 with IP (Institutional Police), GGRC (Golden Gate Regional Center), IDT (interdisciplinary team), Administrator and Nursing Supervisor. The "IP had a long list of resident's negative interactions with others". Decisions were made to "GGRC will actively look for alternative placement (difficult to find nonambulatory setting for young res. (resident) with behavioral issues)." Another decision was "Team will support and monitor res. (resident). MSW Note in an addendum to 6/25/05 on 7/1/05 documents that it was "also discussed.
Continued From page 52

at the team meeting that sitter will be reconsidered if needed."

Nurses note, dated 6/30/05 at 9:45 pm, documented that IP came to the ward with the resident "whom he reported as being disruptive in the hallway on the third floor" and "cornered the staff by pushing the table."

A Focused Progress Note, dated 7/11/05 at 7pm, documented that the resident was loud and yelling on the elevator, and another resident told him to "shut up," and claimed he hit her on the back of her head. The note also documented she hit his face, hitting him on his head. The other resident, "claimed (Resident) suddenly fell off his w/chair (wheelchair) to the floor." A body check was done, and there was no apparent injury.

MSW Note, dated 7/13/05, documented that the MSW will inform GGRC regarding the event of 7/11/05, and stress the importance of relocation. The note also documented: "Ward will ask for sitter 1:1 until bedtime" and "Team will ask for meeting with the administration."

Nurses note dated 7/13/05 at 10AM documents that the abuse on 7/11/05 was unsubstantiated. "He has behaviors that provoke other residents."

Nurses note dated 7/17/05 at 7:30A documents that while resident passing by other residents-points his finger "states don't hit me, stay away from me."

SW Note dated 7/20/05 documents that the MSW contacted GGRC regarding placement and was told there are no nonambulatory Board and Care Homes in the area. "MSW requested state-wide..."
Continued From page 53

search.

A Focused Progress Note dated 6/4/05 documents that loud voices were heard outside the ward. The resident was found entering a working elevator saying "no one is going to hit (Resident) and left. Another resident was yelling that the resident had hit him and pointed his finger in his face. The nursing supervisor reported that the resident was with her complaining to her. The resident returned to the ward "with new unseen before scratches to his right anterior forearm."

Nurses note dated 8/6/05 at 4:05AM documents that the resident was "awake, irritable mumbling to himself, asked to shut off very loud television. No one is going to tell (Resident) what to do. Came to find me on the Nurses Station pointing his finger in my face. No one tells (Resident) what to do I am going to tell you hit me".

Nurses note dated 9/26/05 documents that the resident was found submerged underwater in the bathtub, unconscious with noisy gurgling, intermittent breathing when pulled out of the water.

The resident was readmitted on 10/3/05. The Admission History and Physical dated 10/3/05 documents that there was no identifiable cause for the submersion in the tub and that the resident survived without apparent neurological damage. The plan is to have another IDT meeting about the patient on Wednesday and try to at least decrease the possibility of a recurrence of this near drowning.

Interview with licensed staff on 2/7/05 revealed
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 224</td>
<td>Continued From page 54 that the resident is assigned a sitter when he returns from his day programs, Monday through Friday, 5pm to 9pm. The IDT Meeting Note dated 11/23/05 documents that the Quality Management staff attended the meeting in addition to the team members to review the current care plan. The plan includes &quot;sitter will continue with emphasis on trying to wean resident of this plan. Sitter will begin observing from a distance to see how resident behaviors w/out (without) being noticed. IDT will f/u (follow up) on plan in next month.&quot; An Interdisciplinary Team Meeting Note dated 10/19/05 documents that the resident was observed hitting another resident. Nurses note dated 10/22/05 documents that the resident had apparently struck two residents without provocation. Nurses note dated 11/2/05 at 7:45pm documents that resident is &quot;very agitated coming in and out of Nurses Station and pointing finger.&quot; &quot;He is now irritable and very intrusive.&quot; Nurses note dated 11/4/05 at 11:35pm documents that the resident is with mild agitation and complaining that someone is bothering him. Nurses note dated 11/8/05 at 1AM documents that he awake, got up in his wheelchair and went outside the unit, talking to himself. 2:15 Back to ward came to nurses station shouting at the staff, went to BR (bathroom). Medication was administered &quot;for agitation.&quot; The resident continued talking to himself in loud manner but then calmed down and went to bed at 4:30 AM.</td>
<td>F 224</td>
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Nurses note dated 11/14/05 documents that the resident fell out of his wheelchair at the day program.

Social Service note dated 11/15/05 at 8:45 AM documents that staff from the resident's day program left a message that the resident was "not focused" and had increased agitation which has been a change from the last two to three weeks.

Nurses note dated 11/15/05 at 10:20 PM documents that resident is easily agitated and is accusing another resident of hitting him but the staff are closely watching him and he was never struck by anyone.

Nurses note dated 11/30/05 at 10:30 PM documents that the supervisor was asking staff to come and pick up the resident on the fifth floor nursing office as he was noted to be agitated and was pointing his finger yelling nobody will hurt (Resident).

Nurses notes dated 12/2, 12/3, and 12/8/05 at 10pm documents that the resident tends to wander around after 10pm. Nurses note dated 12/4/05 at 9pm documents that he is wandering after 9pm despite staff attempts to redirect and/or provide activities and food for him.

Nurses note dated 12/11/05 documents that the resident is "very agitated-threatening to hit me with his fist."

Nurses note dated 12/12/05 at 10:30 PM documents that resident continues to wander around. Staff provided him with food, music, privacy "the more resident get agitated." The
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<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td>NAME OF PROVIDER OR SUPPLIER</td>
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<td>A. BUILDING</td>
<td>02/21/2006</td>
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<td>LAGUNA HONDA HOSPITAL &amp; REHABILITATION CTR D/P SNF</td>
<td>STREET ADDRESS, CITY, STATE, ZIP CODE</td>
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### SUMMARY STATEMENT OF DEFICIENCIES

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<td>F 224</td>
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<td>Continued From page 56 resident goes out of the ward and then returns in ten minutes.</td>
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<td>Nurses note dated 1/16/06 at 1 AM documents that the resident is &quot;awake, turning tv on, turning channels, asked to turn the tv off. Very aggressive pointing swearing.&quot; &quot;You hit (Resident) yesterday. Resident was in the hospital he is very ill.&quot; He was given a prn (as needed) medication after offering nourishment. He was then off the unit in his wheelchair with his PJs (pajamas) on.</td>
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<td>Nurses note dated 2/8/06 at 12:30 pm documents that the resident's sitter reported that the resident got agitated last night when another resident in the hallway on the fifth floor told him (Resident) &quot;you're crazy.&quot; Resident had an episode, witnessed by his sitter, of sliding self down from his wheelchair.</td>
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<td>Review of the facility's Policy and Procedure, File:20-13 Revised 7/29/05, Abuse Prevention, Identification, Investigation and Response revealed: &quot;Laguna Honda Hospital (LHH) shall promote an environment that enhances resident well-being and protects residents from abuse and neglect. Policies: #1. It is the responsibility of all LHH employees and volunteers to protect all residents from physical, psychological, fiduciary and verbal abuse and neglect.&quot; The facility failed to implement their P&amp;P to protect all residents from physical, psychological and verbal abuse and neglect. (Cross reference F-353.)</td>
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7. Resident 55 was admitted to the facility on 12/17/91 with diagnoses of seizure, hemiplegia, alcohol and substance abuse. The MDS, dated 1/10/06, documented she was alert, oriented x3,
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SAN FRANCISCO, CA 94116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

F 224 Continued From page 57

Verbally responsive, and had behavior problems of verbal and physical abuse of other residents.

The 9/27/05 nursing notes documented that the housekeeping supervisor reported that a porter witnessed a male resident from CH South-300 touching Resident 55's breasts in the day room on the first floor. "According to the report, Resident 55 said this has been happening everyday in the dayroom while playing the computer. Asked if she wants to press charges & she said 'no.' 'I just want him to stop.' No injuries noted. Encourage resident to report if it happens again." The nursing notes also indicated that Resident 55 did not want to press charges and just wanted the male resident to stop. She stated she was embarrassed about the incident.

Review of the revised Behavioral Plan, dated 11/09/06, documented: "Resident 55 sometimes engages in excessive physical intimacy in public areas with her man friend. Goal: Resident 55 will not engage in excessive physical intimacy with others while in public areas. She will go to more private areas, such as outside the building, to do so. Plan: She will be redirected to a more private area, such as outdoors. She will be advised of the availability of a privacy room in the main building."

Observation during the survey on 2/05/06, 2/08/06, and 2/15/06 revealed Resident 55 in wheelchair going in and out of the unit. She was alert and verbally responsive, and continually wheeled herself back and forth when she talked to the staff or other residents. When asked how the staff monitored Resident 55 when she was out of the unit, the nursing staff person said "she usually tells the nursing staff where she goes."
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Resident 55 had a history of being physically and verbally abusive to other residents, non-compliant with smoking restrictions, and having sex with male residents. Due to lack of supervision and monitoring by the facility staff, Resident 55 was physically and verbally abused by other residents. She had altercations in which she hit other residents. She was inappropriately touched several times by a resident in the presence of other residents and she stated she was embarrassed.

Review on 2/10/06 of the facility's Policy and Procedure, File:20-13 Revised 7/29/05, Abuse Prevention, Identification, Investigation and Response revealed: "Laguna Honda Hospital (LHH) shall promote an environment that enhances resident well-being and protects residents from abuse and neglect. Policies: #1. It is the responsibility of all LHH employees and volunteers to protect all residents from physical, psychological, fiduciary and verbal abuse and neglect." The facility failed to implement their own P&P to protect all residents from physical and psychological abuse when they failed to protect Resident 55 from another resident's inappropriate touching. (Cross reference F-223, F-250 & F-353.)

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<td>483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS</td>
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The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a
The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to protect individuals from abuse and neglect during three investigations of abuse allegations. (Residents 63, 58, and 8).

Findings:

1. On 2/6/2006, the following written evidence of court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

...
### Continued From page 60

The facility had handled an allegation of abuse was reviewed to determine if the facility had protected residents during an investigation. This summary of an alleged abuse revealed the following:

A Registered Nurse, R.N. reported on 12/29/2005 at 10:00 A.M. that she saw and heard a named Certified Nursing Assistant (CNA) slap Resident 63 on the left leg and right buttock. As a result of the preliminary abuse investigation, the Nurse Manager who had conducted the investigation reported to the Federal surveyor on the morning of February 6, 2006 that the results of her preliminary investigation supported the abuse allegation. This investigating Nursing Supervisor reassigned the alleged CNA to work with other residents on O6 until this CNA's shift was completed at 4:00 P.M. on 12/29/2005. Evidence was lacking as to how the investigating supervisor considered the severity of this R.N.'s witnessed physical and verbal abuse allegation and the investigating circumstances of this case in complying with the Federal requirement: "Must prevent further potential abuse while the investigation was in progress." After completion of her shift at 4:00 P.M. on 12/29/2005, this named CNA did not have contact with residents from O6 until the investigation was completed.

The morning of 2/7/2006, the Director of the Quality Management Department and this Nursing Supervisor were interviewed about the facility's response to the Registered Nurse's allegation that she had witnessed a CNA physically abuse Resident 63.

The Director of the Quality Management Department
Department and this nursing supervisor revealed that the nursing supervisor was new in her position on 12/29/2005 and did not know whether to retain the CNA with her current assignment to the O-6 unit or give this involved employee an interim reassignment pending completion of the full investigation.

Documented evidence was lacking of any protections instituted in order to insure the safety of the residents, from 10:30 A.M. until 4:00 P.M. on 12/29/2005, who resided at O6 in response to the physical abuse allegation reported.

When asked, the Director of the Quality Management Department stated the facility had 14 allegations of staff to resident abuse between the dates of September 1, 2005 and January 31, 2006.

2. Resident 58 alleged that he was pushed and struck by a facility sheriff officer. According to the facility "SUMMARY OF ALLEGED ABUSE PRELIMINARY INQUIRY" the registered nurse and physician physical exam "found a red mark on the back of resident's thigh about 11 cm (centimeters) long and somewhat elevated. "The MD" note addressed the red linear mark, "probable stick injury." According to this report the abuse was not substantiated because the exam six hours later did not reveal any bruising or redness; the resident has bilateral deafness that makes it challenging to communicate with, in addition to his underlying aggressive tendency related to his diagnoses (alcoholism, brain injury, dementia—all these attributes make him very prone to overreact and frequently leads others (who are unfamiliar with his diagnoses) to perceive him as aggressive and belligerent. The
### Statement of Deficiencies and Plan of Correction

**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

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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
<th>Date Survey Completed</th>
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| F 225        | Continued From page 62 report also documents that the officer might have interpreted his behavior that morning as aggressive and non-compliant and proceeded to applied law enforcement protocols based on his training, which are appropriate since the officer has no knowledge of the resident's medical background. In an interview with the Director of Quality Management on 2/9/06, the surveyor was informed that the incident had been investigated by the San Francisco Sheriffs Department and because of their report, the incident was unsubstantiated. This report was not provided to the surveyor as "it is at the SF Sheriff's Department." 3. Facility self reported incidents for Resident 8 documents that on 7/11/05, Resident 8 struck a cognitively intact resident. The investigation conclusion was the abuse was unsubstantiated. The analysis documents that Resident 8 has cognitive impairment, history of difficult behavior that can provoke others. "He is MCI (Missing Considered Incompetent). The victim is alert, oriented X3 (person, place, time) lost her patience and hit him back". On 8/4/05 he hit a cognitively intact resident. The investigation conclusion was the abuse was unsubstantiated. On 10/16/05, Resident 8 was witnessed hitting a resident. The investigation conclusion was "abuse unsubstantiated."
| F 225        |                                                                                                  |              |                                                                                                  | 02/21/2006           |
### Statement of Deficiencies and Plan of Correction

**Provider/Supplies Identification Number:** 555020

**Multiple Construction:**
- **A. Building:** 
- **B. Wing:** 

**Date Survey Completed:** 02/21/2006

**Name of Provider or Supplier:** Laguna Honda Hospital & Rehabilitation CTR D/P SNF

**Street Address, City, State, Zip Code:**
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- San Francisco, CA 94116

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On 10/22/05, Resident 8 was witnessed to strike two different cognitively intact residents without provocation. Investigation conclusion was "abuse substantiated."

In an interview on 2/17/06 at 3:30 P.M., the Director of Quality Management revealed that the facility "does not consider it abuse if it is not a willful act; a cognitively impaired resident cannot be willful." The Director stated that the incidents are considered "aggressive problem behaviors." The Director stated that these episodes are collected by the Threat Assessment Team and are examined for repeat offenders, location, time of day, and review of care planning. The Director did not provide any additional documentation of these incidents by the time of the survey exit conference on 2/21/06. Since the facility only considered investigating the possibility of "abuse" and did not consider these incidents as mistreatment, the facility failed to protect residents from further incidents.

**483.13(c) Staff Treatment of Residents**

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
- Based on observation, interview and record review, the facility failed to accurately develop and implement five of the seven required components of the facility's Abuse Prevention, Identification,
F 226 Continued From page 64

Investigation and Response Policy, (training, prevention, investigation, protection and reporting) for three of 96 sampled residents. (Residents 77, 63, and 83).

1. The facility failed to provide SMART Training on appropriate interventions to deal with aggressive reactions of residents to one CNA on L-6 before she was injured by an assaultive resident (Resident 77) on 10/15/05.
2. The facility failed to provide one licensed nurse and two CNAs assigned to work on K-6 on 2/9/06, and one CNA assigned to work on K-6 on 2/16/06 with SMART Training.
3. The facility failed to adequately develop and operationalize the second component of their 7/29/05 abuse policy, "Training," by failing to state that they would have procedures to train ALL staff, not just CNAs, and failed to state that the training would include appropriate interventions to deal with aggressive reactions of residents.
4. The facility failed to develop and/or fully implement four key components to prevent abuse and neglect: prevention (Resident 63), investigation, protection and reporting.
5. The facility failed to operationalize the reporting component of its abuse policy for Resident 83.

Findings:

1. Resident 77 was admitted to the facility on 4/22/04 with diagnoses including organic brain disease, diabetes, and delusions. She had a 10/27/05 physician's order for Seroquel (an antipsychotic medication) 75 mg at 7 am, 75 mg at 1 PM, and 100 mg at bedtime every day for delusions. She had a 1/12/05 care plan for: "Behavioral symptoms with agitation, aggression,
Continued From page 65

accusatory (staff or family stealing her belongings)," and "acting violent (yell, threaten, physically confront) R/T (related to) OBD (organic brain disease) with delusional thought."

Review of the facility's 10/18/05 "Summary of Resident to Staff Aggressive Behavior" revealed that on 10/15/05 at 1:30 pm, Resident 77: "without provocation suddenly grabbed (CNA's) (L) breast. She was observed restless and at the moment thought that (the CNA) was her niece."
The form also stated that Resident 77: "had the belief thoughts that the CNA was her niece who she was upset at ('You sold my house...')." "Yes" was checked following the question: "Was the staff injured?"

Observation on 2/15/06 at 1 pm revealed Resident 77, a heavy-set woman in a wheelchair, wheeling herself in the hall. She responded verbally and seemed confused.

In an interview on 2/16/06 at 10 am, the CNA who was assaulted and injured by Resident 77 on 10/15/05 on L-6 stated: "The resident grabbed my breast hard. She thought I was her niece and kept telling me "you sold my house!" It hurt my breast and I had a large bruise." When asked, she said she did not have the SMART (Safety Management and Response Techniques) Training before the assault. (SMART Training teaches staff how to safely manage residents with assaultive behavior in order to keep themselves and other residents safe.)

Review of the facility's 3/21/05 Annual Recertification Survey Statement of Deficiencies revealed that the facility received a deficiency last year for failing "to provide all staff with training
necessary to safely manage residents with assaultive behaviors and recognize the signs of their escalation." The deficiency stated: "Most facility staff, especially those on units K-6, L-6, C-3 and Clarendon Hall 200 lacked training to handle residents with a history of assaultive behavior toward staff and other residents." On 6/7/05 the facility submitted the following Plan of Correction for the deficiency: "Educational curriculum will be drafted and education will be provided to staff on K-6, L-6, S200, and O-4 to enhance staff knowledge around identifying triggers of violence, recognizing escalation and signs of impending danger, staff strategies to deal with staff's own response. The hospital has adopted the Safety Management and Response Training Program (SMART) to implement at (the facility)." The completion date the facility's Plan of Correction stated this training would be operationalized was 4/20/05.

In an interview on 2/16/06 at 11 am, the facility's Director of Nurses (DON) stated the CNA injured by Resident 77 on 10/15/05 on L-6 did not receive SMART Training until 12/2/05. When asked why the CNA, who was assigned to a high risk unit, did not receive the training until 12/2/05 when their 2005 Plan of Correction said all staff on K-6, L-6, C-3 and Clarendon Hall 200 would receive it by 4/20/05, the DON said the facility could not start the training before October 2005 due to "scheduling problems" and because they "couldn't find a room."

Even though she was assigned to L-6, a high risk unit where she was required to care for aggressive, violent, and physically confronting residents, the facility had not provided one CNA with the SMART training before she was
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<th>COMPLETION DATE</th>
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<td>F 226</td>
<td>Continued From page 67</td>
<td>assaulted and injured by Resident 77 on 10/15/05.</td>
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<td>2.</td>
<td>During the survey on 2/9/06 at 4:15 pm, a licensed nurse and two of the three CNAs assigned to work that evening on the high risk unit, K-6, stated they had not received the SMART training. On 2/16/06 at 2:30 pm, one of the three CNAs assigned to work that day on K-6 stated she had not received the SMART Training.</td>
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<td>In an interview on 2/16/06 at 11 am, the facility's Director of Nurses confirmed that the above staff had not received SMART Training because they were newly hired.</td>
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<td>3.</td>
<td>Review of the facility's abuse policy entitled Abuse Prevention, Identification, Investigation and Response Training revealed that the second component of their 7/29/05 policy, Training, stated: &quot;DET (Department of Education and Training) provides additional abuse prevention training to CNAs, including recognition of catastrophic reaction in residents.&quot; The facility's policy failed to state that the facility would have procedures to train ALL employees, not just CNAs, and failed to include that they would train them about appropriate interventions to deal with aggressive and/or catastrophic reactions of residents,&quot; not just about how to recognize a catastrophic reaction.</td>
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<td>4.</td>
<td>The facility failed to develop and/or fully implement four key components of a systemic approach to prevent abuse and neglect, including prevention, investigation, protection and reporting. When asked on 2/5/2006, the Director of Quality Management stated that the facility had self reported 130 cases to the California Department</td>
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of Health Services of alleged abuse and neglect, including resident to resident altercations, staff to resident alleged abuse, and resident to staff aggression between the dates of September 1, 2005 and February 5, 2006.

a. Prevention
The facility failed to develop and implement the prevention component of their Abuse Prevention, Identification, Investigation and Response policy by failing to provide residents families and staff with the name of the current Executive Administrator to whom they could report concerns. Also, the facility failed to develop a formal system to provide feedback to staff concerns.

b. Investigation
The facility's Abuse Prevention, Identification, Investigation and Response policy failed to stipulate the process to be implemented for the thorough investigation of injuries of unknown origin that included all residents of the facility. Injuries of unknown origin were not defined in P&P (File #20-13, revised June 16, 2005).

c. Protection
The facility's system did not protect individuals from abuse and neglect during investigations of an allegation of abuse. The facility failed to develop and implement the protection component of their Abuse Prevention, Identification, Investigation and Response policy by failing to protect the residents on O-6 from abuse on 12/20/2005 from 10:30 A.M. - 4:00 P.M. (See F 225)

d. Reporting
The facility failed to develop in its P&P the
Federal regulation to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility.

1. Prevention:
   a. On 2/6/2006, a review of the facility's policy and procedure did not include the requirement under the regulation (483.13(b)&(c)), the prevention component which requires facilities to provide residents, families and staff with information about how, and to whom, to report concerns, incidents and grievances, and that such reporting should be without the fear of retribution. The regulation also requires facilities to provide feedback to residents, families and staff regarding the concerns they reported. The facility failed to integrate this Federal guidance in the prevention component of their abuse P & P. The Laguna Honda Policies and Procedures, LHPP, contains a section under training entitled Resident Education. It reads: “Residents are presented on admission with a Residents' Handbook that contains information on residents' rights and responsibilities, contacting advocates, and the abuse reporting process. Residents are informed to whom they may report concerns, incidents and complaints.” The Resident Rights was assigned LHPP (File: # 20-18) dated as Revised September 2002, listed the name of a previous Executive Administrator for residents to call or write with a grievance. The present, unnamed, Executive Director had been in this position since November 2004.

The resident Rights form given to each resident (or his representative, or responsible relative) prior to, or upon admission to Laguna Honda.
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 226</td>
<td>Continued From page 70</td>
<td>Hospital, failed to provide the current Executive Administrator’s name with the telephone number to call or write if they wanted to file a grievance and/or report concerns, incidents and complaints.</td>
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<td>b.</td>
<td>A Registered Nurse (R.N.) reported on 12/29/2005 at 10:00 A.M. that she saw and heard a named Certified Nursing Assistant, CNA, slap Resident 63 on the left leg and right buttock. As a result of the preliminary investigation, the Nurse Manager who had completed conducting this investigation, reported to the surveyor on the morning of February 6, 2006 that the results of her preliminary investigation on 12/29/2005 supported the allegation.</td>
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<td>On 1/5/2006 another Nursing Supervisor wrote to the CNA who was named in the abuse allegation officially notifying this CNA that the investigation into the allegation of abuse had been completed. This memo stated: &quot;No evidence to substantiate the abuse allegation was found.&quot;</td>
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<td>When asked at 11:45 A.M. on 2/7/2006 the R.N. who reported witnessing the staff hitting Resident 63, described by facility as demented, told the surveyor that exactly what she had written in her abuse witness report was what she had seen and heard. When asked if she had received any feedback on the final results of the facility’s abuse investigation she said she had not receiving any feedback regarding the abuse she had reported.</td>
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<td>During the afternoon of 2/7/2006, Nursing Management was asked if the had provide any feedback to the RN who had reported witnessing this abuse. Nursing management replied that they had not given any feedback to this nurse.</td>
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After asking the Director of Quality Management how the facility provided feedback to staff, on 2/9/2006 the surveyor was given a memo dated 2/9/2006 addressed to this RN informing her there was no evidence to sustain the abuse allegation.

The facility had no written procedures to provide feedback to the RN or any other staff that had reported abuse or any other related concerns to the facility.

2. Investigation
   The facility's Abuse Prevention, Identification, Investigation and Response policy failed to stipulate the process to be implemented for reporting and for the thorough investigation of injuries of unknown origin that included all residents of the facility. Injuries of unknown origin were not defined in (P&P) (File #20-13, revised June 16, 2005). In an interview with the Director of Quality Management, approximately 9:00 A.M. on 2/10/2006, a blank copy of the Laguna Honda Hospital Quality Management Department Confidential Report of Unusual Occurrence Form F-821 was given to the Federal surveyor. Under the section entitled investigation of (P&P) (File #20-13, revised June 16, 2005) 7.1 reads: "The reporting employee shall complete the "Unusual Occurrence Reporting" form and forward them to the Department of Quality Management." The Director of Quality Management did not produce the policy for review of injuries of unknown origin.

3. Protection:
   The facility's policies are not clear as to how the facility protects individuals from abuse and neglect during investigations of allegations of abuse and neglect. Section 7.0 entitled...
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<td>F 226</td>
<td>Continued From page 72 Investigation of the (P &amp; P) (File #20-13) Section 7.6 reads: &quot;If an abuse allegation involves a Laguna Honda employee and the preliminary investigation does support the allegation, the investigating supervisor/manager may either make an interim reassignment or place the employee on administrative leave, pending completion of the full investigation.&quot; After receiving a report of alleged staff abuse, the facility did not protect the other residents on O6 from staff abuse or neglect between the 10:30-4:00 on 12/29/2005. Based on interview with the O6 nursing supervisor, she stated that after the abuse allegation was reported, the investigating nursing supervisor/manager reassigned the alleged CNA to work with other residents on O6 until her shift was completed at 4:00 P.M. on 12/29/2005. Evidence was lacking as to how the investigating supervisor considered the severity of the allegation and the circumstances of the case per the investigation in complying with the Federal requirement (483.13(c)(3): &quot;Must prevent further potential abuse while the investigation was in progress.&quot; After completion of her shift at 4:00 on 12/29/2005 this named CNA did not have contact with residents from O6 until the investigation was completed. (Cross Reference F. 225)</td>
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**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

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**PREFIX**

**TAG**

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**PREFIX**

**TAG**

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**DATE SURVEY COMPLETED**

02/21/2006
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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SAN FRANCISCO, CA 94116

**DATE SURVEY COMPLETED**

02/21/2006

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<td>F 226</td>
<td>Continued From page 73 requirement 483.13(2) that the facility must ensure that all alleged violations including mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator. This reporting should result in the immediate protection of the residents involved in the incidents.</td>
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Review of section 8.0 entitled Reporting of the (P & P) (File #20-13) revealed the following: Section 8.1 the facility mandates all staff to report suspected abuse to the local Ombudsman Office as required by the State Law. Section 8.2 states that this policy designates the Director of Quality Management as the primary mandated reporter for Laguna Honda Hospital. The Director of Quality Management /designee shall report all resident abuse allegations to the Ombudsman and to the California State Licensing and Certification office within 24 hours.

When asked, by the Federal surveyor on 2/6/2006, the Director of the Quality Management Department, the individual identified by the facility as responsible for coordinating and operationalizing these policies and procedures verified that these written policies and procedures does not direct that all allegations are reported immediately to the administrator.

Upon further interview, the Director of the Quality Management Department shared a copy of the Laguna Honda Hospital and Rehabilitation Center May 14, 2003 training in abuse investigation and reporting. This process included the following slide on Nursing Supervisor Responsibility to: "Notify AOD, Administrator on duty, on weekends, PM's or AM's. and to notify the Department of..."
### Statement of Deficiencies and Plan of Correction

**Tag: F 226**

**Summary Statement of Deficiencies**

*Continued From page 74*

Quality Management.

Review of the September 1, 2005 Conducting Effective Investigations training slides directs staff to complete the Preliminary Inquiry Form for Alleged Resident Abuse and directs that this must be done within 24 hours. The LHH Reporting and Investigation Flow Chart Process reads: "Your duty is to complete the report within 24 hours and route it to the appropriate departmental representatives." This form does not ask the staff to record if or when they reported this to the administrator, immediately, as required. Cross Reference: F- 225.

5. Resident 83 was admitted to the facility on 12/16/05 with diagnoses including progressive myelopathy leading to paraplegia. His 12/27/05 MDS (Minimum Data Set, an assessment tool) indicated that the Resident was alert and oriented and had no memory problem. He also needed assistance from staff when transferring to the bed, and used a wheelchair for locomotion.

On 2/14/06 at 9 a.m. Resident 83 was observed awake, alert, and lying in bed with his breakfast tray in front of him on the overbed table.

During an interview with him at the same time and date, Resident 83 stated that four or five days ago, "a staff punched and kicked" him "in the stomach". He denied any discomfort at the time of the interview and observation.

On 2/14/06, a review of the 2/8/06, 10:35 p.m. Nurses Notes revealed that Resident 83 was extremely agitated. He was screaming and accused staff and patients of "not being nice" and "hitting him with a cane." RN1 notified Physician!...
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<td>F 226</td>
<td>Continued From page 75 about the agitated behavior of the Resident. Physician 1 ordered Ativan 2mg. to be given at 30 minute intervals to calm him down. There was no documented evidence that RN1 notified the nurse manager about the Resident's allegation of abuse.</td>
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<tr>
<td>F 240</td>
<td>483.15 QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.</td>
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This REQUIREMENT is not met as evidenced by:

Based on a group interview with residents, the facility failed to ensure that residents' quality of life was maintained when staff did not answer call
During a group meeting of residents on 2/8/06 at 10 AM, four residents stated that staff were using cell phones and ignoring residents' call lights while they were on the phones. The residents present mentioned in particular the L-7 night shift and evening shift.

During an interview at 1:45 p.m. on 2/15/06, the nurse manager stated that she had not heard about this happening on her unit. She said that the facility had recently distributed a memo restricting cell phone usage for staff, but was not sure if there was a facility wide policy to that effect.

**483.15(a) DIGNITY**

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to promote care for three of 96 sampled residents in a manner that maintained their dignity. (Residents 45, 7, & 87)
1. Staff failure to respond to Resident 45's requests for assistance with her dinner tray resulted in a fall that rendered her blind.
2. Resident 7 was heard yelling, "Nurse, nurse,"
**NAME OF PROVIDER OR SUPPLIER**
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**
Continued From page 77

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only one caregiver was present in the ward, and the resident’s call light alarm was on for 15 minutes with no response from staff.

3. Resident 87 needed a low bed to go to the bathroom independently at night. Because her bed was too high, she had to use the bedpan at night because she was afraid to fall, and the sight of the bedpan full of urine on the overbed table bothered her.

**Findings:**

1. Record review on 2/9/06 revealed that Resident 45, age 92, was admitted to the facility on 1/3/06 and with diagnoses including hip fracture after a fall on 12/14/05 at home, arthritis, cataracts, and depression. Her 1/9/06 MDS indicated her memory was O.K., she was alert and oriented to person, place, and time, had modified independence in decision-making, and impaired vision. She required extensive staff assistance to turn in bed, get out of bed to a chair, move around her unit, toilet, and hygiene. She did not walk, and was totally dependent on staff to dress, and bathe. She needed one staff person’s limited assistance to eat.

Record review on 2/9/06 revealed that Resident 45's 1/11/06 care plan stated: "Resident is at risk for fall." One of the interventions was: "Anticipate needs of resident by checking or asking her what she needs."

Record review on 2/9/06 revealed that on 1/18/06 at 6:45 PM, Resident 47's Integrated Progress Notes stated: "Passed by resident and I saw her standing at the foot part of her bed and fixing her dinner tray. I attended to her and told her we will take care of her dinner tray and I assisted her to..."
In an interview on 2/9/06 at 11:20 am, a supervisory nurse stated: "The PM nurse saw her. She was there when the resident got up, and told her to sit down. The nurse went to the back ward and was passing medications."

In a telephone interview on 2/15/06 at 1:45 PM, Resident 45's daughter stated her mother told her that on 1/18/06: "She kept pushing the buzzer but no-one came and her fwd was sitting there. She wanted to reach for the food. She got up and hit the corner. She was waiting a long time, maybe a half hour, for someone to help her. Her food got cold, and she was tired."

The facility failed to respond to Resident 45's request for assistance with her dinner tray. When Resident 45 turned on her call light at 6:45 PM on 1/18/06, instead of attempting to determine what the resident (who did not speak English) wanted, a nurse told her to sit down, and went in the back ward to pass her medications. The resident, who was alert and oriented with no memory problems, told her daughter she put her call light on for help with her dinner tray, she waited a long time, and her food was getting cold. No other staff were present in the front ward. (Cross-reference: F-272, F-324, F-353, F-463.)

2. On 2/7/06 at 1:30 p.m., Resident 7 was heard yelling, "Nurse, nurse." There was only one caregiver present in the ward at the time the resident was calling for assistance. The call light alarm stayed on for 15 minutes with no response from the staff. When asked, Resident 7 stated that she needed to use the bedpan. The resident stated that she is one of the few residents in the
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<td>On 2/7/06, at 2 p.m., the nurse manager stated there was an abuse in-service training conducted at that time attended by the other staff working in the day shift. There was one caregiver was left in the floor, however she was attending to another resident.</td>
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<td>Resident 7 was admitted in the facility on 1/30/06 with diagnoses of chronic obstructive pulmonary disease, hypertension, osteoarthritis and pancreatitis. The Admission Nursing Assessment dated 1/30/06 indicated the resident was alert and oriented.</td>
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<td>On 2/9/06 at 12:23 p.m., during a phone interview with Resident 7's conservator, she stated that the resident has always been very demanding. She has never worked all her life and thinks that she is &quot;royalty.&quot; She added that she prides herself of her grooming and personal appearance.</td>
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<td>3. On 2/16/06 at 10:30 a.m., Resident 87 thru facility's interpreter stated that she really needed a low bed to be able to go to the bathroom independently. Her husband comes in everyday to make sure that she gets everything ready next to her at night. She stated that she goes to the bathroom during the day and had to use the bedpan at night because she is afraid to fall. She also stated that the sight of the bedpan full with urine placed on the overbed table bothers her.</td>
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| F 242 | 483.15(b) SELF-DETERMINATION AND PARTICIPATION | F 242 | The resident has the right to choose activities,
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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

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schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the residents have the right to choose activities consistent with his or her interests, assessments, and plans of care; and make choices about aspects of his or her life in the facility that are significant to the resident for residents with a primary Chinese cultural and language orientation, and residents in Clarendon hall and in the main building who smoke.

1. 19 of 19 residents in an Asian focus group meeting stated no Chinese menus were provided to them.
2. Sixteen cognitively alert residents in one of two Group Interviews at Clarendon Hall stated there was no sheltered area for residents to smoke.
3. Three residents in the third floor smoking area at the main building stated they had no sheltered area to smoke when it rained.

Findings:

1. On 2/8/06 at 10:30 a.m. during the resident group meeting with the Asian-focused group, 19 of 19 residents stated that there are no Chinese menus provided to them. Eight of eight residents in K5 unit stated that they wanted to know what they were going to have before the meals arrived.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 242</td>
<td>Continued From page 81</td>
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They also stated that there are no Chinese speaking dietary staff that interact with them to determine food likes and dislikes. 19 of the 19 residents also stated that the substitute menu is not translated in Chinese. There are limited food substitutes offered such as rice porridge and tea. The residents informed the surveyors that food is a significant factor in their lives and if they are not satisfied with the food served, they request family members to bring food from home to meet their personal food preferences.

On 2/9/06, an interview with the dietary manager confirmed that none of the facility menus are written in Chinese. They expect the nurses in the units to interpret the food in the menu to the residents. The menus are not written in Chinese because there are various cultural ethnicities in the facility and if one culture is favored all other cultural preferences will demand the same attention.

2. Sixteen cognitively alert residents attended either one of two Group Interviews conducted on 02/08/06. These interviews had residents representing each of Clarendon Hall's three resident floors. The residents in each Group Interview stated the only designated resident smoking areas were outside the building and residents who smoked were required to stand at least 20 feet from the building while smoking. They stated there was an absence of any sheltered areas 20 feet from the building, therefore in inclement weather, residents desiring to smoke would be required to stand in the rain.

On 02/15/2006, at approximately 10:00 AM, while on tour of the general environment of Clarendon Hall with the facility's Director of Quality.
Continued From page 82

Management, Interim Director of Facilities Operations, General Services Manager and the Associate Administrator of Operations, the surveyor discussed the concern while standing outside the former main entrance of the building. The facility's Chief Stationary Engineer acknowledged any areas more than 15 feet from the building were unprotected from rain and stated a shelter would be built and was currently going through a required approval process. Residents in the Group Interviews stated this has been a longstanding problem without resolution as evidenced by the following excerpt to the minutes of the 09/2005 Clarendon Hall Residents Council, "Old Business: There has not been a response regarding the smoking shelters. The council continues to request the response."

3. Observation during the survey from 02/05/06 to 02/21/06 revealed that there was no area provided for the residents at the main building and at Clarendon Hall to smoke when it rains. The residents in the third floor smoking area stated during those days that they had to smoke under the weather in strong wind and rain, and they were upset about it.

F 246

483.15(e)(1) ACCOMODATION OF NEEDS

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and record review, the facility failed to accommodate the need for a bed of appropriate height for two sampled and seven randomly observed residents on Ward K-5. (Residents 87, 86) Two of 96 sampled residents.

Findings:

1. On 2/16/06 at 10:20 a.m., Resident 87 stopped the surveyor and gestured pointing at her bed. Through a facility interpreter, a social worker, Resident 87 stated that she really needed a low bed due to difficulty to transfer to/from bed and wheelchair. She stated that she will be able to go to the bathroom independently. Also, her husband comes in every day to make sure that she gets everything ready within her reach at night. She stated that she goes to the bathroom during the day and had to use the bedpan at night because she is afraid to fall again. A review of the resident's Integrated Progress Notes revealed the resident had two fall incidents, 11/20/05 and 12/2/05.

Resident 87 was admitted in the facility on 2/2/05 with diagnoses of status post left hemorrhagic cerebrovascular accident (CVA) with right hemiparesis, hypertension, hyperlipidemia, depression with anxiety, and status post cataract surgery. The resident is monolingual and speaks Cantonese only.

The annual minimum data set (MDS) dated 1/12/06 revealed the resident has no memory problems and independent with daily decision making. She required limited assistance with one person physical assist to transfer to/from bed and wheelchair. She also required limited assistance.
On 2/16/06, at 10:30 a.m., Resident 86 was observed at the edge of the bed attempting to transfer from the bed to the wheelchair. The social worker who was interpreting for another resident immediately ran to Resident 86's bedside preventing the fall. The surveyor had to summon the nursing staff on the opposite end of the ward to request for more assistance. The social worker pointed out the height of the resident's bed in relation to the resident's height of 62 inches. The resident was having difficulty touching her feet to the floor in order to reach and lock the wheelchair in place. This was confirmed by the charge nurse who stated that the resident was unable to lock the wheelchair due to the resident's inability to transfer safely from bed to wheelchair.

On 2/16/06 at 2:55 p.m., in the presence of the social worker as interpreter, Resident 86's regular bed was measured. The distance from the top of the bed to the floor was 24 inches. The distance of the resident's wheelchair from the top of the cushion to the floor was 20 inches. A difference of 4 inches was confirmed.

Resident 86 was re-admitted on 11/29/05 with diagnoses of arthritis and gout with decreased mobility, end stage renal disease (ESRD) diabetic retinopathy and neuropathy, coronary artery
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
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<th>(X1) PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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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

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<th>(X4) ID PREFIX TAG</th>
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<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 246</td>
<td>Continued From page 85 disease (CAD), status post coronary artery bypass graft (CABG). The resident is monolingual - Cantonese and Mandarin speaking. A review of the Integrated Progress Notes revealed the resident three fall incidents: 12/22/05, 1/1/05 and 2/10/06. On 2/16/06 at 11:15 a.m., the social worker interpreted seven other Chinese-speaking residents' requests for low beds. The seven randomly observed residents all stated that a low bed would help them get in and out of bed to the toilet during the day and at night, and would help them prevent falls. The above indications for low beds were verified with the night shift charge nurse on 2/17/06 at 7:45 a.m.</td>
<td>F 246</td>
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<td>F 248</td>
<td>483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to provide for an ongoing program of activities designed to meet the residents' interests in accordance with the comprehensive assessments of eight (8) Chinese</td>
<td>F 248</td>
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F 248 Continued From page 86

speaking residents on Ward K-5, and limited number of residents on Ward L-5, one resident (Resident 31) on E-3 and residents who watch the large rear projection television in the first floor main activity room at Clarendon Hall.

Findings:

1. On 2/8/06, during the resident group meeting with the Asian focused group, four (4) of eight (8) residents from K5 stated that after the Chinese speaking activity therapist left last year, outings and Chinese-focused activities have occurred less frequently.

A review of the February activity calendar for K5 unit showed Chinese New Year’s Program scheduled on 2/16/06 as a hospital-wide activity. On 2/28/06, a bus trip to a restaurant is scheduled as an outing. The January activity calendar for K5 unit revealed Chinese lantern making on 1/11/06 and cooking class (fried wonton) on 1/25/06. The December activity calendar did not reflect activities for the Asian focused residents in the unit. The activity calendars do not reflect the residents' interests. Residents simply fit into the already established activity calendar.

During the survey, observations were made in the ward with the Chinese speaking residents on 2/7/06, 2/8/06, 2/9/06, 2/10/06, 2/14/06, 2/15/06, and 2/16/06. Four of the eight residents in the group meeting were observed doing morning exercises in the hallway and stayed in the ward after the exercises.

In the resident group meeting on 2/8/06, the four outspoken, alert residents in K5 stated that
Continued From page 87

Although they have one or two activities in the calendar they wanted to go outside of the hospital more often, like stroll in the hospital grounds as the weather permits. On 2/16/06 at 11:15 a.m. two residents stated that on weekends when there are no activities that are of interest to them, they form their own group and create their own activities such as walking outdoors in the hospital grounds.

On 2/8/06 at 1:35 p.m., during a phone interview, the social worker assigned to K5 who speaks Chinese stated that she helps in the activities program as the group interpreter. They also have a Chinese social group that meets twice a month to voice the residents concerns. She stated that she has been conducting these groups since November, 2004 and has never been a part of activity program. She also stated that she participated in the Chinese lantern making activity last January. She also took the residents for an outing to the Tea House on 11/17/06. She stated that she assists in the language interpretation, however, she is not an activity therapist who is trained to meet the activities needs of the residents.

Resident 86's activity preferences were reading Chinese newspaper, music and watching Chinese television programs. The resident was observed on 2/16/06 from 10 a.m. to 10:30 a.m., napping in bed with nothing to do. The social worker stated that Chinese newspapers are either brought in by family or volunteer staff from the Asian focused unit in G4. She also stated that videos and DVDs of Chinese opera and movies are supplied by family members. Chinese radio station 68 is not accessible due to the bad reception in the ward.
F 248 Continued From page 88

On 2/9/06 at 10 a.m., the activity therapist assigned to K5 stated that the activity therapists rotate assignments for K5. She stated that she does not speak Chinese and asks the social worker’s assistance whenever she needs an interpreter. She also stated that most of the activities she conducts are demonstrative type not requiring complex explanations and easy to follow steps by gestures - examples are exercises and arts and crafts.

An interview with the Activity Director on 2/8/06 at 3 p.m. confirmed that K5 and L5 units are shared units. He stated that there are two Chinese speaking activity therapists in the facility - one is assigned on the second floor in Clarendon Hall and one in the Asian focused unit G4. He also acknowledged that the facility has an increasing number of Chinese speaking residents.

2. On 2/16/06, a review of the activity participation book for the residents in L5 unit revealed blank spaces on Sunday 2/5/06 and Monday 2/6/06. A review of the activity calendar for January and February indicated recurring hospital-wide weekend activities that included 10 a.m. Catholic Mass service and 2:30 p.m. Bingo. Interview with the activity therapist in 2/16/06 at 11:30 a.m. revealed the following: She works up to Saturday and she is off on Sundays. The activity therapist assigned for those days should have recorded the list of attendees to the Sunday activities and documented their presence. Residents who are able to wheel themselves around or who request the staff to take them to those activities attend them. There were no provisions for ongoing activities for residents who are bedbound and no families that visit.
The activity participation book also documented 1:1 visits that do not reflect the actual activity the resident engaged in to reflect how meaningful these visits are for the resident. An example is as follows: Resident 76 had 1:1 visits on 2/2/06, 2/7/06, 2/8/06, 2/9/06, 2/10/06, 2/11/06, and 2/15/06. Resident 76, a 43-year old female was admitted on 5/10/2001 with diagnosis of subarachnoid hemorrhage secondary to aneurysm. The MDS dated 12/09/2005 revealed the resident has short and long term memory problems. The resident has communication issues secondary to aneurysm and global aphasia. One activity intervention dated 1/13/05 was to provide verbal and non-verbal cues when communicating in activities. Also the resident will be asked questions pertaining to activities which she will answer verbally "yes" or "no." There were no documented activity plans that reflect the resident's individual interests to bring meaning to the 1:1 visits. On 2/16/05 at 10:00 a.m. Resident 76 was observed alert, pleasant, sitting in a wheelchair watching a cooking show. She is able to answer questions with yes or no responses.

The activity calendar also showed no scheduled activities on holidays with letters TBA (to be announced). Examples 2/20/06 - Presidents Day and on 1/16/06 - MLK.

3. Record review and staff interview revealed that Resident 31 was a 22 year old female admitted on 10/26/2004 with a history of cerebral palsy secondary to meningitis at the age of eight, S/P pulseless electrical activity, seizure disorder, hypothyroidism and adrenal insufficiency.

At 3: 55 P.M. on 2/10/2006, Resident 31 was observed on E-3, sitting alone, in her wheelchair in the area next to her bed. The surveyor...
### F 248

**Summary Statement of Deficiencies**

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<tr>
<th>ID Prefix Tag</th>
<th>Statement</th>
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<td>F 248</td>
<td>Continued From page 90</td>
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- **Resident 31** in the presence of the Certified Nursing Assistant, CNA. Resident 31 appeared to be demonstrating significant psychomotor restlessness, moving the left side of her body voluntarily and flailing her left upper extremity. Resident 31 was agitated and moving around a lot. The CNA stated that Resident 31 is calmer in a group environment with music. But, Resident 31 was by her bed without music at 3:55 P.M. on 2/10/2006. When asked how or where Resident 31 could listen to music, the CNA took the surveyor to another area of the E-3 unit where there was a music player for residents to gather to listen to music. Resident 31 had not been taken to this area.

- When asked at 3:55 on 2/10/2006, the CNA who was assigned to work with Resident 31 from 6-7 A.M. and 3-4:00 P.M. on 2/10/2006 stated that as her assigned CNA she: "Doesn't know what to do for her." The CNA went on to say: "We are learning as we go." The CNA went on to stated that the Activity Therapist does not come on the E-3 unit to work with Resident 31 on Friday afternoons. Note: 2/10/2006 was a Friday.

- Staff and record review on 2/10/06 at 4 PM revealed that Resident 31 was relocated from Unit F5 bed 27 to E3 on 2/2/2006.

- When the surveyor asked if Resident 31 had any activity materials or supplies that she could hold in her hand, the charge nurse and CNA told and showed the surveyor that Resident 31 had only one toy rattle, which was out of her reach.

- Record review on 2/10/2006, revealed a 2/18/05 interdisciplinary team meeting note that for activities she "likes music and T.V." Additional.
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

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

F 248 Continued From page 91

record review revealed the 11/02/05 Physical Medicine and Rehabilitation Consultant wrote that: "When given an object the patient was able to extend her arm out fully and grasp the object with her right hand."

Further record review of page one of Resident 31's current care plan, dated 10/27/04, listed her preferences/personal habits/special needs and activities: "She like to watch "Barney Show and "Sesame Street. She like to chew soft toys."

When staff was asked why Resident 31 had no activity supplies to hold in her hand or to stimulate and interest the resident, the staff replied that Resident 31 would just fling these objects and it was not safe to leave any objects with her.

Resident 31 also had a 2/1/2005 care planned problem for potential for social isolation. The written target date of 9/1/2005 read: "Activities will make contact with Golden Gate Regional Center, GGRC, to determine nature and type of activities that resident participates in so that they can be duplicated or supplemented while resident is at Laguna Honda Hospital." The target date of 9/1/05 for implementation and completion was crossed out and changed to 12/1/2005. The intervention for these dates read: "Activities will coordinate with GGRC staff to develop activity program for resident's potential reintegration into the community, for example social and communication skill development, awareness of "others" and ability to follow simple directions."

The activity therapist was interviewed by telephone, by the surveyor, on 2/13/2006 at 11:30 A.M. The Federal surveyor asked why there were no other activity supplies, besides the baby's rattle, at Resident 31's bedside. The Activity
Continued From page 92

therapist stated that Resident 31 needed 1 staff member with her at all times to facilitate use of any objects.

During this interview, the activity therapist stated that she had barely just met Resident 3 on 2/8/2006 or 2/9/2006. The activity therapist told the surveyor that no activity or recreational program had been developed for Resident 31. The activity therapist went on to state that she was planning to visit Resident 31's school and learn what goals the school had for her so that the facility could coordinate and possibly carry over some recreation programs from her school.

As of 2/13/2006 the facility had not coordinated with GGRC to provide for an ongoing program of meaningful activities for Resident 31 during the time she spent at Laguna Honda Hospital.

4. Sixteen cognitively alert residents attended either one of two Clarendon Hall Group Interviews conducted on 02/08/06. These interviews had residents representing each of Clarendon Hall's three resident floors. The residents in each Group Interview stated the cable no longer works for the large projection television in the first floor main activity area. One group stated the cable has not been functioning for 11/2 months but the other group stated it has only been about two weeks. Both groups agreed this is an very important issue to them but they have not heard from facility staff why it has taken at least two weeks to fix the broken cable or when the cable might be repaired. On 02/15/2006, at approximately 10:15 AM, the surveyor toured the general environment of Clarendon Hall with the facility's Director of Quality Management, Interim Director of Facilities Operations, General
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/Clinic Identification Number: 555020

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _______________
B. WING _______________

(X3) DATE SURVEY COMPLETED
02/21/2006

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

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID: CA220000512

Continued From page 93

Services Manager and the Associate Administrator of Operations and pointed out the residents' concern. The administrative staff members stated they were not aware of the situation. After testing the channel changer, the administrative staff acknowledged the finding.

F 248

483.15(g)(1) SOCIAL SERVICES

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, resident and staff interview, facility document and record review, the facility failed to provide medically related social services for six of 96 sampled residents (Residents 5, 20, 21, 55, 60, 69) to help them attain or maintain their highest practicable physical, mental and psychosocial well being.

1. The facility failed to provide social services to address Resident 69's suicidal ideation.
2. The facility failed to provide social services to Resident 55 to address her handling of the sexual advances of another resident and her concerns over her involuntary seclusion.
3. The facility failed to provide social services to address Resident 21's need for help with her discharge status to ensure she doesn't lose her apartment.
4. The facility failed to provide social services to determine whether discharge goals were met for Residents 5, 20, & 60.

FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: 09ME11
Facility ID: CA220000512
If continuation sheet Page 94 of 274
Findings:

1. Closed record review on 02/10/06 documented that Resident 69 was admitted on 10/05/05 with a diagnosis of Stage III heel ulcers (full-thickness tissue loss extending through dermis to involve subcutaneous tissue). There was no documented psychiatric diagnosis, although the Resident had a long history of suicide attempts.

Record review on 02/10/06 documented that on 10/30/05 Resident 69 was 5150'd (72 hours involuntary detention) and transferred to an acute care hospital emergency psychiatric unit for threatening to harm herself. Resident 69 was re-admitted on 11/01/05 with a diagnosis of Stage III heel ulcers. Again, there was no documentation of a psychiatric diagnosis. For the second time, on 01/12/06 Resident 69 was 5150'd to an acute care hospital emergency care unit for refusing food, fluid, and medications. She was gravely ill.

Review on 02/10/06 of Resident 69's 10/19/05 MDS documented that she had no cognitive problems, was able to understand others and to make herself understood by others, had repetitive anxious complaints, a sad appearance, and episodes of crying. She also exhibited behavioral symptoms. She needed extensive staff assistance to transfer from bed to chair, for personal hygiene, and for bathing.

Record review on 02/10/06 revealed that the facility failed to provide social service interventions to identify, assess, monitor, and evaluate Resident 69's mental and psychosocial functioning, and to develop interventions to
Review on 02/10/06 of her 10/05/05 History And Physical Examination documented that Resident 69 had a history of "depression with psychotic features and/or schizoaffective disorder, and a history of suicide attempt at least x1 via an overdose of benzodiazepines. She needs to be watched carefully."

In an interview on 02/05/06 at 10:00 a.m., a licensed nurse stated that 01/12/06, Resident 69 was 5150'd (involuntarily emergency transferred) to the hospital emergency room in grave condition due to her refusing food, fluids, and medications.

Review on 02/10/06 of Resident 69's 10/05/05 Care Plan indicated that at that time the facility was aware that she had a history of suicide attempts. There was no care plan development or intervention instituted to provide social services counseling and interventions for Resident 69's suicidal ideation.

Review on 02/10/06 of the 10/06/05 Resident Social History Assessment revealed that social service staff member revealed that Resident 69 was child-like and dependent, and was receiving psychotropic medications (Ativan and Seroquel). However, there was no documentation of needed counseling and interventions by social services.

Record review on 02/10/06 documented that Resident 69 was re-admitted on 11/01/05.

Review on 02/10/06 of Resident 69's 11/01/05 Integrated Progress Notes documented that Resident 69 stated: "I want to die."

Review on 02/10/06 of the 11/05 Monitoring Form.
Continued From page 96

documented that Resident 69 had a poor appetite since 11/19/05. Resident 69's Weight Record noted that her weight was 224 pounds on 11/06/05. In addition, on 12/09/05, her weight declined to 204 pounds, then declined to 195 pounds on 01/09/06 (an unintended weight-loss of 29 pounds, constituting a 13% loss of weight in 65 days (from 11/06/05 to 01/09/06). There was no documented evidence of social service interventions: e.g. that the resident needed emotional support to address the problem of unintended weight loss.

Review of Resident 69's 11/01/05 Resident Care Plan documented that Resident 69 had diabetes. The 11/09/05 Care Plan documented that Resident 69 had "decreased appetite secondary to depression, dizziness, and stomach sickness." There was no documented evidence of social service interventions to address the problem of reduced food intake.

Review on 02/10/06 of the 01/10/06 Integrated Progress Notes revealed that Resident 69 had been refusing her medications. There was no documented evidence of social service interventions to address the problem of refusing medications. On 01/12/06, when Resident 69 had to be involuntarily emergency transferred (5150'd) to the acute care hospital emergency room due to her refusing medications, food and fluids, she was gravely ill.

The facility failed to provide social service interventions to address Resident 69's depression, suicidal ideation, and refusal to eat, drink, and take her medications. The resident had an extensive psychiatric history, and had been taking psychoactive medications, yet social...
**Statement of Deficiencies and Plan of Correction**

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<td>B. Wing</td>
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**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

<table>
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<th>(X4) ID Prefix Tag</th>
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<th>(X5) Completion Date</th>
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<tbody>
<tr>
<td>F 250</td>
<td>Continued From page 97 services failed to aggressively identify her physical, mental and psychosocial problems to prevent her decline and grave illness. (Cross reference F-279, F-325.)</td>
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<td>2. Resident 55 was admitted to the facility on 12/17/91 with diagnoses of hemiplegia, seizure, and drug abuse. The 1/10/06 MDS-assessment documented that she was alert, oriented to people, place, and time, and verbally responsive. She made negative statements, called out, and had repetitive physical movements and disruptive behavior. Review of the medical record on 2/9/06 revealed that Resident 55 had a history of verbal and physical aggression with residents and nursing staff; used alcohol and illegal substances, was an unsafe smoker; and had unsafe sex with another Resident. The 6/9/05 nursing notes at 4:30 p.m. documented that Resident 55 threw a cup of coffee at a male Resident while he was weeding the plants outside in the smoking area. Two security officers brought Resident 55 back to South 200 at Clarendon Hall (CH). Resident 55 told the nursing staff that the other Resident was killing the plants that he had planted, and that the other Resident &quot;had no respect for nature.&quot; The nursing staff told Resident 55 that her assaultive behavior was wrong and that she needed to be restricted to the second floor for 24 hours. Her cigarettes and lighter were taken away. The nursing notes indicated that Resident 55 was upset and said, &quot;I did not do anything wrong.&quot; The 7/28/05 nursing notes at 7:10 p.m. documented that staff heard a commotion and</td>
<td>02/21/2006</td>
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<td>F 250</td>
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<td>witnessed Resident 55 punching Resident 60 on his back as he was going into the elevator on the first floor. The Residents were screaming at each other, and nursing staff intervened. Resident 55 said Resident 60 grabbed the cigarette from her mouth. There were no injuries noted on either Resident.</td>
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The IDT discussed the incident on 7/29/05 and agreed to restrict Resident 55 to the Unit for 24 hours and have her cigarettes taken away. She was offered a nicotine patch. At 10:30 a.m. Resident 55 was "caught smoking in violation of her restriction. Extension of her restriction until tomorrow 7/30/05 at 10:30 a.m. will be imposed. Refused nicotine patch." The Social Service notes on 7/29/05 documented: "Resident agitated & angry about being restricted to the ward, feeling she was being treated unfairly even though she acknowledges physical conflict with the other Resident."

On 9/23/05 at 3:50 p.m., the nursing notes documented that a Resident went into the elevator and triggered the alarm. Resident 55 told him to get out but the other Resident did not listen. He later exited from the elevator and Resident 55 hit him on the face. He hit her back three times. The nursing staff separated both Residents. Both Residents were assessed by the licensed nursing staff and there were no injuries noted. The incident was discussed with the Interdisciplinary Team (IDT) and Resident 55 was restricted to the second floor for 24 hours. According to the nursing notes Resident 55 was cooperative with her restriction but she refused to use a nicotine patch. On 7/26/05, Resident 55 attended Substance Abuse Training Services (SATS) Program.
The 9/27/05 nursing notes documented that the housekeeping supervisor reported that a porter witnessed a male resident from South 300 touching Resident 55's breasts in the day room on the first floor. "According to the report Resident 55 said this has been happening everyday in the dayroom while playing the computer. Asked if she wants to press charges & she said "no". I just want him to stop." No injuries noted. Encourage resident to report if it happens again." The nursing notes also indicated that Resident 55 did not want to press charges and just wanted the male Resident to stop. She stated she was embarrassed about the incident.

The 10/19/05 nursing notes documented: "At around 12:15 p.m., LV (Licensed vocational nurse) had seen Resident 55 and (a) Resident having intimate position on CH West ramp 1st floor. (The) Resident was seen sitting on (the) lap of Resident 55 (and) facing each other (while) in front of the public."

According to the Nurse Manager's documentation she discussed with Resident 55 the fact that the other Resident had a diagnosis of HIV and Resident 55 said she was aware of it. She was offered by the staff the availability of condoms and the use of a private room if needed. On 10/23/05 Resident 55 went out on pass with the boyfriend and they both returned to the facility at 1:50 p.m. smelling of alcohol. The facility did a toxicology test on both residents.

Resident 55 was observed during the survey wheeling herself constantly from the Unit to the hallways. She appeared alert, oriented, verbally responsive, and kept wheeling herself back and forth.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CJA
IDENTIFICATION NUMBER:

555020

MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

DATE SURVEY COMPLETED

02/21/2006

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

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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| F 250     |     | Continued From page 100

forth while talking to the Surveyor and to the staff. On 2/8/06 at 11:00 a.m. this Surveyor attempted to interview Resident 55. When asked how she felt about being confined in the Unit several times she responded, "I hate it. They think I could be punished but they don't know what I can do."

In an interview on 2/15/06 at 10:50 a.m. the licensed staff stated Resident 55 had brain injury and was very impulsive. She also stated Resident 55 calms down every time she was reminded by the staff that she would be restricted to the Unit. The Nurse manager said, "The care plan is revised for every incident. The best intervention according to the IDT is confinement on the second floor. This intervention works best because the Resident does not like being confined."

According to the record, the Resident was not compliant with the interventions and even though her cigarettes were taken away, she was able to get cigarettes from other Residents.

The Resident was angry about her involuntary seclusion without her consent every time she had altercations with other Residents. She told the Social Service staff she felt she was not treated fairly. Resident 55's behavioral interventions were not effective and social service failed to therapeutically deal with the Resident's behavior and the inappropriate sexual advances of another resident (Cross reference F-223, F-224, F-353.)

3. Resident 21 was admitted to O-4 on 12/8/05 with diagnoses of pneumonia, chronic obstructive pulmonary disease (COPD) exacerbation, HIV infection, squamous cell cancer of hypopharynx, hepatitis C with cirrhosis and pulmonary
hypertension. On 2/7/06 at 9:55 a.m., Resident 21 stated she wanted to go home. She also stated that she saw a social worker last December, 2005. She was informed that the social worker will be on vacation in January, 2006 and has not heard from any of the social workers about possible discharge plan. On 2/9/06 at 10:30 a.m., Resident 21 requested the surveyor to look into her discharge status. She stated that she may lose her apartment. On the same day at 10:40 a.m., the social worker assigned to O4 confirmed that there were no social service documentation in the resident’s record. She stated the resident was moved from another unit, F4. Before she was moved to O4, her case had been assigned to Targeted Case Management (TCM). A social worker from TCM was supposed to follow up Resident 21’s discharge plan. A review of the resident’s record on 2/9/06 showed no evidence of any documentation from social services. The social worker from O4 with the facility's social worker director obtained a copy of the Resident Social History Assessment dated 10/23/05 from the computer with a note that the initial assessment was done on 6/14/05. They also printed a partially documented Discharge Assessment form from F4 Unit. The document has not been signed or dated by the Medical Social Worker. The entries for possible living setting, barriers to discharge, resources needed to support care outside of skilled nursing facility (SNF) setting and team recommendations were not identified or completed as of the date of inquiry.
On 2/9/06 at 11:20 a.m., the social service director explained TCM issue and confirmed that the assigned social worker from TCM went on medical leave.

An attempt to contact TCM was done by leaving a message on voice mail on 2/14/06. However, as of 2/17/06, TCM did not return the call.

On 2/9/06 at 10:40 a.m., the resident's physician stated that there are several medical issues that need to be resolve. The resident is still on antibiotic for C-defici infection, plan to close the tracheostomy for better communication, and she still needs to gain some weight to be able to have radiation therapy.

A review of the Integrated Progress Notes dated 2/10/06 revealed a social worker note to indicate that the facility social worker phoned the resident's daughter at the request of the physician. There was a concern that TCM worker has not moved forward with discharge plan and the resident is in danger of losing her housing.

On 2/14/06 at 8:30 a.m., Resident 21 stated that she has an appointment in San Francisco General to discuss the status of her tracheostomy. She also stated that over the weekend a social worker discussed with her possible discharge plan.

4. Record review and interview revealed that social services did not always conduct ongoing assessment and evaluation to determine whether discharge goals were met, and/or whether continued stay at the facility by residents with documented aggressive behaviors continue to be
Continued From page 103

appropriate relative to the protection and safety of other residents.

For example:

a. Resident 20 was admitted to the facility on 12-20-05 with several diagnoses including gout, hypertension, alcohol abuse, and diabetes mellitus. Review of the minimum data set (MDS) dated 12-30-05 revealed that Resident 20 had short term memory problems and required assistance with some activities of daily living (ADLs). An interdisciplinary note dated 12/29/05 further documented that Resident 20 "needs supervision" and that she "desires discharge."

Review of the medical record revealed that Resident 20 was previously admitted to an acute hospital after being found in her hotel room on the floor after a fall. The resident was then transferred to the facility for further care including physical and occupational therapy. A transfer note dated 12-20-05 described Resident 20's "baseline function" as "usually able to use her walker to go to the store about a block and a half from her hotel." The same note added that she had "in-home help 24 hours per month." A licensed staff interviewed on 2-7-06 described Resident 20 as alert and pleasant and "interviewable."

During an interview on 2-7-06, Resident 20 stated that she had been told by staff that she "might go home at the end of the month (February)." She added that she was "better" and "improved" and that she was looking forward to returning to her hotel room located somewhere in the city. When asked if plans have been made regarding discharge, Resident 20 stated that she could not
recall any adding that staff had not given her any more updates.

Further record review described a facility stay which noted continuing improvement in Resident 20's condition. Integrated progress (IP) notes dated 1-10-06 for example, described Resident 20 as "continues to participate with her personal hygiene," and that she was "ambulatory with a front wheel walker." The same note revealed that the resident "was being followed by PT and responding well." On 1-18-06, Resident 20 was noted as requiring "limited person assist with dressing, needing staff set-up."

On 12-22-05, Resident 20 was described in physical therapy (PT) notes as "alert and oriented (times) 4," and that she was "able to ambulate greater than 150 (feet) with supervision" using a front wheel walker. The same note added that "she was able to turn (with the) walker (without) problems and no loss of balance." Subsequently, Resident 20 was discharged from PT.

On 12-30-05, occupational therapy (OT) notes described the resident as "able to prepare a meal (with) supervision in the kitchen," and that Resident 20 did not need further skilled therapy and was therefore being discharged from OT.

Further record review revealed that on 1-27-06, a physician's progress note referenced Resident 20's discharge from PT and OT and that she "should be ready to go back" to her hotel with "(additional) services relatively soon."

Review of social service notes however revealed the lack of evidence that ongoing assessment and evaluation were conducted to determine
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| F 250 | Continued From page 105 whether Resident 20 could be discharged in accordance with identified goals and in keeping with the resident's wishes. In addition, there was no evidence that discharge planning had been initiated to identify other services that Resident 20 may need and how these could be provided and arranged. On 2-14-06, Resident 20 was observed walking independently with a front wheel walker under the watchful eye of staff in the hallway leading to the resident unit. When asked how she was doing, Resident 20 stated that she was "doing fine." During the same interview on 2-7-06, Resident 20 stated that she would like to go home as she was also concerned about personal items she had left behind in her hotel. The resident added that she was also getting "bored" and needed to get on with her life. b. Resident 5 was initially admitted to the facility on 11-21-03 following a stroke with residual right-sided hemiparesis and aphasia, and several other diagnoses including seizure disorder, hypertension, and depression. Review of the medical record revealed a quarterly assessment dated 11-29-05 which described Resident 5 as having no short or long term memory deficits and that he required "limited assistance" with transfer and with walking in his room and corridor. The same assessment noted that the resident was continent of both bowel and bladder functions. On 12-12-03, a discharge assessment noted Resident 5's possible discharge and living situation as to "home with family" and outlined the need for "maintaining regular contact (with) family to assess their ability to provide care for resident
Continued From page 106

Review of the medical record revealed a facility stay for Resident 5 significant for improvement in the areas of activities of daily living and cognition. On 5-30-05, for example, PT notes revealed that Resident 5 "continues to ambulate" with a walker "with standby assist," was "able to tolerate (walking) 100 feet (times) 2," and that Resident 5 had "attained his goals" for this quarter. On 10-12-05, another note by PT indicated that Resident 5 "has done well transferring to Level 2 restorative care," and that he "has been ambulating consistently on unit." The same note revealed that Resident 5 was therefore being discharged from PT." In addition, a note by speech therapy dated 6-15-05 detailed Resident 5's discharge adding that he was able to use a communication book pictures "with an average of 87% accuracy." On 6-20-05, integrated progress notes made by nursing staff described Resident 5 as "definitely improved."

During an interview on 2-6-06, a family member stated that Resident 5 had indeed improved.
Continued From page 107

significantly, being able to walk with a cane notwithstanding his right hemiparesis. The family member added that during brief visits to home, Resident 5 was able to negotiate a 17-foot stairway in their home without assistance. This was verified by a physical therapist who was interviewed on 2-8-06 after making the same observation during a home visit as part of an evaluation. The physical therapist further described Resident 5 as a "success story." On 2-7-06, Resident 5 was observed walking in the hallway leading to the unit with good balance and a steady gait and using a cane under the supervision of nursing staff.

Review of the medical record revealed that on 1-19-06, a social service note indicated that Resident 5 was not a candidate for discharge "given the need for supervision, help with self-care, behavioral issues and family unable to provide the necessary care at home." Further record review however revealed the lack of documentation by social services of an evaluation taking into consideration gains made by Resident 5 in the areas of cognition, performance of activities of daily living, and physical mobility to determine if discharge goals previously identified have been met. In addition, there was a lack of indication regarding attempts made to obtain or explore available community resources that could help prepare or assist Resident 5, a 50-year old resident, transition into community living. During an interview on 2-6-06, speech and physical therapy staff indicated that Resident 5 was not receiving any more rehabilitative therapy having been discharged several months prior from these services. Record review also revealed the lack of evidence of ongoing interventions relative to any behavioral issues referred to in social service
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

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<td>F 250</td>
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<td>Continued From page 108 notes. During the same interview on 2-6-06, one family member stated that Resident 5 does not engage with a lot of other residents because he is younger than most and higher functioning cognitively. Another family member added that Resident 5 gets frustrated sometimes when he could not express himself or when other residents (and staff members) could not understand what he was trying to say because of his aphasia. c. Resident 60 was admitted to the facility on 2-13-01 following repair of a femoral fracture and several other diagnoses including advanced organic brain disease secondary to head trauma and alcoholism. A quarterly assessment dated 7-11-05 described Resident 60 as having short and long-term memory deficits, has persistent anger with self and others, has an unpleasant mood in the morning, and independent in all activities of daily living (ADLs). A history and physical examination dated 2-13-01 revealed that prior to this admission, Resident 60 had been admitted to a psychiatric unit of an acute care hospital because of aggressive and assaultive behavior, and that during a previous stay at the facility, had &quot;multiple attempts to leave the unit and was also wandering into other patients' beds and into the female section of the ward.&quot; On 4-10-02, a neuropsychological evaluation indicated that Resident 60 &quot;demonstrated several areas of significant difficulty, including attention, immediate and delayed memory (ability to learn and retain new information), and in mental flexibility, planning, and organization, all of which were found to be in the severely impaired range based on a normative sample of same-age peers.&quot; On 7-24-02, an annual patient medical review revealed that while Resident 60 had &quot;no difficult behavior&quot; following his transfer to another building</td>
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Review of the medical record revealed several incidents involving Resident 60 and other residents and staff members over issues including his aggressive behavior and non-compliance with care and other instructions. On 4-14-05, for example, physician’s progress notes revealed that Resident 60 was “found to have a small (alcohol) bottle hidden in his shoe,” and that staff were “not sure who supplied (patient) this.” The same note added that the resident “does not acknowledge that he has a problem and refuses SATS (substance abuse training services).” On 8-18-05, another physician’s note described Resident 60 as “territorial and residents have been made aware to stay away from (Resident 60’s) usual areas as (he) is unable to understand the concept of sharing.”

On 9-26-02, a care plan was developed following a "reported incident of aggressive behavior" and "complaints from other residents," and Resident 60’s "cursing and yelling at other residents in smoking room 3rd floor because they are taking his place."

Further record review revealed a psychiatric "urgent" note dated 11-3-05 which described Resident 60’s "long history of aggressive and assaultive behavior since 2001 at (the facility)," including an event on one unit when "this resident attacked and choked another resident after this resident’s (Resident 60) Neurontin was stopped.”
**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

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<td>F 250</td>
<td>Review of integrated progress (IP) notes further revealed several other incidents including:</td>
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|               | At 2 a.m. on 12-21-04, Resident 60 was observed smoking outside the building and but was refused to come in even as he was told that "it's cold outside." The same note indicated that three hours later at 5 a.m., Resident 60 was "still outside of the west wing ramp picking up old butt cigarettes and coffee cup-told to come in. Skin is cold, (with) some sniffles ..."
|               | On 12-22-04, IP notes revealed that a certified nurse aide (CNA) "found a miniature bottle of Jack Daniels by his bedside table and resident hid it immediately in his jacket pocket." The same note added that when asked, Resident 60 gave the bottle to the station office but would not say the source or who gave him the bottle.
|               | On 3-22-05, another IP note by a social service staff member who, after observing and addressing "inappropriate smoking" by Resident 60 documented that "resident screamed 'Godammit!!' and "slammed the door then accused me of 'snitching' on him."
|               | At 4:45 p.m. on 6-9-05, IP notes revealed that an institutional police officer reported that Resident 60 had an altercation with another resident from another unit who "threw cup of cold coffee" on Resident 60. Additional IP notes regarding this incident by an activity staff on 6-28-05 revealed that the "resident 'weeds' (usually pulling out flowers such as agapanthus; sometimes pulling out weeds as well) which led to the conflict." The same note added that the activity staff was "not able to redirect resident to other gardening tasks" |
Continued From page 111
and that "in general is difficult to redirect or change behavior."

At 8 p.m. on 6-20-05, IP notes described nursing staff receiving a phone call from an activity in the day room that Resident 60 was "talking to himself and hallucinating and kept walking around in the dayroom, pushing his wheelchair back and fort (sic)," and that when assisted back to the unit, he was noted as "agitated and irritable."

On 7-19-05, IP notes by nursing staff further described Resident 60 as "agitated, talking in a loud voice, argumentative" with his roommate, accusing him of getting his shirt and underwear. IP notes added that institutional police was notified of the incident during one of their routine rounds.

On 7-28-05, IP notes revealed that another resident "was punching (Resident 60) on his back" because Resident 60 took his cigarettes. Another note following this incident dated 7-28-05 indicated that while there were no physical injuries, Resident 60 however was agitated and uncooperative eventually returning the cigarettes only after a discussion with institutional police officers. Accordingly, Resident 60 was alleged to have stated, "I'm unable of quitting, (sic) you can put me to jail."

On 8-11-05, IP notes further described resident as having been found in the west ramp of the building "very agitated" even as institutional police carried on a conversation with him. Accordingly, Resident 60 who was in his wheelchair was blocking the ramp refusing to yield to anyone because he was "continuously cleaning the floor."
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<td>At 2 p.m. on 8-13-05, IP notes revealed that Resident 60, when “woken up for lunch” yelled and screamed at the nurse saying repeatedly, “I don't want none, I don't want none.” Accordingly, Resident 60 was noted as seen by a physician an hour later with no new orders being made.</td>
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<td>At 8:15 p.m. on 9-15-05, IP notes described Resident 60 who was on the west ramp as “hallucinating” holding a pad and “swaying it to the ground,” stating “there is a bugs on the ground (sic).” The note added that when approached “to pull his pants up” (since they were down to his “lower extremities” earlier), Resident 60 could not be redirected to return to the unit and became more angry and agitated even while institutional police was talking to him. The resident was described to carry on this activity for about 45 minutes becoming quiet only as he grew tired. Several hours later at 3 a.m. on 9-19-05, IP notes by nursing staff again revealed that Resident 60 was observed “swaying pad to the ground” stating “There's a lot of bugs, I'm trying to get rid of them.”</td>
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<td>On 9-22-05, IP notes revealed that Resident 60 was being moved to a private room because of a prior incident where he stayed in the bathroom from 4:30 p.m. through 10:30 p.m. on 9-21-05 refusing to leave preventing his roommate from using the bathroom.</td>
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<td>At 9:30 a.m. on 9-26-05, IP notes described Resident 60 as “agitated, cursing and yelling at staff, very insulting ...” The note added that the resident went to his previous room and cursed when told that the room was no longer his by nursing staff.</td>
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### Statement of Deficiencies and Plan of Correction

**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

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| F 250 | Continued From page 113 | At 9:30 p.m. on 9-26-05, Resident 60 was described in IP notes as reporting that he was "hearing a voice that tells him to do things that gets him in trouble. He also said the voice' threatens to kill him," and tell him to "curse on people around him."  
At 4:30 p.m. on 9-27-05, IP notes by social services revealed that Resident 60 had reported hearing a male voice "for the last two weeks" which "brought him to tears by creating excruciating amount of pain in his back," and that the voices "threatened him as well."  
At 9:20 a.m. on 9-29-05, Resident 60 was described in IP notes as being in the hallway bathroom blocking the doorway and throwing water on the floor and to other people." The note added that Resident 60 was talking "on and on-what do you want,' then threw water at me (nursing staff)." The same note revealed that the resident was "very aggressive," that "staff can't go near him," and that he "tried to hit 3 other residents during this incident." Subsequently, Resident 60 was discharged to an acute psychiatric unit by 5150 (involuntary transfer).  
During an interview on 2-16-06, quality assurance staff as well as a nursing administrative staff revealed that facility process and practice required that each behavioral outburst by a resident, as well as other incidents affecting the care, safety and security of residents, are reviewed by the IDT (interdisciplinary team) during a meeting. In this meeting, discussions are conducted and recommendations are made to develop a course of action including determining the appropriateness of the resident's continued facility stay depending on the | F 250 |
Review of the medical record on 2/16/06 however revealed that although quarterly IDT meetings were held for Resident 60 and discussions about his behavior and current treatment plan were held, additional meetings by the IDT were not always conducted following each of Resident 60's behavioral episodes and whether or not his continued stay was in the best interest of other residents, staff, and Resident 60. Although reference, for example, was made on at least two occasions where alcohol was found in his possession, there was no review of these incidents by the IDT.

Record review on 2/16/06 revealed that although the physician was notified, there was no meeting as a group by other members of the team where a review was conducted and where appropriate interventions were recommended or implemented. Further record review revealed that any follow through regarding the incidents stopped after Resident 60 refused to reveal the sources of the alcoholic substances.

Review of the facility's policy on "Illicit or Prohibited Drugs or Paraphernalia Possession/Use by Residents or Visitors" which, according to a quality assurance committee staff interviewed on 2-21-06 included use of alcohol, revealed that the "use, possession, solicitation and/or distribution of illicit or prohibited drugs or paraphernalia" is prohibited, and that "staff shall take steps to prevent illicit or prohibited drugs or paraphernalia use or access ..." Furthermore, although the policy required that the "admitting care unit will require residents with a documented history of drug use, abuse, dependence or
Continued From page 115

distribution of illicit or prohibited drugs to agree to a substance abuse behavior plan as a condition of admission;" there was no indication that on these two instances, discussions about Resident 60's possession of alcohol relative to the policy, was conducted.

Following Resident 60's behavioral escalation resulting in a 5150 discharge on 9-28-05, further record review revealed the lack of an IDT review into the incident to determine if Resident 60's return to the facility would be appropriate. On 11-1-05, Resident 60 was readmitted to the facility.

On 11-2-05, one day following his return to the facility, review of the medical record revealed a psychiatric evaluation (dated 11-2-05) which noted that Resident 60 was "seen urgently due to verbal agitation and statements re: (hospital) as 'jail' and 'not stay here.'" The evaluation added, "cannot rule out future violence, (especially) (with) provocation (and/or) substance(s)."

At 3 p.m. on 11-2-05, an IP late entry note described Resident 60 as "verbally abusive" and "disruptive." At 5 p.m. (on 11-2-05), IP notes described Resident 60 as "being in the male bathroom cleaning the sink and other fixture," with "some irritability when talked to." At 8 p.m., the same notes revealed that the resident was once again seen in the bathroom cleaning the sink until 9:15 p.m. when nursing staff persuaded him to return to bed.

At 11:20 a.m. on 11-3-05, IP notes by nursing staff revealed that Resident 60's behavior "suddenly changed" and that he became "upset," and "verbally abusive to staff and another
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

555020

**Date Survey Completed:**

02/21/2006

**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

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### Summary Statement of Deficiencies

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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<tr>
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<td>F 250</td>
<td>Resident. A psychiatric “urgent” note dated 11-3-05 described Resident 60’s “agitated and threatening behavior” and that the day prior, on 11-2-05, the resident “was agitated and yelling loudly and moving about (with) an angry expression, and staff and other residents were fearful.” The note added that Resident 60 became very agitated with staff attempted to remove a (wheelchair) near his bed, and he began to yell and throw things out of the wheelchair (i.e. can of Ensure, etc.). Accordingly, the resident yelled, “Call the police! I’m a nasty S_O_B_. I’m going to kill somebody.” Further record review revealed that less than 48 hours after his return, Resident 60 was once again discharge by way of 5150 from the facility because of “unprovoked and unpredictable aggressive behavior and his threats to kill somebody.”</td>
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<td>F 252</td>
<td>483.15(h)(1) Environment The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on interview with residents and staff, record review, and observation, the facility failed to provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible in two areas of Clarendon Hall and on Wards K-6, L-6, G-3, C-3, C-2 of the Main</td>
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Findings:

1. On 02/15/2006, at approximately 09:45 AM, as the surveyor toured the general environment of Clarendon Hall with the facility's Director of Quality Management, Interim Director of Facilities Operations, General Services Manager and the Associate Administrator of Operations a half full two liter plastic bottle of "700 Disinfectant Cleaner" was found in an open cabinet in an unsupervised area of the first floor that staff referred to as the "inactive kitchen." This area was open to the dining room without any barriers in place to prohibit resident use.

2. On 2/5/2006 at , during an initial tour of C-2, the tub room was observed. The doorway leading into the tub room had paint chipped off of it, up and down a large portion of the doorway on both sides. When the surveyor touched these areas, the doorway was found to have many splinters. A staff nurse stated that the residents pass through this entryway when they are transported from their beds into the tub room for bathing.

3. Environmental tour of Ward M6 on 2/10/06 at 9:45am revealed a wheelchair at the bedside of Bed 27 had cracked, uneven upholstery on both arms, exposing a rough surface. The right arm of the wheelchair at Bed seven was broken, missing a piece and not attached firmly to the arm. On Ward L6 at 10am two community lounge chairs had torn upholstery. On Ward K6, a number of community lounge chairs were missing pieces of the upholstery, leaving areas exposed. This lack of repair presents an accident risk to residents.
### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>F 252</td>
<td>Continued From page 118</td>
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</tbody>
</table>

4. On 2/15/06 during an inspection of the medication room located on K-5, beginning at 14:05; 9 pair of eyeglasses were found in a drawer. Only 2 of the glasses had resident identifiers on them. The charge nurse acknowledged that they were resident property.

5. Observation during the survey between 2/5/06 and 2/21/06 revealed that the locked Wards K-6 and L-6 lacked home-like personalization that could help confused, wandering residents recognize their bedside area as familiar. Each ward was the size and shape of a football field, with approximately 12 beds lined up, side by side, down one side of the ward, and 12 beds the identical way along the other side. Each bed, and bedside-stand was identical in color and form to the one beside it, and the wall at the head of each bed was bare except for a sign with a resident's name.

In an interview on 2/16/05 at 2 PM, a supervisory nurse on K-6 pointed out cards with resident's names at the head of the beds as an example of individualization. But she agreed that a resident with memory problems and confusion would not remember to look for his name, let alone be able to read it. She said the facility can't put posters individualized to each resident's life interests on the walls because the Fire Marshall won't let them, and the residents might tear them down.

In an interview on 3/1/06 at 9:15 am, a Life and Safety Code surveyor stated that there was no regulation barring a poster on the wall above a resident's bed as long as it did not take up more than 25% of the wall space.
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 252              | Continued From page 119
6. During an environment tour of Ward G-3 on 2/5/06 at 9:00 a.m., a hole on the metal frame of a heater in the bathroom was observed to have sharp edges. The hole, measuring six inches by one inch, was located at the end of the bathroom at approximately two feet above the floor. The licensed nurse accompanying the tour acknowledge the hole and that the metal sharp edges could cut a resident's hand.  
7. During the same tour, the paint on the ceiling in the Ward C-3 bathroom was peeling off and falling on the residents in the bathroom. The licensed nurse accompanying the tour acknowledge the peeling paint. | F 252 | 483.15(h)(2) HOUSEKEEPING/MAINTENANCE  
The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  
This REQUIREMENT is not met as evidenced by:  
Based on observation and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a clean, odor-free, orderly, and safe environment for the residents in Wards C-2, O-4, D-5, E-5, F-5, G-5, all of 5th floor in the main building, F-6, K-6 and all three floors at Clarendon Hall. | 2/21/2006 |
Findings:

1. On 2/05/06 at 12:55 p.m. in Unit 0-4, three pairs of slippers were scattered on the floor at the left side of the Resident in bed B, Room 219. This was a safety hazard, and a potential cause of falls for the Resident when getting out of bed.

2. During the tour on 2/06/06 at 9:30 a.m. at Clarendon Hall South 200, an uncovered urinal with 200 cc of amber-colored urine stood on the floor at the left side of bed B in Room 219. When brought to the facility’s attention, a licensed staff person stated: "This should not have been left on the floor." Facility staff failed to empty the urinal promptly after the resident used it, and failed to store the urinal in its proper place.

3. During an environment tour in Ward F-6, observation revealed boxes and bags of a resident’s personal belongings stored on the floor between the beds. The residents had difficulty walking over the cluttered boxes and bags, and the residents could have fallen over them. The licensed nurse accompanying the tour acknowledged that this cluttered condition was unsafe.

4. Observation on 2/7/06 at 1:30 p.m., revealed that the windows in the residents’ TV room on Ward K-6 were dirty on both sides, with gummy liquid caked with dirt on the outside, and the ward windows were also dirty.

In an interview at the same time, a housekeeping staff person stated that the residents "pour things outside," and the windows were cleaned at the end of the year. He said he wasn’t tall enough to...
Continued From page 121

reach the outside, and it doesn't help to clean them because they just get dirty again. He said he wasn't tall enough to reach the window that opened into the room, but discovered a way to clean them.

5. On 2/5/2006 at approximately 11:30 AM, during an initial tour of C-2, the tub room was observed. At that time, there was a gurney placed over the bathing tub. A staff nurse stated that the gurney was used to transport residents from bed to the tub area for those residents who are unable to ambulate. The legs and underneath areas of the gurney were covered with dirt and other matter.

On 02/15/2006, from approximately 09:40 AM to 11:30 AM the surveyor toured the general environment of Clarendon Hall with the facility's Director of Quality Management, Interim Director of Facilities Operations, General Services Manager and the Associate Administrator of Operations. The following findings were made:

First Floor Dining Room and Inactive Kitchen: Entrance door wall tiles with prominent streaks along with food residue on the adjacent walls.

First Floor Women's Restroom (near previous main entryway to building): broken toilet paper holder and soiled toilet seat.

First Floor South Exit area: Broken plaster near the vinyl baseboard and the surrounding area of the door.

First Floor, all resident hallways: The majority of doors with scrapes and gouges along with with prominent scrapes on all heating system radiators.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

- **(X4) ID PREFIX TAG**
  - F 253

#### SUMMARY STATEMENT OF DEFICIENCIES

**ID PREFIX TAG**

**PROVIDER'S PLAN OF CORRECTION**

**COMPLETION DATE**

---

**Both Elevators:** Prominent scrapes of the paint approximately three to five inches below the level of the elevator handrails. The staff stated this was most likely from the food carts hitting and rubbing against the elevator walls. Adjacent to the elevator doors, in the open hallways on all three resident floors, the handrails were placed at a lower height than in the elevators. During meal tray delivery, it was noted by the tour group that the lower height of the handrails in the hallways prevented the walls from being scratched and gouged by the meal tray carts. However in the elevators, the trays made contact with the walls.

**Individual Rooms:** A small sample of rooms were toured. Room 151, prominent marks on the walls and a dirty, dusty bathroom vent. Room 146, prominent marks on the walls. Room 142, prominent marks on the bedroom and shower stall walls, also a dirty, dusty vent in the shower room. Room 249 (2 East), many scrapes on the door and walls, mildew in the shower stall along with a dirty, dusty shower vent. In each of the aforementioned bathrooms and shower stalls, there were not windows that open or other means of ventilation outside of opening the door.

Sixteen cognitively alert residents attended either one of two Group Interviews conducted on 02/08/06 in Clarendon Hall. These interviews had residents representing each of Clarendon Hall’s three resident floors. The residents in each Group Interview stated their bathrooms were stuffy and the vents worked poorly. One resident in the Group Interview with first and second floor residents, stated the shower and bathroom vents were last cleaned two years ago. The other residents attending this particular Group Interview...
6. On 2/5/06 at 11:10 a.m., during the initial tour, the following were observed:

K-5 Unit: The bathroom at back had two handwashing sinks that were wrapped and taped with white cloth. The facility staff stated that the sinks were out of order and the status has been reported. There were four bedside commodes with no identifiers to determine the users. The staff was also unable to determine whether the commodes were dirty or clean. A pair of used blue gloves was left in one handwashing sink.

One toilet seat riser was observed in the toilet floor in one of the toilet stalls. Two toilet commodes had urine and brown materials left unflushed. The toilet had multiple pieces of torn toilet paper all over the toilet floor. Two Hoyer lift that were non-working were stored in the bathroom.

During the initial tour on 2/5/06 at 11:10 a.m. - 1:00 p.m., the solarium in K-5 and L-5 units were observed with resident wheelchairs, recliners and black plastic bags with resident clothing that were
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**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

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<td>7. On 2/7/06 at 9:00 a.m. in O-4 Unit the bathroom at the back had a large puddle of water next to the tub. A large area of corroded paint in the wall was also observed in the same bathroom.</td>
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<td>8. On 2/7/06 at 9:45 a.m., Resident 21's room was observed cluttered with medical equipment to include oxygen tank, bedside table with suction, tube feeding pole, electric scooter, and books next to the resident. The room has six occupied beds. The resident was observed with oxygen mist mask over the tracheostomy. She stated that she could have walked a lot more often if she was not attached to the big oxygen tank. An interview with nursing staff revealed that the facility provides the smaller oxygen tanks when the resident wants to get out of the unit using the wheelchair or scooter.</td>
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<td>9. Ward O-5: On 2/7/06 at 1:45 p.m., mouse traps were observed under bed 16 and bed 22. On 2/9/06 at 7:45 a.m., the night charge nurse confirmed that she has seen a number of mice at night during her 22 years of working in the facility. The heater between Beds 22 and 23 had a missing left side of the bottom metal frame. The gap created a hole that measured 6 feet wide and 4 feet in height. A second hole inside the heater was observed with an approximate size of a fist. A slightly bent metal portion of the heater next to Bed 7 measured 6 inches away from the wall.</td>
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<td>10. On 2/15/06 during an inspection of the medication room located on K-5, beginning at</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (Continued)**

**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

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Continued From page 125

14:05; an abundance of miscellaneous items were found stored under the sink. These items included plastic basins, paper bags, personal reading material, a hammer, an unwrapped bar of soap in a paper cup, 2 storage-type tin cans and 2 empty soda cans. Trash (paper towels and paper cups) was also found wedged between the medication refrigerator and the wall.

11. During the initial tour on 2-5-06 and again during the environmental rounds on the fifth floor of the main building on 2-7-06 and 2-14-06, the following observations were made:

   a. Extensive area of cracked and peeling paint was noted on the left side of the hallway leading to the "breezeway area" on the 5th Floor.

   b. A cabinet marked "major emergency supply cabinet" located left of the door leading to G-5 had a retaining bracket on the right that had separated from the wall. On closer inspection, trash and large accumulation of dust and debris were noted in the space between the cabinet and the wall.

   c. A pool of water was noted inside the dispenser platform of the ice machine on G-5 in spite of a drain hole that was noted at the base. In addition, dark-colored mold-like material was observed around the base of the dispenser.

   d. The door of the blanket warmer in the hallway on G-5 does not close easily so that the door was observed slightly ajar on several occasions.

   e. Metal panels that covered the heaters located around the walls and behind each resident's bed...
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<th>COMPLETION DATE</th>
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<td>F 253</td>
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</table>

were noted heavily laden with dust, debris and trash on D-5, E-5, F-5 and G-5. In several instances, the panel covers were noted either out of place or had completely fallen off. On E-5 for example, heater panel covers behind beds 10 and 15 were out place. The panel cover behind bed 8 was noted on the floor.

Heater panel covers were also noted with thick accumulation of dust and debris behind beds 23, 24, 25 and 27 on E-5; and were out place behind bed 28. A hole approximately 3 inches by 6 inches was noted on the wall beside this heater panel.

f. Areas of cracked and peeling paint were also observed on the ceiling in several communal bathrooms on D-5, E-5 and F-5, including on the wall and ceiling of the bathroom adjacent to the solarium on E-5. The ceiling of bathroom 509 on D-5 also had a large area of peeling paint above the tub.

A large area of peeling paint was likewise noted on the ceiling above bed 17 on F5.

g. Ventilation grills located in several of the bathrooms on D5, E5, F5 and G5 were observed heavily laden with dust. The ventilator grill in the communal bathroom marked 508 on D5, for example, was heavily laden with dust that dust particles had fallen onto the cover of the light switch located directly below.

h. Sections of handrail between rooms 501 and 502; 513 and 514; and 503 and 504 on F5 were observed loose from where the brackets attached to the wall.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**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

**DATE SURVEY COMPLETED:**
02/21/2006

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</table>
| F 253         | Continued From page 127
i. The light fixture above bed 28 on F-5 was observed uneven and loose from where it attached to the wall. | F 253         |                                                                                  |                |
| F 257         | 483.15(h)(6) ENVIRONMENT- TEMPERATURE
SS=B
The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F
This REQUIREMENT is not met as evidenced by:
Based on interviews with both residents and facility staff, the facility failed to provide comfortable temperature levels in both the main building and Clarendon Hall.

Findings:
1. Sixteen cognitively alert residents attended either one of two Group Interviews conducted on 02/08/06 in Clarendon Hall. These interviews had residents representing each of Clarendon Hall's three resident floors. The residents in each Group Interview stated the building's hallways, day room, and most of the third floor were too warm during the daytime hours.

On 02/15/2006, at approximately 10:40 AM, as the surveyor toured the general environment of Clarendon Hall with the facility's Director of Quality Management, Interim Director of Facilities Operations, General Services Manager and the Associate Administrator of Operations the higher uncomfortable temperature of the third floor hallway (adjacent to the dining room) was pointed...
### Statement of Deficiencies and Plan of Correction

#### Laguna Honda Hospital & Rehabilitation Ctr D/P SNF

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<tr>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
</tr>
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<tbody>
<tr>
<td>F 257</td>
<td>Continued From page 128 out. Staff members provided an explanation that the older radiator heating system was cumbersome to turn completely off during the daytime hours and instead during periods of warmer daytime weather, it was easier to cool the building by opening the windows. Few of the available windows were opened during the tour.</td>
</tr>
<tr>
<td>F 258</td>
<td>2. On 2/8/06 at 10:45 a.m., during the resident group meeting with the Asian-focused residents, 19 of 19 residents stated that it gets really hot in the facility at summertime. They also stated that the facility provides electric fans in the units, however, the room temperatures are really hot and the fans offer minimal relief.</td>
</tr>
</tbody>
</table>

#### Findings:

- **F 257**
  - 483.15(h)(7) ENVIRONMENT- SOUND LEVELS
  - The facility must provide for the maintenance of comfortable sound levels.

- **This REQUIREMENT is not met as evidenced by:**

  Based on observation, interview, and record review, the facility failed to provide for the maintenance of comfortable sound levels for one of 96 sampled residents. (Resident 7)

- **Findings:**

  On 2/6/06 at 8:45 a.m., Resident 7 complained of the noise level from the resident's radio across her bed. The radio was usually on from 6 a.m. until somebody turned it off. The resident told the nurses that the radio bothered her, however she was told by the staff that the radio is the resident's...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**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

**DATE SURVEY COMPLETED:**
02/21/2006

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**SUMMARY STATEMENT OF DEFICIENCIES**

**ID TAG**
F 258

**ID TAG**
F 272

**SS=D**
483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS

**ID TAG**
F 258

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**F 258 Continued From page 129**
only consolation.

Observation on 2/7/06 at 1:30 p.m., revealed Resident 7 yelling, "Nurse, nurse." Only one caregiver was present in the ward at the time the resident was calling for assistance. The call light alarm stayed on for 15 minutes with no response from the staff. At the same time, the resident across Resident 7's bed was observed yelling incomprehensible words at intervals. Another resident to the left side across Resident 7 kept on pulling the string connected to the overhead light fixture.

In an interview on 2/5/06 at 1:30 p.m. during the initial tour of the Dementia Unit - 05, the charge nurse stated that the unit was noisy due to five screaming residents. The resident across from Resident 7 with the radio and yelling on and off was one the five residents exhibiting frequent screaming identified by the charge nurse.

Record review revealed that Resident 7 was admitted in the facility on 1/30/06 with diagnoses of chronic obstructive pulmonary disease, hypertension, osteoarthritis and pancreatitis. The Admission Nursing Assessment dated 1/30/06 indicated the resident was alert and oriented.

**F 272**

**SS=D**
483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident’s functional capacity.

A facility must make a comprehensive assessment of a resident’s needs, using the RAI
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

555020

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED

02/21/2006

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

(F4) ID PREFIX TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(F4) ID PREFIX TAG
PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(F5) COMPLETION DATE

F 272 Continued From page 130

specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to accurately assess two of 96 sampled residents. (Residents 45 & 15.) Their failure to assess Resident 45 for orthostatic hypotension prevented the facility from determining whether she was a fall risk due to postural hypotension, and Resident 15's record did not contain quarterly dietary assessments for October 2005 and January 2006.

Findings:

1. Record review on 2/9/06 revealed that
Resident 45, age 92, was admitted to the facility on 1/3/06 and with diagnoses including hip fracture after a fall at home, arthritis, atrial fibrillation, cataracts, and depression. Her 1/9/06 MDS indicated her memory was good, she was alert and oriented to person, place, and time, and had modified independence in decision-making, and impaired vision. She required extensive staff assistance to turn in bed, get out of bed to a chair, move around her unit, toilet and hygiene. She did not walk, and was totally dependent on staff to dress, and bathe.

Record review on 2/9/06 revealed that Resident 45's 1/11/06 care plan stated: "Resident is at risk for fall R/T (related to) history of fall and use of BP (blood pressure) meds." The goal was: "Resident will have no fall in 3 months." One of the interventions was: "Monitor BP for orthostatic hypotension." (Orthostatic hypotension, as defined by Mosby's Pocket Dictionary of Medicine, Nursing & Allied Health, Fourth Edition, is: "abnormally low blood pressure that occurs when an individual suddenly assumes the standing position. It can produce dizziness and fainting." Orthostatic hypotension monitoring is measured by taking a person's lying, sitting and standing blood pressures consecutively to determine if the blood pressure drops when he or she stands.) The record contained no documentation to show that Resident 47 was ever monitored for orthostatic hypotension.

Record review on 2/9/06 revealed that Resident 45 had a 1/3/06 physician's order for: "Metoprolol 12.5 mg po (by mouth) BID (twice a day) hold for SBP (systolic blood pressure) below 110." (Metoprolol is a blood pressure medication with a common side-effect of hypotension, or
### F 272

**Excessively low blood pressure**

Review of the resident's January 2006 Medication Administration Record (MAR) revealed that a dose of her Metoprolol was not given because her systolic blood pressure was below 110 on the following days: 1/3/06 at 5 PM, 1/4/06 at 9 AM, 1/5/06 at 9 AM and 5 PM, 1/6/06 at 9 AM and 5 PM, 1/7/06 at 5 PM, and 1/9/06 at 5 PM. On 1/11/06, the physician changed the order to "Metoprolol 12.5 mg once a day. Hold for SBP below 110." The January 2006 MAR showed that her once a day Metoprolol was not given on 1/16/06 and 1/17/06 because her systolic blood pressure was below 110 at 9 AM on those days. However, on 1/18/06 the MAR stated: "1/18/06, 9 AM, Metoprolol is hold (sic), BP (blood pressure) =103/59—114/88 mmHg 2 PM, AP (apical pulse) 94; Metoprolol is given."

Record review on 2/9/06 revealed that Resident 47's 1/18/06 Integrated Progress Notes at 7 PM stated: "Per witness, Resident stood up from her bed (#28) took a few steps in between her bed and bed #29 then she swayed and fell and she hit her head at the corner of bed #29. Resident stood up without calling for assistance or help.....Resident had a low BP 75/53 after the fall."

Record review on 2/14/06 revealed that Resident 45’s 1/24/06 History and Physical Examination stated: "The patient returns from a six-day admission at (the hospital) where she was taken after having a fall on ward K-7 in the evening of 1/18/06. During that fall she struck her right periorbital area on what is believed to be the side of a neighboring resident's bed. Due to the nature of the injury, she was sent urgently to (the hospital) immediately after the fall....A CT scan..."
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<th>F 272</th>
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|       | done in the emergency room showed: a) a right posterior "blowout" fracture of the orbit with bony fragment displaced medially and superiority, b) right frontal lobe contusion (2/4 x 2.6 cm) and c) right frontotemporal subdural hematoma..... Ophthalmology did take the patient to the operating room for repair of her right globe rupture on her hospital day #2..... The patient has no vision at her right eye at this time. It is unclear whether this is a permanent condition or whether she will regain some sight."

Observation on 2/9/06 at 10:30 am revealed Resident 45 sitting in a wheelchair at her bedside. An eye-patch covered her right eye. Her head was down, she mumbled non-English words, and was not responsive when greeted.

Observation on 2/14/06 at 11:30 am revealed Resident 45 dressed and sitting in her wheelchair. Her eye-patch was in place, her head was covered in a scarf, and she was mumbling to herself in a non-English language. She did not respond when the surveyor attempted a greeting in her language.

In an interview on 2/14/06 at 11:35 am, a facility physician stated she had discontinued the resident's Metoprolol on 1/26/06, two days after her re-admission from the hospital after her fall, because of her concerns over whether the fall had been the result of a syncopal (fainting) episode and low blood pressure due to the Metoprolol."

The facility failed to assess and monitor Resident 45 for orthostatic hypotension even though she had a history of falls, received a medication (Metoprolol) with a common side-effect of
postural hypotension, and had a care plan that stated they would monitor her for orthostatic hypotension. The resident’s once a day Metoprolol was held at 9 am on 1/16/06, 1/17/06, and 1/18/06, because her systolic blood pressure was below 110. But at 2 PM on 1/18/06, her blood pressure was 114/88 and she received a dose of Metoprolol. At 7 PM on 1/18/06, five hours after she received the dose of Metoprolol, Resident 45 stood up, fell, hit her head, and sustained a subdural hematoma and blow-out fracture of her one good eye, her right, rendering her blind. Her blood pressure at the time of the fall was 75/53. The facility’s failure to monitor Resident 45 for orthostatic hypotension prevented them from discovering whether standing caused Resident 45 to have very low blood pressure (postural hypotension), and could have helped them decide whether Metoprolol was the appropriate drug for her. (Cross-reference: F-241, 324, 353, 463.)

2. Resident 15 was a 53 year old admitted to the facility on 6/21/05 with diagnoses including left above the knee amputation, right hip disarticulation, severe peripheral vascular disease, and hepatitis C.

A 2/7/06 review of the Resident’s medical record revealed that he had 4 Stage II pressure ulcers on his buttocks. He was on a regular diet, and had a physician order for Ensure (a dietary supplement drink), 1 can, tid pm (three times a day when necessary).

During an interview at his bedside on 2/6/05 at 11 a.m. the Resident refused to have the surveyor present to observe his skin when it was time for his dressing change.
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<th>F 272</th>
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<tr>
<td>Interview with the charge nurse on 2/7/06 at 10:30 a.m. revealed that the Resident often refused to get out of his motorized wheelchair to sleep on his Air Loss bed (pressure relieving type), and continued to smoke despite being educated by staff of the serious health ramifications.</td>
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Further review of his medical record revealed that the Resident only contained evidence of an initial dietary assessment on 7/11/05. The quarterly assessments for October 2005 and January 2006 were missing.

During an interview on 2/8/06 at 1:30 p.m., the licensed nurse agreed that the dietitian had not done the quarterly assessments. (Cross reference F-286.)

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<tr>
<th>F 279</th>
<th>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</th>
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<tbody>
<tr>
<td>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</td>
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The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under
This REQUIREMENT is not met as evidenced by:

- Resident 33 developed a pressure sore on her left buttock that was not identified before it developed to a Stage 2, and there was no care plan for Resident 33’s use of Digoxin with interventions to monitor for adverse effects.
- There was no care plan to reflect the significant weight loss of Resident 19.
- There was no care plan developed to provide services to Resident 69 who had a history of suicidal attempts and significant weight loss.
- No adequate care plan developed to prevent Resident 84 from verbally abusing other residents and to protect him from their assaults.
- There were no care plans to protect Resident 86 and prevent skin burns in the dialysis unit and to improve communication with the dialysis unit to ensure continuity of care.
- There was no care plan developed to reflect constipation and Resident 39’s use of a Foley catheter.

Findings:

- Resident 33 was admitted to the facility on 7/11/2000 with diagnoses of peripheral vascular disease, dementia, and anemia. The Quarterly Minimum Data set (MDS-assessment tool) with a
**SUMMARY STATEMENT OF DEFICIENCIES**  
(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<th>ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 279</td>
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|               |               | date of 11/15/05 indicated Resident 33 had short-term and long-term memory problems and his decision making was moderately impaired. He was non-ambulatory and needed maximum assistance from staff in most areas of activities of daily living. He was incontinent of bowel and bladder. The care plan dated 9/9/03 documented, "Potential for skin breakdown due to B&B (Bowel and Bladder) incontinence and refused to go to bed at night." The care plan intervention dated 6/9/05 documented "Roho seat cushion to low seat wheelchair. Try recliner as accepted at night to keep buttocks off pressure." The pressure sore was assessed by the licensed nurse on 2/6/06 as a Stage 2 (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The nursing notes on 2/6/06 documented, "Skin breakdown sustained a 1.5 cm. x 0.2 cm. superficial Stage 2 open area. The facility's policy on "Pressure Ulcer Prevention and Treatment" (File; K 1.0 February 2005, Page 1) indicated, "The Licensed Vocational Nurse (LVN) is responsible for monitoring residents at risk for pressure ulcers, for observing, reporting and documenting wound status, for implementing plans of care that address pressure ulcer risk and treatment, and for collaborating with RNs in the evaluation of related plans of care. Procedure: "Pressure Ulcer Management: When a pressure injury is identified an RN:  
a. Assesses the ulcer, stages it and initiates a Wound Assessment Record (WAR)  
b. Notifies the nurse manager, physician, and family or surrogate decision maker, and contacts other team members as needed to initiate a plan
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

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F 279

F 279
Continued From page 138
of care
c. Initiates or revises care plan entries to address risk factors and wound treatment strategies."

In an interview with the licensed staff on 2/9/06 at 10:00 a.m., this Surveyor asked for an assessment of a Stage 1 (Non-blanchable erythema of intact skin) before the pressure sore developed to a Stage 2. The licensed staff said, "The C.N.A reported the skin breakdown to the licensed staff and that was when an assessment of the Stage 2 was done." This Surveyor asked for the Wound Assessment Record. The licensed staff said it was not done but there was a documentation of the wound assessment in the nursing progress notes.

There was no care plan developed on the Stage 2 pressure sore on the Resident's left buttock as soon as it was reported to the licensed nurse by the C.N.A. There was no Wound Assessment Record initiated by the RN as indicated in the facility's policy and procedure.

Resident 33 had a diagnosis of atrial fibrillation (Rapid involuntary contractions of the atrial myocardium) and had a Physician's order for Digoxin 0.125 mg. daily. There was no care plan developed on the use of Digoxin with interventions to monitor for adverse effects. (Cross reference F-314, 329.)

2. Resident 19 was a 78 year old admitted to the facility on 6/13/05 with diagnoses including diabetes, pneumonia, a stage III ulcer on the right heel, congestive heart failure and chronic renal failure. His 12/16/05 MDS indicated that the Resident was alert and oriented and no memory problem. He was able to eat independently with
On 2/6/06 at 2:40 p.m., Resident 19 was observed sitting on his wheelchair in the hallway. He appeared alert, and was pleasant and conversant. He had dry dressings to his lower extremities and was wearing soft booties.

In an interview on the same date and time, the Resident told the surveyor that his legs were swollen and he had an ulcer on his right heel. He added that the staff did the dressing changes.

A 2/6/06 review of the weight record confirmed that the Resident's weight on admission was 150 lbs. on 6/13/05. Further record review disclosed that he had significant weight changes in the following months:

- 7/27/05: 160 lbs. increase of 10 lbs.
- 10/31/05: 180 lbs. increase of 20 lbs.
- 12/28/05: 160 lbs. decrease of 160 lbs.
- 2/05/06: 170 lbs. increase of 10 lbs.

During an interview on 2/6/06 at 2:30 p.m., Staff 1 stated that: "His weight fluctuated because of his edema. He is on Lasix 80 mg. twice a day. He is on fluid restriction of 1500 cc per day." Although the Resident was on fluid restriction and on a diuretic drug (Lasix), Staff 1 admitted to the surveyor: "We have not been recording his intake and output."

A continued review of the clinical record confirmed that there was no evidence that the Resident's intake and output had ever been monitored or recorded.

The facility failed to develop a comprehensive care plan for Resident 19's edema and significant

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 279</td>
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<tr>
<td>F 279</td>
<td>Continued From page 140 weight changes related to congestive heart failure and diuretic therapy. (Cross reference F-328.)</td>
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3. Closed record review on 02/10/06 documented that Resident 69 was admitted on 10/05/05 and re-admitted on 11/01/05 with a diagnosis of Stage III heel ulcers (full-thickness tissue loss extending through dermis to involve subcutaneous tissue).

Review on 02/10/06 of Resident 69's 10/19/05 MDS documented that she had no cognitive problems, was able to understand others and to make herself understood by others, had repetitive anxious complaints, and behavioral symptoms, a sad appearance, and episodes of crying. She also needed extensive staff assistance to transfer from bed to chair, for personal hygiene, including combing hair, brushing teeth, washing face and hands, and for bathing.

Review on 02/10/06 of Resident 69's 10/05/05 Care Plan also documented that at that time the facility was aware that she had a history of suicide attempts. There was no care plan intervention to provide counseling and to prevent Resident 69 from harming herself.

Review on 02/10/06 of the facility's Monitoring Form of 11/05 for Resident 69 documented that Resident 69 had poor appetite since 11/19/05. Review on 02/10/06 of Weight Record documented that Resident 69's weight was 224 pounds on 11/06/05. In addition, on 12/09/05, her weight was reduced to 204 pounds, and then reduced to 195 pounds on 01/09/06 (an unintended weight change of 29 pounds, or 13 percent, in 65 days from 11/06/05 to 01/09/06). There was no documented evidence of care plan interventions to address the weight loss.
### Statement of Deficiencies (XI)

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<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
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The facility failed to develop comprehensive care plans for Resident 69 that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs in counseling for a history of suicide attempts and significant unintended weight loss. (Cross reference F-250, 325.)

4. Resident 84 was originally admitted to the facility on 1/20/93 and readmitted on 2/1/01 with diagnoses including subdural hematoma, seizure disorder, and altered mental status. His 11/28/05 MDS indicated he had short and long-term memory problems, severely impaired decision-making ability, and was not oriented to person, place or time. He was rarely able to make himself understood, and sometimes understood what others said to him. He had the behavioral symptoms of daily wandering not easily altered, verbally abusiveness several days a week that was easily altered, socially inappropriate/disruptive behavior, and resisted care daily.

Review of his Integrated Progress Notes revealed that on 9/18/05 at 6:45 am: "Resident was punched in the chest by resident (Resident 66)-sustained skin redness on the chest." The RN Assessment on 9/18/05 at 8am stated: "Resident is at risk for being injured by others related to his sudden outburst of yelling, verbally abusive using "F" word and using obscene hand gesture which provoke other residents. Resident is advised to stop such behavior so he won't get hurt." Review of his care plan revealed that he was "at risk for injury by others," he had "episodes of shouting, yelling, screaming," and "in dining area he should sit by self to prevent altercations." His care plan
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<td>contained no interventions aimed at protecting him from the assaults of other residents such as by supervising, intervening and redirecting him when he was verbally abusive.</td>
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Review of Resident 84's Integrated Progress Notes on 10/15/05 at 6:20 am revealed: "Heard that resident saying the word "fuck you" to resident (Resident 65) and returned incident (sic) resident (Resident 65) put his hands on his (Resident 84's) neck and slapped him on his left cheek." The RN Assessment of the incident at 7:20 pm stated: "Resident has a history of being verbally abusive." Neither the assessment nor the care plan contained interventions aimed at protecting Resident 84 from the assaults of others by supervising and redirecting him away from other residents when he was verbally abusive.

Review of Resident 84's Integrated Progress Notes revealed that on 12/17/05 at 5:50 pm, Resident 84 "was struck by resident (Resident 65) on his face/punches with an open hand (after) he made an obscene gesture and cursed this resident." The RN Assessment included: "Residents were separated and closely watched....Has history of being loud and verbally abusive." Two hours later, on 12/17/05 at 7:55 am, the notes stated: "Staff heard loud voices at the back ward. When checked CNA saw resident (Resident 65) hitting Resident 84 on his (L) temporal area (the left side of his head) 1x with a fist and 1x with an open hand. Resident 84 was sitting on his own bed at the time." The RN Assessment stated: "Resident unable to give report of what happened related to dementia." Neither the assessment nor the care plan contained any plan or intervention aimed at supervising Resident 84 and redirecting him when
he was verbally abusive in order to protect him from repeated physical abuse and victimization by other residents.

Review of the record revealed that only on 1/9/06, after Resident 84 had been assaulted four times (9/18/05, 10/15/05, and twice on 12/17/05) by two different residents over a period of four months, did the facility develop a care plan for: "At risk for injury from others due to his shouting obscenities and intrusive behavior R/T (related to) internal stimuli (S/P head trauma)." The care plan interventions were: "Observe resident pacing and redirect him to others activities," and "hang signs 'no cursing, hitting here' where resident can observe them," and "if resident shouts, yells, speak in a very low, soft voice," and "also bring him to sign and say: 'this is a rule, no cursing, no hitting."

In an interview on 2/10/06 at 11:30 am, a supervisory nurse stated that Resident 84 provokes the other residents by yelling the F word and makes gestures," but offered no explanation for why staff did not monitor and intervene when Resident 84 began verbally abusing other residents to prevent other residents from him assaulting him.

Observation on 2/16/06 at 2 pm revealed Resident 84 sitting on the edge of his bed near the window. His shoulders were slumped, and he shrunk back when approached by the surveyor. He was a small man (his MDS showed 5'5" tall) and seemed frail. He had trouble answering when asked how he was, mumbling something unintelligible in almost a whisper.

The facility failed to develop a care plan to protect...
F 279 Continued From page 144

Resident 84, diagnosed with subdural hematoma (accumulation of blood in an area of the brain usually caused by injury to the head) and seizure disorder, from being struck in the face, hit in the head with a fist, slapped in the face, stuck on the back of the head, and otherwise repeatedly assaulted by other residents on his unit. The facility failed to develop a care plan to address the problem of assaults on him due to his shouting obscenities until he had been assaulted four times (9/18/05, 10/15/05, and twice on 12/17/05) by two different residents over a period of four months. When they finally did address it, the care plan intervention of hanging signs that said "no cursing, hitting here" where resident could observe them were clearly inadequate for a resident with memory and severely impaired cognitive (reasoning) problems. And, with the exception of redirecting the resident when he was pacing, the plans of care addressed only Resident 84's behavior of shouting obscenities, and failed to develop strategies to monitor and intervene when he began cursing at others to prevent his victimization and assault by others. (Cross reference F-224, F-353.)

5. Resident 86 was re-admitted on 11/29/05 with diagnoses of arthritis and gout with decreased mobility, end stage renal disease (ESRD) diabetic retinopathy and neuropathy, coronary artery disease (CAD), status post coronary artery bypass graft (CABG). The resident is monolingual - Cantonese and Mandarin speaking.

The Integrated Progress Notes dated 1/4/06 revealed the resident went to a dialysis center at 1:00 p.m.. At 8 p.m., the certified nursing assistant reported to the charge nurse a skin redness that measured 20 cm x 9 cm. on the right arm.
Continued From page 145

hip to the thigh. There were also two blisters noted: an open blister that measured 3 cm x 3 cm and an intact blister above which measured 1.5 cm x 1.5 cm. Per Chinese interpreter the resident told the nurse that the incident happened in the dialysis unit. The resident spilled a cup of hot water on her side when the cup was placed on the arm of the chair. The progress notes indicated that there was no report from the dialysis unit.

On 2/16/06 at 2:30 p.m., the charge nurse stated the dialysis unit should report any unusual or significant issues that happen during the dialysis treatment to the unit nurse. A review of the resident care plan indicated the resident goes to dialysis 3 x a week. There were no comprehensive care plans to protect Resident 86 from potential accidents to prevent the recurrence of skin burns in the dialysis unit and how to improve lines of communication with the dialysis unit to ensure continuity of care.

6. Resident 39 was readmitted to the facility on 10-25-05 with several diagnoses including pneumonia, organic brain disease with dementia, diabetes mellitus, and hypertension. Review of the quarterly assessment dated 2-7-06 revealed that Resident 39 had short and long term memory problems, was cognitively impaired, and was dependent on staff for all activities of daily living. The same assessment noted that Resident 39 also had an indwelling urinary catheter.

During wound care observation on 2-14-06, Resident 39 was noted to have an indwelling catheter through which amber colored urine drained. Review of the medical record however revealed the lack of a care plan for the use of the
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<td>F 279</td>
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<td>device. Although mention of the indwelling catheter was made relative to the resident's risk for pressure sore development, a specific plan of care for the catheter was not available. Further record review revealed daily nursing care records which indicated the lack of documented bowel movements extending several days, including up to five days on occasions. Although the resident has a physician's order for the use of laxatives on an &quot;as needed basis&quot; to help ensure that Resident 39 had regular bowel movements, there was no evidence that a care plan was developed outlining acceptable parameters for when laxatives were necessary and how absence of bowel movements could be conveyed to appropriate nursing staff for intervention.</td>
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<td>F 286</td>
<td>483.20(d) RESIDENT ASSESSMENT - USE</td>
<td>A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain 15 months of assessments in the active records of two of 96 sampled residents. (Residents 15 and 72). Findings: 1. Resident 15 was a 53 year old admitted to the facility on 6/21/05 with diagnoses including left above the knee amputation, right hip disarticulation (amputation at the hip joint).</td>
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<tr>
<td>F 286</td>
<td>Continued From page 147 peripheral vascular disease and hepatitis C.</td>
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<td>A 2/10/06 review of his clinical record revealed that there were only two quarterly assessments present instead of the 15 months of assessments required by OBRA.</td>
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<td>During an interview on the same day at 1:30 p.m. the licensed nurse also reviewed the record and stated that they would have to contact Medical Records for the missing assessment. (Cross reference F-272.)</td>
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<td>2. Resident 72 was a 35 year old originally admitted to the facility with myelopathy, neurogenic bladder and multiple decubitus ulcers.</td>
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<td>A 2/10/06 review of his medical record revealed that there were only two quarterly assessments present instead of the 15 months of assessments required by OBRA.</td>
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<td>During an interview on the same day at 10:30 a.m., the licensed nurse also reviewed the record and acknowledged that the missing information.</td>
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<tr>
<td>F 309</td>
<td>483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</td>
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<tr>
<td>SS-D</td>
<td>This REQUIREMENT is not met as evidenced by:</td>
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Based on observation and interview with licensed nursing staff, the facility failed to insure each resident receives and the facility provides the necessary care and services (medical supplies) to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for two of 96 sampled residents (Residents 6 and 39) and three of eight nurses' stations in Clarendon Hall.

Findings:

1. Resident 6 was admitted to the facility on 10-12-05 with several diagnoses including dementia, myelofibrosis, hypertension, and failure to thrive. The Minimum Data Set (MDS) dated 10-21-05 described Resident 6 as having short term memory problem and that she required minimal assistance with activities of daily living (ADLs).

Review of the medical record revealed a facility stay significant for deterioration in Resident 6's medical condition owing to several co-morbidities including severe anemia for which the resident was determined "too ill for chemotherapy;" and enlargement of her spleen as a consequence. On 2-8-06, Resident 6 was transferred to the facility's designated hospice unit for comfort care.

On 2-8-06, integrated progress (IP) notes revealed that "excoriation (was) noted on buttocks" of Resident 6. The same notes added that Nystatin cream was applied as ordered.

At 12 p.m. on 2-8-06, another IP note revealed that Resident 6 had an "open area Stage 2 present on coccyx and peri (perineal) area with
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**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

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<th>COMPLETION DATE</th>
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| F 309         | Continued From page 149

angry rash." Thereafter, an indwelling catheter was inserted "due to being incontinent and having perianal rash." At 11 p.m. (on 2-8-06), IP notes indicated that Resident 6 was "incontinent of loose BM (bowel movement) (times) one at this time."

During observation at 9:15 a.m. on 2-10-06, Resident 6's excoriated areas on the coccyx and both buttocks appeared bright red, with raw open skin that had weepy drainage. During the observation, Resident 6 complained of pain around the excoriated areas. In an interview, a licensed staff stated that the resident had been having loose stools which further contributed to the skin breakdown.

Review of the medication administration record (MAR) revealed that notwithstanding the loose stools, Resident 6 was given laxatives twice daily on 2-8-06 and again on 2-9-06, and in the morning of 2-10-06. Further record review revealed that the physician was only notified about the loose stools at 2 p.m. on 2-10-06 which resulted in both laxatives being discontinued.

Following another observation on 2-14-06, the excoriated areas on Resident 6’s coccyx and both buttocks appeared dry and non-draining and was described by a licensed staff as "much improved" overall.

2. Resident 39 was readmitted to the facility on 10-25-05 with several diagnoses including pneumonia, organic brain disease with dementia, diabetes mellitus, and hypertension. Review of the quarterly assessment dated 2-7-06 revealed that Resident 39 had short and long term memory problems, was cognitively impaired, and was
NAME OF PROVIDER OR SUPPLIER
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF
375 LAGUNA HONDA BLVD.
SAN FRANCISCO, CA 94116

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<td>F 309</td>
<td>Continued From page 150 dependent on staff for all activities of daily living. Further record review revealed that Resident 39 received enteral feedings by way of a nasogastric tube. Review of daily nursing care records (DNCR) revealed several instances when Resident 39 had no recorded bowel movements extending several days, including up to five days on occasions. During the month of January 2006, for example, no recorded bowel movements were available for Resident 39 from 1-1-06 through the day shift on 1-5-06 (a five-day period); from 1-9-06 through the night shift on 1-12-06 (a four-day period); from 1-18-06 through the day shift on 1-20-06 (a three-day period); and from 1-25-06 through the evening shift on 1-29-06 (five-day period). In February 2006, no bowel movements were recorded from 1-30-06 through the day shift on 2-2-06 (a four-day period); and from 2-9-06 through the day shift on 2-12-06 (another four-day period). Review of the medical record revealed a physician's order dated 10-27-05 for the use of a Dulcolax suppository once daily as needed for constipation. Review of the medication administration records (MAR) however revealed that in spite of the physician's order, there was no evidence that Resident 39 was always administered a Dulcolax suppository, as needed. In some instances when a suppository was given, there was no evidence that a follow-up was made to ensure that Resident 39 indeed had a bowel movement. At 6:30 a.m. on 1-3-06, for example, the MAR revealed that Resident 39 was given a...</td>
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FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: 09ME11
Facility ID: CA220000512
If continuation sheet Page 151 of 274
suppository for constipation. No notation however was available in the MAR (or in the medical record) to indicate if the resident indeed had a bowel movement. On 1-11-06, Resident 39 was noted as having been given a suppository at 6:30 a.m. Again, further record review revealed the lack of any follow-up or documentation to indicate if the resident had a bowel movement.

Review of the medical record revealed that although notations were being made relative to the absence or presence of bowel movements by Resident 39 in the DNCR, there was no indication that the information was always conveyed to nursing and/or dietary staff, or to the physician, for intervention. In addition, record review revealed the lack of dietary involvement in the evaluation of the resident's enteral feeding regimen to help minimize constipation. Further record review revealed the lack of a care plan outlining certain goals and interventions to further prevent constipation and to determine baseline parameters for when laxatives are necessary and how the absence of bowel movements could be conveyed to appropriate nursing staff for intervention.

3. In the presence of each station's respective charge nurse, between the hours of 2:00 PM and 3:05 PM on 02/15/2006, the surveyor observed the following in Clarendon Hall: a.) Station One-East, two Kendall Irrigation Trays, one with an expiration date of 07/31/2005 and the other with an expiration date of 08/2005; b.) Station Two-South, one silastic catheter 18 French with an expiration date of 07/2005 and one 18 French catheter with an expiration date of 03/2003, and c.) Station Two-West, one silicone elastomer coated 22 French catheter with an expiration date
### SUMMARY STATEMENT OF DEFICIENCIES

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**483.25(a)(1) ACTIVITIES OF DAILY LIVING**

Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.

This REQUIREMENT is not met as evidenced by:

Based on observation, family member interview, resident and staff interview, and record review, the facility failed to ensure that one of 96 sampled residents' ability to ambulate did not diminish. (Resident 82).

**Findings:**

Record review on 02/05/06 documented that Resident 82 was admitted on 09/21/04 and re-admitted on 05/02/05 with diagnoses including organic brain disease, end stage renal failure, heart problems, and old stroke.

A 02/05/06 review of Resident 82's 01/25/06 MDS (Minimum Data Set, an assessment tool) documented that Resident 82 had short-term memory problems, poor decision-making skills,
mood and behavior patterns of persistent anger with himself and others, and he resisted care. He had difficulty walking, and needed extensive staff assistance to dress, comb his hair, brush his teeth, shave, wash his hands and face, and bathe. He had partial loss of the voluntary movement of one arm and hand. However, there was no documented evidence that nursing rehabilitation restorative care had been provided to Resident 82 in the last seven days.

Review on 02/05/06 of the facility's "Care Plan: Resident Needs" documented that Resident 82 needed ambulation with the assistance of one person. Review of Resident 82's 05/10/05 Care Plan document that he had been refusing to ambulate at times, depending on his mood. The care plan goals were that the resident would "co-operate to ambulate with walking with one person stand-by assist daily, and will increase ambulation to 35 feet daily." The care plan interventions were the following: "Staff to ambulate resident without walker. Staff stand by and assist as tolerance. Observe for any dizziness, discomfort with ambulation." The Target Date of the care plan was updated to 05/06. There was no documented evidence that the facility had implemented the care plan interventions.

Review on 02/05/06 of the facility's Treatment Record revealed that the facility had assisted Resident 82 to ambulate only during the months of 09/05 and 10/05.

During the initial tour on 02/05/06 at 10:00 a.m., Resident 82 was observed sitting on the side of his bed. At the same time and date, his spouse, who was at Resident 82's bedside on a visit, told...
### Statement of Deficiencies and Plan of Correction

**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

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<tr>
<th>ID Prefix</th>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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<th>Provider's Plan of Correction (Each Corrective Action Should be Cross-referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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<td>F 310</td>
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<td>Continued From page 154 the surveyor that her husband was not able to stand up or walk by himself shortly after the facility failed to assist him to walk. During an interview at that time, Resident 82 stated he and his spouse were upset that the facility did not assist him to ambulate. In an interview on 02/16/06 at 2:00 p.m. a licensed nurse stated that Resident 82 had therapy before, and he could walk a few steps. She also stated that in 09/05 and 10/05, Resident 82 had been assisted to walk by the nursing staff. However, since 11/05 the facility had only verbally encouraged Resident 82 to ambulate. The facility failed to ensure that Resident 82's ability to ambulate did not diminish when they failed to implement their own care plan intervention for ambulation, resulting in Resident 82's diminished ability to ambulate.</td>
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<td>F 311</td>
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<td>483.25(a)(2) Activities of Daily Living A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to provide appropriate treatment and services to two of 96 sampled residents. (Residents 87, 86) They failed to maintain Resident 87's ability to transfer and toilet, and Resident 86's ability to transfer. Findings:</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF
375 LAGUNA HONDA BLVD.
SAN FRANCISCO, CA 94115

(X4) ID PREFIX TAG: F 311

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

1. Resident 87 was admitted in the facility on 2/2/05 with diagnoses of status post left hemorrhagic cerebrovascular accident (CVA) with right hemiparesis, hypertension, hyperlipidemia, depression with anxiety, and status post cataract surgery. The resident is monolingual and speaks Cantonese only.

The annual minimum data set (MDS) dated 1/12/06 revealed the resident has no memory problems and independent with daily decision making. She required limited assistance with one person physical assist to transfer from bed and wheelchair. She also required limited assistance with one person physical assist to toilet.

On 12/2/05, the physician ordered a low bed but the resident continues to sleep in a bed of regular height. On 2/16/06 at 10:20 a.m., Resident 87 stopped the surveyor and gestured pointing at her bed. Through the facility's interpreter, a social worker, Resident 87 stated that she really needed a low bed due to difficulty to transfer from bed and wheelchair. She stated that she would be able to go to the bathroom independently. Also, her husband comes in everyday to make sure that she gets everything ready within her reach at night. She stated that she goes to the bathroom during the day but had to use a bedpan at night because she is afraid to fall again.

A review of the resident's Integrated Progress Notes revealed the resident had two fall incidents - 11/20/05 and 12/2/05.

The Interdisciplinary Team Meeting Note dated 11/21/05 identified the resident as alert, oriented, usually leaves the ward independently. The note
revealed the resident stated per interpreter she was attempting to move something out of the way in the bathroom, leaned forward and slid from the wheelchair landing on her buttocks. The resident denied any pain.

The Integrated Progress Notes dated 12/2/05 showed a Focused Progress Note describing the resident fall: Nursing staff heard a loud noise, staff found the resident lying on her tummy with right hand holding on to the side of bed rail. Resident states via interpreter, "I did not hit my head. I tried to go to go to BR (bathroom) by myself." The resident complained of slight bearable pain on the right shoulder and right knee but no bruise nor swelling was noted. The RN assessment indicated upon examination, range of motion on all extremities was done and the resident was able to move without difficulty. Nursing staff advised the resident to use call light when she needs help.

A plan of care dated 2/2/05 identified a problem that the resident was at risk for falls. On 11/20/05 a care plan indicated the resident fell. The interventions dated 12/05 included: keeping wheelchair locked when transferring at all times; call staff when transferring, and remove or keep empty wheelchair in the designated places.

The physical therapy initial assessment dated 12/22/05 revealed problems that included transfer impairments, gait impairments, functional mobility impairments and generalized decrease strength/endurance. Part of the treatment plan were transfer and gait training. The "current comments" section of the assessment form stated, "Overall pt (patient) has good mobility on a hard surface (mat) and supine to sit on a low
surface.” The failure of the facility to obtain the low bed for this resident had prevented the resident from independently using the bathroom.

2. Resident 86 was re-admitted on 11/29/05 with diagnoses of arthritis and gout with decreased mobility, end stage renal disease (ESRD) diabetic retinopathy and neuropathy, coronary artery disease (CAD), status post coronary artery bypass graft (CABG). The resident is monolingual, Cantonese and Mandarin speaking.

On 2/16/06, at 10:30 a.m., Resident 86 was observed at the edge of the bed attempting to transfer from the bed to the wheelchair. The social worker who was interpreting for another resident immediately ran to Resident 86’s bedside preventing the fall. The surveyor had to summon the nursing staff on the opposite end of the ward to request for more assistance. The social worker pointed out the height of the resident’s bed in relation to the resident’s height of 62 inches with difficulty in keeping her feet touch the floor to reach and lock the wheelchair in place. This was confirmed by the charge nurse who stated that the resident was unable to lock the wheelchair due to inability to transfer safely from bed to wheelchair.

On 2/16/06 at 2:55 p.m., in the presence of the social worker as interpreter, Resident 86’s regular bed was measured. The distance from the top of the bed to the floor was 24 inches. The distance of the resident’s wheelchair from top of the cushion to the floor was 20 inches. A difference of four (4) inches was confirmed.

A review of the Integrated Progress Notes revealed the resident had three fall incidents on
### F 311

Continued From page 158
12/22/05, 1/1/05 and 2/10/06.

Fall #1: The Focused Progress note dated 12/22/05 at 9:40 p.m revealed the resident was found lying in the floor on her left side in front of the wheelchair. Per interpreter, resident stated she stood up and when she sat on the wheelchair, the wheelchair moved back and she lost her balance. The resident had no injuries at the time of the fall. On 12/23/05 at 2:45 a.m. the resident was moaning and complaining of severe pain on the right knee and leg and assessed as #8 in the scale of 1 - 10 with #10 as severe pain.

### F 314

483.25(c) PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:

Based on observation, medical record review, and interview, the facility failed to provide necessary treatment and services to promote healing and prevent new sores from developing on three of 96 sampled residents. (Residents 33, 85, and 39) Resident 33 was not identified with a Stage 1 before it developed to a Stage 2. Resident 85 had a blister that the staff broke with dirty gloves. Resident 39 who had a Stage 2...
Continued From page 159

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<td>Pressure sore on the sacral area was not repositioned regularly to relieve pressure on the sacrum.</td>
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Findings:

1. Resident 33 was admitted to the facility on 7/11/2000 with diagnoses of peripheral vascular disease, dementia, and anemia.

A review of the medical record on 2/9/06 revealed that the 11/15/05 Quarterly Minimum Data set (MDS-assessment tool) noted that Resident 33 had short-term and long-term memory problems and his decision making was moderately impaired. He was non-ambulatory and needed maximum assistance from staff in most areas of activities of daily living. He was incontinent of bowel and bladder.

Resident 33 had physician orders for Lasix (Diuretic) 10 mg. daily, Vitamin C 250 mg. daily and Aspirin 325 (Analgesic and Anti-inflammatory) mg. daily.

The 9/9/03 care plan documented, "Potential for skin breakdown due to Bowel and Bladder incontinence and refused to go to bed at night." Resident 33's Ideal Body weight was 98 more or less 10% (88-108). The Dietary care plan dated 3/9/05 documented: "Recent significant weight loss, unplanned potential for wt. (weight) fluctuations secondary to diuretics. On Lasix and Digoxin secondary to congestive heart failure and wt. (weight) fluctuations expected, monitor changes. Offer Ensure TID (3x a day) between meals to provide added kcals & protein." The 6/9/05 care plan intervention indicated: "Roho seat cushion to low seat wheelchair. Try recliner
On 2/6/06, Resident 33 developed a Stage 2 pressure sore on her left buttock (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The nursing notes on 2/6/06 indicated: "Skin breakdown sustained a 1.5 cm. x 0.2 cm. superficial Stage 2 open area, clean & pink, no odor, no discharge located in left buttock area." On 2/6/06, the physician wrote a treatment order for "Polyman dressing to left buttock. Change when 75% saturated. Do wound assessment weekly left buttock every Monday."

In an interview with the licensed staff on 2/9/06 at 10:00 a.m., this Surveyor asked for an assessment of a Stage 1 (Non-blanchable erythema of intact skin) before the pressure sore developed to a Stage 2. The licensed staff said the C.N.A reported the skin breakdown to the licensed staff on 2/5/06. She said the pressure sore was a Stage 2 at that time.

On 2/9/06 at 11:40 a.m., the licensed staff did an assessment of the pressure sore with this Surveyor. Resident 33 was alert, followed instructions by the staff, and she was verbally responsive in Chinese with an interpreter at the bedside. The pressure sore on her left buttock was healed with a thin light brown scar.

The staff did not identify a Stage 1 pressure sore on the Resident's left buttock. The Stage 2 pressure sore would have been avoided had the staff identified a Stage 1, and implemented interventions to prevent the pressure sore from
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<td>Continued From page 161 developing to a Stage 2. (Cross reference F-279, 329.)</td>
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<td>2. Resident 85 was admitted to the M-5 unit of the facility on 10/25/2005 with diagnoses that included pressure sores and SDAT (brain condition); the resident was subsequently transferred to the Hospice Unit at C-2.</td>
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<td>On 2/7/06 at approximately:15 A.M. in the Hospice unit, a CNA was observed completing care for resident #85, which included peri care; she had gloves on her hands. The CNA then provided assistance to the staff nurse during wound care; however, the CNA did not change her gloves prior to the start of the wound care procedure.</td>
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<td>Following the personal care, performed by the CNS, a staff nurse, with the assistance of the CNA, performed wound care for Resident 85. The staff nurse performed wound care to the coccyx area for this resident according to physician orders. When the surveyor asked to observe the right heel of the resident, the CNA lifted the Resident's right heel for observation. There was a blister on the resident's right lateral heel. The CNA then took her gloved hand and ran a finger over the blister at which time the blister broke and fluid from the blister oozed from the area. The CNA then opened the chest of drawer next to the resident's bed and reached in and dipped her finger into a jar of vaseline and scooped some of the vaseline out of the jar. She then proceeded to apply the vaseline onto the opened blister on the right heel. The staff nurse then used a piece of sterile Kerlix to wipe the vaseline from the wound; however, this procedure did not remove all of the vaseline from the now open area. The staff nurse</td>
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then proceeded to dress the wound with polymen, taped the polymen in place, then covered the polymen with gauze, wrapped the heel with Kerlix and taped the dressing in place.

The physician's order for wound care is dated 11/07/05 and reads: "Wounds: Dilute ioprep wash/polymen." The staff nurse did not use the dilute ioprep when cleansing the wound of the vaseline and before applying the polymen.

The unit charge nurse was interviewed regarding the wound care procedure that was done by the staff nurse. She agreed that it was not the right procedure.

The resident's care plan, dated 10/25/05 includes as a goal: "Altered skin integrity re: Stage II - R heel;" the goal: "will have no signs of infections, no complications." For the date of 10/27/05 an intervention on the care plan reads, "Decub mattress with cube removed under pressure area."

During an interview, the charge nurse stated that the resident had been admitted to the M-5 unit and that the right heel pressure had healed while the resident was still on that unit. The resident was then transferred to the Hospice unit with no current pressure sore on the right heel. The charge nurse further stated that the right heel was fragile and had to be watched for possible further breakdown.

On 2/9/06 at 11:10 A.M. the resident's bed was observed to determine if there was a special mattress in place to help prevent pressure sores from developing. The unit Charge Nurse was at the bedside and showed the surveyor the
"pressure sore mattress." When asked how this particular mattress works, the charge nurse stated that there were sections that had to be manually removed for particular parts of the body that rested on the mattress and that when these sections were removed, that created more air and less pressure on a particular area of the resident's body. When asked, the charged nurse showed the surveyor the section of the mattress that was under the resident's heels. She further stated that this section of the mattress had not been removed.

3.) Resident 39 was admitted to the facility on 10-25-05 with several diagnoses including pneumonia, organic brain disease with dementia, diabetes mellitus, and hypertension. Review of the quarterly assessment dated 2-7-06 revealed that Resident 39 had short and long term memory problems, was cognitively impaired, and was dependent on staff for all activities of daily living. The same MDS also noted that Resident 39 had an indwelling catheter.

Review of the medical record revealed a care plan dated 10-25-05 regarding Resident 39's risk for skin breakdown "secondary to her immobility and incontinence of bowel." The care plan included interventions including monitoring the resident's skin every shift, repositioning every two hours while in bed, and performing prompt pericare after each soiling of bowel movement.

Further review of the medical record revealed the development of an open area on the coccyx as noted in integrated progress (IP) notes dated 1-10-06. During observation of wound care on 2-14-06, the open area on the coccyx was noted to be about 0.5 cm by 0.5 cm and was clean and...
Continued From page 164

dry without drainage. During an interview on 2-14-06, the licensed staff stated that the open area on the coccyx had previously healed but had reopened. Review of treatment records indicated that the open area on the coccyx had indeed healed on 12-29-05. In spite of this, there was no evidence that ongoing evaluation was conducted to determine the cause of the recurring open areas, including the need for more frequent turning if appropriate. In addition, while observations were made during the survey when Resident 39 was repositioned every two hours while in bed, in several instances however, staff did not always ensure that the resident's coccyx area was off the bed. At 10:50 a.m. on 2-15-06, for example, while Resident 39 was observed lying on her right side, her lower body however was noted to be flat in bed in spite of a pillow behind her. The resident was observed in this position until 1:15 p.m.

F 314

483.25(d) URINARY INCONTINENCE

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility
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<td>did not ensure that a resident who entered the facility without an indwelling catheter was not catheterized unless the resident's clinical condition demonstrated that catheterization was necessary (Resident 6); and that a resident who was incontinent of bladder function received appropriate care and services to prevent urinary tract infection and restore as much normal bladder function as possible (Resident 39) for two of 96 sampled residents.</td>
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<td>Findings:</td>
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<td>1. Resident 6 was admitted to the facility on 10-12-05 with several diagnoses including dementia, myelofibrosis, hypertension, and failure to thrive. The minimum data set (MDS) dated 10-21-05 described Resident 6 as having short term memory problem and that she required minimal assistance with activities of daily living (ADLs).</td>
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<td>Review of the medical record revealed a facility stay significant for deterioration in Resident 6's medical condition owing to several co-morbidities including severe anemia for which the resident was determined &quot;too ill for chemotherapy.&quot; On 2-8-06, Resident 6 was transferred to the facility's designated hospice unit for comfort care.</td>
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<td>On 2-8-06, integrated progress (IP) notes revealed that &quot;excoriation (was) noted on buttocks&quot; of Resident 6. At 12 p.m. (on 2-8-06), another IP note revealed that Resident 6 had an &quot;open area Stage 2 present on coccyx and periarea with angry rash.&quot; Accordingly, an indwelling catheter was inserted &quot;due to being incontinent and having perianal rash.&quot;</td>
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Review of the medical record however revealed the lack of a medical justification for the use of the indwelling catheter. In an interview on 2-10-06, a licensed staff stated that the resident had been having loose stools which contributed to the skin breakdown. Further record review revealed IP notes dated 2-8-06 (at 11 p.m.) indicating that Resident 6 was incontinent of loose bowel movement.

Following an observation on 2-14-06 after the loose stools have subsided, the excoriated areas on Resident 6's coccyx and both buttocks appeared dry, non-draining and was described by a licensed staff as "much improved" overall. In light of this, there was no indication that an evaluation was conducted or that attempts were made by staff to remove the indwelling catheter because of the lack of indications for its use.

2. Resident 39 was admitted to the facility on 10-25-05 with several diagnoses including pneumonia, organic brain disease with dementia, diabetes mellitus, and hypertension. Review of the quarterly assessment dated 2-7-06 revealed Resident 39 had short and long term memory problems, was cognitively impaired, and dependent on staff for all activities of daily living. The same MDS noted that Resident 39 had an indwelling catheter.

Review of the medical record revealed that although integrated progress (IP) notes contained documentation regarding the indwelling catheter, there was no indication that a physician's order was obtained for the use of the device. In addition, further record review revealed the lack of documented medical indication for its continued use.
Continued From page 167

During an interview on 2-16-06, nursing staff stated that the indwelling catheter may have been in place since the resident’s admission to the facility on 10-25-05.

**F 322**

**483.25(g)(2) NASO-GASTRIC TUBES**

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and interview, the facility did not ensure that one resident out of 96 sampled residents who was fed by a naso-gastric tube received appropriate treatment and services to prevent potential complications of long-term naso-gastric tube use including the development of naso-pharyngeal ulcers (Resident 39).

**Findings:**

Resident 39 was admitted to the facility on 10-25-05 with several diagnoses including pneumonia, organic brain disease with dementia, diabetes mellitus, and hypertension. A quarterly assessment dated 2-7-06 described Resident 39 as having short and long term memory problems, was cognitively impaired, and dependent on staff.
### Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)

<table>
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<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
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</thead>
<tbody>
<tr>
<td>F 322</td>
<td>Continued From page 168 for all activities of daily living.</td>
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<td>F 323 SS=E</td>
<td>483.25(h)(1) ACCIDENTS</td>
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Review of the medical record revealed that Resident 39 received enteral feedings of Glucerna by a nasogastric tube at 50 cc's/hour, a regimen ordered by the physician since the resident's readmission on 10-25-05. During an interview on 2-14-05, a licensed staff stated that Resident 39 had been on nasogastric tube feedings for "a long time."

At 10 p.m. on 10-25-05, integrated progress (IP) notes revealed that the nasogastric tube was "clogged" and thereafter "reinserted." The note added that Resident 39 "continues holding the tube trying to pulling out (sic)."

Further record review revealed the lack of indication of any discussion or evaluation by the interdisciplinary team to determine the appropriateness of placement of a gastrostomy tube to promote patient comfort and minimize potential complications of long term use of the nasogastric tube. Review of the medical record revealed that enteral feedings would be a long term intervention to meet the resident's nutritional needs in light of her current medical condition.

The facility must ensure that the resident environment remains as free of accident hazards as is possible.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, the
F 323  Continued From page 169

facility failed to ensure that the resident environment remained free of accident hazards on the third floor smoking area.

Findings:

During the environmental tours on 02/05/06 at 11:00 a.m., and 02/06/06 at 11:30 a.m., six resident beds were observed stored on the third floor smoking area. Three resident beds contained mattresses. Residents were observed sitting on the mattresses and smoking.

Litter such as empty food cartons, used plastic food wrapping, used napkins, used paper cups, old newspapers, and old banana peels were also observed on the tours.

In an interview on the same date and time as the tours, a security staff member acknowledged that empty beds and mattresses were stored on the third floor smoking area because they were waiting to be repaired. The security staff also acknowledged that the residents' smoking on or near the mattresses was a fire hazard.

483.25(h)(2) ACCIDENTS

The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that eight of 95 sampled residents received adequate supervision.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**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

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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| F 324 | Continued From page 170 and assistance devices to prevent accidents. (Residents 2, 6, 45, 47, 48, 49, 59, and 60). (1.) The facility failed to inventory Resident 6's belongings on admission to discover her loaded firearms. (2.) The facility failed to supervise Resident 47 to prevent her fall and left hip fracture; six weeks later they failed for eight days to discover her right hip fracture after she complained of right leg pain when she attempted to walk. (3.) The facility failed to supervise and meet the needs of Resident 45 to prevent her fall that resulted in subdural hematoma, and blow-out fracture of her one good eye, rendering her blind. (4.) The facility failed to supervise Resident 2 to prevent him from drinking alcohol and smoking in bed. (5.) The facility failed to supervise Resident 48 to prevent him from selling or trading drugs. (6.) The facility failed to supervise Resident 49 to prevent him from verbally threatening other residents. (7.) The facility failed to supervise and prevent Resident 59 from obtaining methamphetamine after he was admitted on 9/6/2005, requiring his involuntary transfer (5150) to the hospital Psychiatric Emergency Service (PES) on 10/31/2005 after he put a plastic bag over his head, broke a window and attempted to bite police. Re-admitted a day later on 11/1/2005, he was again 5150'd on 11/8/2005 after he obtained methamphetamine, threatened staff, attempted to set his pubic hair on fire with a cigarette lighter, and tried to bite staff. On 2/6/06 during the survey, an administrative staff person said the facility would readmit Resident 59 despite previous unsuccessful attempts to supervise and prevent him from obtaining methamphetamine. (8.) The facility failed to supervise Resident 60 to
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| OMB NO. 0938-0391 | | | | | | | |

| FORM APPROVED | | | | | | | |

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| OMB NO. 0938-0391 | | | | | | | |

| FORM APPROVED | | | | | | | |

| PRINTED: 03/23/2006 | | | | | | | | |
Continued From page 171

prevent him from drinking in bed, falling, and altercations with other residents.

Findings:

1. Record review on 12/5/05 revealed that Resident 6, age 71, was admitted to the facility on 10/12/05 with organic brain syndrome and dementia. Her 10/18/05 Minimum Data Set (MDS) revealed she had memory problems, persistent anger, reduced social interaction, and resistance to care. She required supervision to get out of bed and walk, but needed extensive staff assistance to bathe and dress.

Review on 2/16/06 of the facility's Handling Resident's Property and Prevention of Theft and Loss Policy, revised 10/30/96, revealed: "Upon admission to (the facility), the nursing staff member and the resident and/or his representative shall complete an inventory of the resident's property. Inventory on the resident's property will be recorded on a form entitled "Inventory of Patient's Property (IRP).....(The facility) reserves the right to exclude property on the IRP (such as....firearm/weapons, hazardous waste, toxins.)"

In an interview on 12/5/05 at 3 PM, Resident 6 stated she always had the guns, an old boy-friend gave them to her a long time ago, and she didn't want to leave them in the hotel room where she had been living because she was afraid they would get stolen.

In an interview on 12/5/05 at 3:15 PM, a licensed nurse on Ward M-5 where Resident 6 was first admitted stated staff usually search resident's belongings on admission, but the resident was
Continued From page 172
very protective of her things.

In an interview on 12/5/05 at 3:45 PM, a licensed nurse stated that when Resident 6 was relocated to Ward F-4 on 11/29/05, the nurses' aide who inventoried her belongings found the two guns in the bottom of a bag under some clothes. The nurse said she called the institutional police who took the guns.

Review on 12/5/05 of a San Francisco Police Department Police Report, dated 11/29/05, revealed an incident entitled: "Possession Loaded Handgun/Property (for) Safekeeping." It showed that two stainless steel S&W (Smith and Wesson) 4" Black grip 5 shot revolvers and ten Winchester .38 caliber bullets with silver tips were taken into custody by the police on 11/29/05. The report stated: "...they were loaded with unexpended .38 caliber bullets. I unloaded the firearms in a safe manner and secured the firearms and unexpended bullets." The report stated the resident told the officer the guns were registered in her name. It said the guns were confiscated, and the resident gave permission for them to be given to her son.

The facility failed to follow their own policy to inventory Resident 6's belongings when she was admitted. After she had been in the facility a month and a half, two loaded Smith and Wesson revolvers were found among the belongings she brought with her to the facility.

2. Record review on 2/9/06 revealed that Resident 47 was originally admitted to the facility on 7/26/05 with diagnoses of organic brain disease, hypertension, and falls. Her 8/1/05 MDS indicated she had short and long-term memory
### Statement of Deficiencies

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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
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<tbody>
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<td>F 324</td>
<td>Continued From page 173 problems, moderately impaired decision-making ability, periods of restlessness, anger, daily wandering, physically abusive symptoms, and resisted care. She required extensive assistance to change positions in bed, get out of bed, dress, bathe and use the toilet. She could feed herself, needed only supervision to walk in the room and corridor, and was usually continent of bowel and bladder. She had moderate pain less than daily. She had a 7/26/05 care plan for &quot;at risk for elopement&quot; due to cognitive impairment and asking to leave. The interventions were: &quot;Staff to supervise whereabouts of resident and provide redirection if resident is getting confused or wandering,&quot; and &quot;1:1 close observation at all times.&quot; Review on 2/9/06 of her 10/9/05 Interdisciplinary Notes revealed: &quot;At 7:55 am (Resident 47) was found sitting on the floor in the shower room, calling for help as she was in pain, could not move. She went there as she was redirected to dining area for breakfast, but confused she got into shower room (next area). She stated that she slipped (sic) and fell on her buttocks.&quot; The RN Assessment at the same time stated: &quot;Patient sat on the floor, both legs straight forward with slippers on, partly on pad and floor. She c/o pain at (L) hip, but (L) leg and foot rotated outward.... She stated that she slipped and fell. Area around dry, well-lighted, but there are 2 pads on the floor.&quot; She was transferred to the hospital at 9:40 am. on 10/9/05. Later that day at 3:10 PM, the notes stated that the hospital called and informed the facility that Resident 47 &quot;had (L) hip fracture and will be scheduled for surgery today.&quot; In an interview on 2/9/06 at 11:30 am, a licensed nurse said that on Sunday morning, 10/9/05</td>
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about 8 or 9 am, Resident 47: "was in bed and got up to go to the table for breakfast. She was confused and went to the shower room while staff were passing breakfast trays." The nurse said she heard staff calling from the shower room, and "found Resident 47 in a sitting position on the floor with her PJs and sandals on saying she was having pain."

Record review on 2/9/06 revealed that Resident 47 was readmitted to the facility on 10/13/05 with diagnoses of (L) hemi-arthroplasty (surgical repair of (L) hip fracture), dementia and cataracts. Her 10/17/05 MDS indicated she had short and long-term memory problems, moderately impaired decision-making ability, was easily distracted, had periods of altered perception, restlessness, and resisted care. She required two person extensive assistance to turn in bed, was totally dependent on two persons to get out of bed, did not walk, needed to be fed, and was totally dependent on staff to move in her wheelchair. She was totally dependent on staff for hygiene, and was incontinent of bowel and bladder. She had limited range of motion and loss of voluntary movement of one leg, excruciating pain daily, and 3 Stage II pressure sores. Her 10/25/05 Interdisciplinary Team Meeting notes revealed that Resident 47 had "started walking in PT (physical therapy) with a FWW (front-wheel walker)." Her 11/15/05 Integrated Progress Notes stated Resident 47: "No fall during this week. Walks 2/day 15 min each time...limited to extensive assistance with one CNA. Resident can feed herself after set-up."

Record review on 2/9/06 revealed that seven days later, on 11/22/05 at 9:30 am, the Integrated Progress Notes stated: "CNA tries to walk
### Statement of Deficiencies

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<td>F 324</td>
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- Resident to BR from bedside with FWW. Resident yells and complains pain at (R) leg. Dr. examines resident and orders Roxanol 5mg p.o. (by mouth) every 9 am prior to ambulation and evaluate in one week." At 11 am on 11/22/05, the notes stated: "Remains alert, oriented x 2, verbally responsive. Able to communicate her feelings and needs. (L) hip incision wound-opening healed already...on fall precaution. No fall this week....Sometimes resident refuses to walk."

- Record review on 2/9/06 revealed that on 11/29/05 at 10 am, the Integrated Progress Notes stated: "On restorative ambulation, transfer/dressing/toileting program. Refuses to ambulate and is unable to pivot transfer by yelling and refuses to participate. According to resident she has pain in both legs. MD is aware she is on trial of Roxanol 5 mg p.o. prior to ambulation since 11/22/05 but it does not help. Today Dr. orders to change Roxanol to bedtime instead of in the morning. Keeps Tylenol 3x/day. Will evaluate after 1 week. Staff transfer resident with EZ lift from bed to chair and vice-versa." On 12/1/05 at 11:50 am, the Integrated Progress Notes stated: "X-ray hip taken this morning indicates possible dislocation (R) hip. Dr. sends resident to hospital for evaluation."

- Record review on 2/14/06 revealed that after her surgery, Resident 47 was readmitted to the facility on 12/5/05 with diagnoses of (R) femoral neck (hip) fracture, (R) hemiarthroplasty (surgical repair of R hip fracture) on 12/2/05, organic brain disease, (L) hemiarthroplasty (surgical repair of L hip fracture) 10/10/05, hypertension and hearing deficit. Her 12/12/05 MDS indicated she still had memory and moderately impaired thinking problems, sad face, and was now totally...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F 324</td>
<td>Continued From page 176</td>
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Dependent on staff for all her care, including turning herself in bed, getting out of bed, dressing, toileting, bathing, and needed to be fed. She remained incontinent of bowel and bladder, but had moderate pain less than daily, and a Stage I pressure ulcer.

In an interview on 2/14/06 at 12 PM, a licensed nurse stated that Resident 47 "complained of pain in her right hip at 9 am on 12/1/05. When the CNA tried to get her up, she said she had pain and refused to walk. The nurse asked the doctor to check her. The doctor came, checked the resident, and said there was no swelling or bruise on her right hip. The next day the resident still had pain, but nobody had reported anything about a fall."

Observation on 2/14/06 at 12 PM revealed Resident 47 sitting in her wheelchair at the table in the unit's dining room. She smiled and nodded when asked how she was by the surveyor through a translator. Resident 47 was alert and verbally responsive in her non-English language. She appeared neatly dressed, and comfortable.

In an interview on 2/16/06 at 11:45 am, a licensed nurse was asked why, since Resident 47 complained of pain in her right hip on 11/22/05, it took the facility eight days until 12/1/05 to discover she had a hip fracture. The nurse said when the doctor looked at the resident on 11/22/05, she said there was no discoloration and no bruise. She said she thought "she's confused" about where her pain was.

The facility failed to monitor Resident 47 with 1:1 supervision and intervene to prevent her fall and left hip fracture on 10/9/05. After she returned to
Continued From page 177

The facility on 12/5/05 following surgery on her left hip, she complained of right leg pain on 11/22/05 and refused to walk. It took the facility eight days (until 12/1/05) to discover she had a right hip fracture requiring surgery. For eight days, the resident was moved around in bed, urged to walk and bear weight, and transferred in and out of bed with a lift, movement which caused her pain and may have aggravated her un-stabilized fracture. When the resident told facility staff she had pain in her right leg, facility staff concluded she was confused. When Resident 47 was originally admitted on 7/26/05, she could feed herself, needed only supervision to walk in the room and corridor, and was usually continent of bowel and bladder. When she was readmitted on 12/5/05 after her second hip fracture, Resident 47 needed to be fed, no longer walked, was totally dependent on staff for all her care, including turning in bed, getting out of bed, dressing, toileting, bathing, and was incontinent of bowel and bladder.

3. Record review on 2/9/06 revealed that Resident 45, age 92, was admitted to the facility on 1/3/06 and with diagnoses including hip fracture after a fall on 12/14/05 at home, arthritis, atrial fibrillation, cataracts, history of breast cancer with right mastectomy, and depression. Her 1/9/06 MDS indicated her memory was O.K., she was alert and oriented to person, place, and time, had modified independence in decision-making, and impaired vision. She required extensive staff assistance to turn in bed, get out of bed to a chair, move around her unit, toilet and hygiene. She did not walk, and was totally dependent on staff to dress, and bathe. She needed one staff person's limited assistance to eat, had limited range of motion and partial loss.
**F 324** Continued From page 178

of use of one foot and leg, and was frequently incontinent of bowel and bladder. The 1/13/06 RAP Summary stated: "Speaks (non-English language) Translator needed for communication. Refer to face sheet of care plan."

Record review on 2/9/06 revealed that Resident 45 had a 1/3/06 physician’s order for: "Metoprolol 12.5 mg po (by mouth) BID (twice a day) (hold for SBP (systolic blood pressure) below 110." (Metoprolol is a blood pressure medication with a common side-effect of hypotension, or excessively low blood pressure) Review of the resident’s January 2006 Medication Administration Record (MAR) revealed that her Metoprolol was not given because her systolic blood pressure was below 110 on the following days: 1/3/06 at 5 PM, 1/4/06 at 9 am, 1/5/06 at 9 am and 5 pm, 1/6/06 at 9 am and 5 PM, 1/7/06 at 5 PM, and 1/9/06 at 5 PM. On 1/11/06, the physician changed the order to "Metoprolol 12.5 mg once a day. Hold for SBP below 110." The January 2006 MAR showed that her once a day Metoprolol was not given on 1/16/06 and 1/17/06 because her systolic blood pressure was below 110 at 9 am on those days. On 1/18/06, the MAR stated: "1/18/06, 9 am, Metoprolol is hold (sic), BP (blood pressure) = 103/59——114/88 mmHg 2 PM, AP (apical pulse) 94; Metoprolol is given."

Record review on 2/9/06 revealed that Resident 45's 1/11/06 care plan stated: "Resident is at risk for fall R/T (related to) history of fall and use of BP (blood pressure) meds." The goal was: "Resident will have no fall in 3 months." One of the interventions was: "Monitor BP for orthostatic hypotension." (Orthostatic hypotension, as defined by Mosby's Pocket Dictionary of Medicine, Nursing & Allied Health, Fourth Edition,
is: "abnormally low blood pressure that occurs when an individual suddenly assumes the standing position. It can produce dizziness and fainting." Orthostatic hypotension monitoring is measured by taking a person's lying, sitting and standing blood pressures consecutively to determine if the blood pressure drops when he or she stands.) The record contained no documentation to show that Resident 47 was ever monitored for orthostatic hypotension. Another care plan intervention was: "Anticipate needs of resident by checking or asking her what she needs." The care plan did not specify how facility staff who did not speak the resident's non-English language were to ask her what she needs.

Record review on 2/9/06 revealed that Resident 47's 1/18/06 Integrated Progress Notes at 6 PM revealed: "Resident sitting in her bed eating her dinner with set-up tray." At 6:45 PM the notes stated: "Passed by resident and I saw her standing at the foot part of her bed and fixing her dinner tray. I attended to her and told her that we will take care of her dinner tray and I assisted her back to sit on her bed." At 7 PM, the notes stated: "Per witness, Resident stood up from her bed (#28) took a few steps in between her bed and bed #29 then she swayed and fell and she hit her head at the corner of be #29. Resident stood up without calling for assistance or help." The 1/18/06, 7 PM, RN Assessment/Comments stated: "Resident was alert and verbally responsive in (a non-English language). She sustained about 1 cm cuts on (R) upper eyelid, swollen and with bleeding....Resident had a low BP 75/53 after the fall."

Record review on 2/14/06 revealed that Resident 45's 1/24/06 History and Physical Examination
Continued From page 180

stated: "The patient returns from a six-day admission at (the hospital) where she was taken after having a fall on ward K-7 in the evening of 1/18/06. During that fall she struck her right periorbital area on what is believed to be the side of a neighboring resident's bed. Due to the nature of the injury, she was sent urgently to (the hospital) immediately after the fall.... A CT scan done in the emergency room showed: a) a right posterior "blowout" fracture of the orbit with bony fragment displaced medially and superiorly, b) right frontal lobe contusion (2 1/4 x 2.6 cm) and c) right frontotemporal subdural hematoma..... Ophthalmology did take the patient to the operating room for repair of her right globe rupture on her hospital day #2..... The patient has no vision at her right eye at this time. It is unclear whether this is a permanent condition or whether she will regain some sight."

Observation on 2/9/06 at 10:30 am revealed Resident 45 sitting in a wheelchair at her bedside. An eye-patch covered her right eye. She was mumbling non-English words, and was not responsive when greeted.

In an interview on 2/9/06 at 10:45 am, a licensed nurse stated that Resident 45 was readmitted to G-5 from the hospital on 1/24/06. When asked how, since the resident did not speak English, the staff determined her needs, the nurse stated they had a list of staff and volunteers who spoke the resident's language. She said they could call any of them if they needed translation, and they have arranged for some to visit the resident about twice a week. She said the resident's daughter also visits about twice a week.

In an interview on 2/9/06 at 11:20 am, a
supervisory nurse on K-7 stated that Resident 45 had been in a low bed in the front part of the ward at bed #28 before she fell on 1/18/06 at 7 PM. She said: "The PM nurse saw her. She was there when the resident got up, and told her to sit down. The nurse went to the back ward and was passing medications. She saw her stand up and started walking. The nurse couldn't get there quickly enough. The resident hit her eye on the next neighbor's bedrail. A relative of a resident across from bed #28 witnessed the fall." The supervisory nurse offered no explanation for how the PM nurse, who did not speak Resident 45's language, attempted to determine why the resident was standing up in order to meet her needs, and how the nurse communicated with her when she told her to sit down.

Observation on 2/14/06 at 11:30 am revealed Resident 45 dressed and sitting in her wheelchair. Her eye-patch was in place, her head was bent down, and she was mumbling to herself in a non-English language. She did not respond when the surveyor attempted a greeting in the resident's language.

In an interview on 2/14/06 at 11:35 am, a facility physician stated that the resident's Metoprolol had been discontinued on 1/26/06, two days after her re-admission, because of concerns over whether the fall had been the result of a syncopal (fainting) episode and low blood pressure due to the Metoprolol. The physician also stated: "She is still on an antidepressant because she is very depressed. The problem is the language barrier. The resident needs a more (non-English language) environment."

In a telephone interview on 2/15/06 at 1:45 PM,
Resident 45's daughter stated her mother told her that on 1/18/06: "She kept pushing the buzzer but no-one came and her food was sitting there. She wanted to reach for the food. She got up and hit the corner. She was waiting a long time, maybe a half hour, for someone to help her. Her food got cold, and she was tired."

Observation of the resident's call-light on 2/15/06 at 2:30 PM revealed that pressing the button on the call-light cord at bed #28 caused a light to go on over the resident's bed, at the entry to the ward; and in the nurses' station, but the buzzer only rang once when the button was first pressed, and did not continue to sound.

In an interview at the same time on 2/15/06, a supervisory nurse stated that the buzzer sounds when the call-light button is first pressed, but the resident must continue to press and hold the button for the buzzer to continually sound, not just turn on the call-light.

The facility failed to adequately supervise and meet the needs of Resident 45 to prevent her injury. They failed to monitor her for orthostatic hypotension even though she received a medication, Metoprolol, with a common side-effect of postural hypotension, she had a history of falls, and a care plan that stated they would monitor her for orthostatic hypotension. When she turned her call light on at 6:45 PM on 1/18/06, instead of attempting to determine what the resident, who did not speak English, needed, facility staff told her to sit down. The resident, who was alert and oriented with no memory problems, told her daughter she put her call light on for help with her dinner tray, she waited a long time, and her food was getting cold. Because no staff came
### Statement of Deficiencies and Plan of Correction

**ID Number:** 555020

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<thead>
<tr>
<th>Statement of Deficiencies</th>
<th>Prefix</th>
<th>Tag</th>
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<th>Prefix</th>
<th>Tag</th>
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<th>Completion Date</th>
</tr>
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<tbody>
<tr>
<td>F 324</td>
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<td>Continued From page 183</td>
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Continued From page 183

- To help her, she stood up from her bed to reach for her food, swayed, fell, hit her head on the corner of the next bed, and sustained a subdural hematoma, and blow-out fracture of her one good eye, her right, rendering her blind. Her blood pressure at the time of the fall was 75/53. When her call-light was tested on 2/15/06, the light came on, but its buzzer only sounded once, and did not continue to buzz unless the resident continued to press and hold the button. (Cross-reference: F-241, F-272, F-353, F-463.)

4. Record review on 02/05/06 of Resident 2's clinical record documented that Resident 2 was admitted on 03/02/05 and re-admitted on 07/28/05 and 12/04/05 with diagnoses including alcohol withdrawal, urinary tract infection, and failure to thrive. Resident 2's 01/30/06 MDS documented he had no cognitive problem, and he could understand others and was able to make himself understood by others.

On 02/16/06 at 2:00 p.m., Resident 2 was observed lying in bed, with a grimace on his face. During an interview at the same time, he stated he was restricted to his ward. He also stated that his cigarettes were taken away, he was not allowed to leave the ward to go to the smoking area, and he could not join any social activity outside of his ward. He stated he had not agreed to the ward restrictions, and he was very upset about them.

Review of Resident 2's 01/14/06 Integrated Progress Notes documented that he was placed on ward restriction and had been grounded since 01/14/06 after he had an altercation with another resident.
F 324 Continued From page 184

Review of his 01/30/06 Integrated Progress Notes documented that at 2:30 p.m., staff detected a smell of alcohol on Resident 2. A 200ml (milliliters) bottle of Vodka with 30ml remaining was found under his pillow. While the nursing staff was attempting to confiscate the alcohol, Resident 2 drank the remaining Vodka in the bottle. Later in the day at 2:50 p.m., Resident 2 was found smoking in bed. (The facility's Smoking Control Policy, revised date 01/01/98, stated: "Smoking is prohibited within the entire facility, with the exception of authorized resident smoking areas, which are clearly identified with appropriate sign(s).") Facility policy does not allow residents to drink alcohol or smoking in bed. There was no documented evidence of supervision and monitoring to prevent Resident 2 from drinking alcohol and smoking in bed.

In an interview on 02/16/06 at 2:30 p.m. a licensed nursing staff stated that there was not enough staff to monitor and to supervise Resident 2 "all-the-time."

The facility was aware that Resident 2 was not cognitively impaired when he was placed on a ward restriction by the facility. The 34-day ward restriction from 01/14/06 to 02/16/06 was against the resident's will, and caused him to become agitated and upset by the restriction. While restricted to the ward, the facility failed to adequately supervise Resident 2 in order to prevent him from drinking alcohol (Vodka) and smoking in bed. Therefore, the facility failed to provide adequate supervision to Resident 2 to prevent potential accidents due to drinking and smoking in bed.

5. Record review on 02/07/06 documented that
### F 324

Resident 48 was admitted on 10/09/97 and re-admitted on 07/15/99 with diagnoses including auto-immunodeficiency disease, seizure disorder, old stroke with right-side weakness, and depression. His 01/06/05 MDS documented that he had short and long-term memory problems, and needed extensive assistance from the staff to transfer from bed to a chair, dress, groom, and bathe. He had a 12/17/03 Care Plan stating that he had a long history of exchanging substances or drugs for cash with other residents.

Review on 02/07/06 of his 01/15/06 Integrated Progress Notes documented that at 11:00 p.m. on that day, Resident 48 was seen selling substances or drugs (Marijuana) to another resident in another ward.

During an interview on 02/07/06 at 10:00 a.m. Resident 48 was alert and oriented to his name, time and place of residency, and was able to answer simple questions. He denied exchanging substances or drugs with other residents.

In an interview on 02/16/06 at 2:15 p.m. a licensed nursing staff acknowledged that Resident 48 had a history of exchanging substances or drugs for cash. She also stated that the facility was not able to supervise Resident 48 "all-the-time, especially when he leaves the ward."

The facility was aware that Resident 48 had a long history of exchanging substances or drugs for cash with other residents. The facility failed to adequately supervise Resident 48 to prevent him from selling or exchanging substances or drugs which could affect the health, safety and welfare of the residents.
6. Record review on 02/10/06 documented that Resident 49 was admitted on 11/17/94, and re-admitted on 08/31/05 with diagnoses including quadriplegia, and infection of right buttock, back and thigh. He had a 08/31/05 Care Plan documenting that he taunted others, particularly frail and vulnerable residents.

Review on 02/10/06 of Resident 49's 10/17/05 Nursing Assessment for behavioral Risk documented that he had risk for aggressive behaviors directed at others.

Review on 02/10/06 of his 11/01/05 Integrated Progress Notes documented that Resident 49 called another resident "Mon-Mon: (meaning "Gay"), and "I will have someone shut you up outside the hospital; your day will come," while he was trying to provoke a fight with another resident.

During an interview on 02/10/06 at 9:00 a.m. Resident 49 was alert and oriented to his name, time, and place, and was able to answer simple questions. He stated he was upset at times, and he did not like the "old people" around here.

The facility was aware that Resident 49 had aggressive behavior and made verbal threats to others. The facility failed to monitor and supervise Resident 49 to prevent him from verbally threatening other residents.

7. A closed record review was conducted for Resident 59 on 2/15, 16 and 2/17/2006 to investigate complaint #s CA00065897 and CA00065901. Resident 59 was first admitted to the facility on 1/6/2005. There were two
### F 324

**Continued From page 187**

Subsequent admissions: one on 9/6/2005 (with a discharge on 10/31/2005) and another admission on 11/1/2005 (one day after the discharge of 10/31/2005) and then the most recent discharge on 11/8/2005. The resident's medical record from another hospital was included in the resident's current medical record of the facility and revealed that the Resident has a history of substance abuse, including the use of amphetamines. Records further indicate that the Resident has a history of attempted suicides dating as far back as 1973 and that this Resident has threatened violence toward others. Some of the actions listed in the history are associated with methamphetamine use. Resident 59 was admitted to the facility on 9/6/2005 and 11/1/2005 for skilled nursing care related to a decubitus ulcer.

Discharge summary for discharge of 10/31/05: "On 10/30 the patient was found by staff to have a plastic bag over his head. He was seen urgently by Psychiatry and denied suicidal ideation, however, the patient was noted to be somewhat altered compared with his previous baseline. A sitter was obtained. The following morning the patient was found by staff to have a kitchen knife in his belongings. This was removed at which point the patient became quite angry and began swinging an IV pole as well as pulled a hanging plant off the wall. When he was seen by his regular physician, he was found to have unusual speech content and although he was awake and alert and oriented his speech content was clearly altered compared with past baseline. An urgent psychiatry call was again made and arrangements were made for the patient's transfer to (name of hospital) Emergency Department under 5150 status for further
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**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

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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 324</td>
<td>Continued From page 188 evaluation both by Medicine and Psychiatry. When the patient was picked up by paramedics the patient became very agitated and attempted to throw various objects and broke a window in his room in the process of this. He also attempted to fight with police and paramedics and attempted to bite them.&quot;</td>
<td>F 324</td>
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Discharge summary for discharge of 11/8/2005: "The Patient is a 41-year old man with (diagnoses) who had returned to Laguna Honda after a 24-hour stay at (name of hospital) in the Medical Emergency Department followed by PES. The patient had been transferred out on 5150 status after making a suicide gesture on 10/30. Over the next 24 hours a sitter was used at his bedside; however, the following morning he had become agitated and also was exhibiting bizarre behavior and speech. He was cleared by both Medicine and Psychiatry and apparently felt to primarily have behavior changes related to methamphetamine use. Starting on the evening of 11/07, the patient was noted to be more agitated than his usual self and he was noted to be playing with a cigarette lighter. Additional Ativan was given. However, on 11/08 the patient again was playing with his cigarette lighter but became more agitated, throwing a pitcher of water and also verbally threatening to kill staff. He was seen urgently by (name of doctor) from Psychology and a 5150 was administered. The patient was threatening violence and attempting to harm staff as he was taken off the ward." On 2/6/06 at approximately 2:45 P.M., a staff nurse on the 04 unit was interviewed regarding the 5150 discharge of Resident 59 that occurred on 11/8/2005. She stated that the Resident is very nice when he is not on drugs. She stated...
that she thought that the resident had been re-admitted back to the facility too soon after the first incident (5150 discharge on 10/31/2005). She thought that the resident should have stayed longer than one day - at the hospital where he was prior to the transfer to the facility; she stated that he wasn't himself when he was readmitted. She further stated that a few days after he was readmitted, he was able to get drugs and that is why he got 5150'd out of the hospital again. She stated that she was fearful of the resident when he was on drugs.

On 2/6/06 at approximately 2:30 P.M., a CNA on the O4 unit was interviewed regarding the incident with Resident 59, which occurred on 11/8/2005. The CNA stated that the resident was nice and that she liked him, but that when he was on drugs, he changed. The CNA came on duty early in the morning. She stated that she had to wash-up the Resident, but he would not let her. At one point she approached him and he got out of hand. He pulled his foley cathether out and tried to spray the staff with urine. She further stated that he had a cigarette lighter and attempted to set his pubic hair on fire and then he tried to start a fire with the cigarette lighter and his after shave lotion. The CNA stated she was able to get the lighter away from him. She further stated that she believed he was "high - he was on something." She stated that the Resident tried to bite her." The CNA also stated that the event "really scarred me." Clinical records indicate that the Resident was 5150'd to (name of hospital) that afternoon.

The following is an Interdisciplinary Team Meeting Note, dated 11/3/2005 regarding Resident 59. "Pt. is restricted to O4 to observe pt
Continued From page 190

how he is doing. On 11/2/05 he said, if the psychiatrist who had him 5150 comes near him, he was going to kill him, kill all the psychiatrists. When asked directly, if he was threatening to hurt the psychiatrist, he said "no" Pt input: Would like to go to (name) house or (another name) Is interested in psychotherapy still at suicide risk? Close monitor Psy referral sent Socialize with others, (name) referral sent. Wound Stage III. Needs to be ?" (sic) (signature illegible)

On 2/6/06 at 3:00 P.M., the Program Manager for O4 was interviewed. When asked if he would consider the readmission of Resident 59 to the O4 unit, he stated, "yes." The Program Manager was then asked to describe how he would ensure that the Resident was supervised in order to prevent a recurrence of the methamphetamine use and behavior. He stated that they would have a "contract" with the Resident. They would be with him when he opened the mail, for example. He also stated that the Resident could be placed at the nurses' station so that he could be visibly monitored by staff. This surveyor was on the O4 unit on 2/6/06; it was observed that a staff member was not always at the nursing station. Also, the physical setting is such that there is a glass area enclosing the nursing station from the hallway. Within this nursing station is another room and while in the second room, one cannot see any patients who are situated in the hallway outside of the glass enclosure. The surveyor then shared with the Program Manager that on the way to the unit, it was observed that there were many people coming and going on and off of the unit. When asked about the Resident's visitors and their easy access to the O4 unit, the Program Manager agreed that there was easy access by visitors to the unit. When
When Resident 59 was admitted to this facility on 9/6/2005, there was no care plan in place to address his history of drug use, suicide or homicidal threats. A toxicology screen, dated 9/8/05 indicates a positive result for methamphetamine; this screen had been completed by the hospital from which the resident was transferred to the current facility. A care plan addressing illegal drug use and past suicidal behavior was not written until 10/30/2005, which is the same day that the resident’s behavior changed and the resident was found with a plastic bag over his head. The resident was 5150’d to another hospital on 10/31/2005.

An incident report from the San Francisco Police Department, dated 10/31/2005 reads, "Res. (59), was 5150 to (name of hospital) this AM (10/31/05) for danger to self/others & being gravely disabled. A search of his room #28 resulted in the confiscation of the following items: 3 empty cigarette packs, 11 coin bags with what appears to be methamphetamine crystal (7 empty & 4 partial full) - 1 cigarette (undecipherable) bag containing marijuana substance with 2 partial smoked joints. 1 cigarette filter used to inhale the methamphetamine. 1 letter from a friend (name, address) stating that he had special ‘treats’ for this resident. Search of res. property completed by 0-4 IDT staff no U.O. to be completed by staff. *Note I.P. was called at 1:30 p.m. on 10/30/04 (sic) to search resident property.

Screening of Applicants reads, "LHH will accept and care for those San Francisco residents: b)
Continued From page 192

for whom it can provide safe and adequate care." The policy further states under 3. "LHH shall assess the physical, mental, social and emotional needs of both new and current residents to determine whether each resident's care environment is best able to meet these needs."

A form entitled, "Admission Information and Rules for 04," reads, "Syringes are absolutely forbidden on the unit. All syringes, illicit drugs, and paraphernalia must be turned in to the staff at the time of admission this will not be held against you. Family and friends are prohibited from bringing syringes on to the unit. Found syringes are grounds for discharge." The form further reads, "Illicit drug and unauthorized alcohol use are forbidden and possession, sales, and/or use are grounds for discharge." Where the form indicates Signature of Patient, it reads, "Refused" and again in another area, "Refused to sign."

8. Resident 60 was admitted to the facility on 2-13-01 following repair of a femoral fracture and several other diagnoses including advanced organic brain disease secondary to head trauma and alcoholism. A quarterly assessment dated 7-11-05 described Resident 60 as having short and long-term memory deficits, has persistent anger with self and others, has an unpleasant mood in the morning, and independent in all activities of daily living (ADLs). A history and physical examination dated 2-13-01 revealed that prior to this admission, Resident 60 had been admitted to a psychiatric unit of an acute care hospital because of aggressive and assaultive behavior, and that during a previous stay at the facility, had "multiple attempts to leave the unit and was also wandering into other patients' beds and into the female section of the ward." On
4-10-02, a neuropsychological evaluation indicated that Resident 60 "demonstrated several areas of significant difficulty, including attention, immediate and delayed memory (ability to learn and retain new information), and in mental flexibility, planning, and organization, all of which were found to be in the severely impaired range based on a normative sample of same-age peers." On 7-24-02, an annual patient medical review revealed that while Resident 60 had "no difficult behavior" following his transfer to another building of the facility, he however "continues to believe that he could live alone and expresses anger at his son for putting him here, believes that this in an 'incarceration.'"

Review of the medical record revealed several incidents involving Resident 60 and other residents and staff members over issues including his aggressive behavior and non-compliance with care and other instructions. On 4-14-05, for example, physician's progress notes revealed that Resident 60 was "found to have a small (alcohol) bottle hidden in his shoe," and that staff were "not sure who supplied (patient) this." The same note added that the resident "does not acknowledge that he has a problem and refuses SATS (substance abuse training services)." On 8-18-05, another physician's note described Resident 60 as "territorial and residents have been made aware to stay away from (Resident 60's) usual areas as (he) is unable to understand the concept of sharing."

Further record review revealed a care plan dated 5-22-05 regarding Resident 60's "multiple incidents of falls" because of several factors including "poor safety awareness," poor sitting
At 12:30 a.m. on 5-4-05, IP notes revealed that Resident 60 "fell on the floor by his bed" and hit his head. On 2-22-05, another IP note by a social service staff member revealed that Resident 60 had two falls and hit one on the floor.

On 3-22-05, an interdisciplinary team meeting note revealed that Resident 60 had two falls and hit one on the floor.

On 5-4-05, IP notes revealed that Resident 60 "fell on the floor by his bed" and "hit his head." The same note added that when asked, Resident 60 gave the bottle to the station office, but would not say the source or who gave him the bottle.

Review of integrated progress (IP) notes revealed several other incidents including:

- On 1-21-05, an interdisciplinary team meeting note revealed that Resident 60 had two falls and one altercation with another resident from another unit, as well as one incident of trying to open an exit door during the past quarter.
- On 3-22-05, another IP note by a social service staff member who, after observing and addressing "inappropriate smoking" by Resident 60, documented that "resident screamed 'Godammit!!' and 'slammed the door then accused me of 'snitching on him'."

Provision of services and supplies was inadequate and human services were not provided in accordance with the individualized service plan (ISPs) for each resident. This is evidenced by the following:

- On 1-22-05, IP notes revealed that a certified nurse aide (CNA) "found a miniature bottle of Jack Daniels by his bedside table and resident hid it immediately in his jacket pocket."
- On 2-22-05, another IP note by a social service staff member revealed that Resident 60 "fell on the floor by his bed" and "hit his head." The same note added that when asked, Resident 60 gave the bottle to the station office, but would not say the source or who gave him the bottle.

Review of integrated progress (IP) notes revealed several other incidents including:

- On 12-22-05, IP notes revealed that a certified nurse aide (CNA) "found a miniature bottle of Jack Daniels by his bedside table and resident hid it immediately in his jacket pocket." The same note added that when asked, Resident 60 gave the bottle to the station office, but would not say the source or who gave him the bottle.

Review of integrated progress (IP) notes revealed several other incidents including:

- On 3-22-05, another IP note by a social service staff member who, after observing and addressing "inappropriate smoking" by Resident 60, documented that "resident screamed 'Godammit!!' and 'slammed the door then accused me of 'snitching on him.'"
### Summary Statement of Deficiencies

**Id Prefix Tag:** F 324

**Date:** Continued From page 195

- **Event:** His head on the bedframe sustaining an irregular cut on the right forehead measuring 3.14 inch long and 1.18 inch wide. The note added that the resident had claimed "he must have been asleep when it happened and that he was just starting with his snack sitting by the edge of the bed and lost balance." An assessment by nursing staff revealed that Resident 60 "seems sleepy and unstable on his legs but still insisted on getting up from the floor and to his bed (with) assist."

At 11 p.m. on 5-5-05, IP notes revealed that Resident 60 was "off the ward most of the time," and that treatment on the right forehead laceration was "not done off the ward."

At 2 p.m. on 6-6-05, another IP note indicated that Resident 60 "presented himself and showed 2 open areas on the (right) dorsal hand approximately 1 cm (by) 0.6 cm each moist and pinkish and has no bleeding." Accordingly, the resident reported that he "bumped it on the toilet."

At 4:45 p.m. on 6-9-05, IP notes revealed that an institutional police officer reported that Resident 60 had an altercation with another resident from another unit who "threw cup of cold coffee" on Resident 60. Additional IP notes regarding this incident by an activity staff on 6-28-05 revealed that the "resident 'weeds' (usually pulling out flowers such as agapanthus; sometimes pulling out weeds as well) which led to the conflict." The same note added that the activity staff was "not able to redirect resident to other gardening tasks" and that "in general is difficult to redirect or change behavior."

At 8 p.m. on 6-20-05, IP notes described nursing
Continued From page 196

staff receiving a phone call from activity in the day room that Resident 60 was "talking to himself and hallucinating and kept walking around in the dayroom, pushing his wheelchair back and forth (sic)," and that when assisted back to the unit, he was noted as "agitated and irritable."

At 6:25 p.m. on 7-28-05, IP notes revealed that another resident punched Resident 60 on the back because Resident 60 took his cigarettes. Another note following this incident dated 7-28-05 indicated that while there were no physical injuries, Resident 60 however was agitated and uncooperative eventually returning the cigarettes only after a discussion with institutional police officers. Accordingly, Resident 60 was alleged to have stated, "I'm unable of quitting, you can put me to jail."

At 9 p.m. on 8-17-05, IP notes revealed that Resident 60 had acquired a "small cut" measuring "0.5 cm on his right hand with a small amount of blood," and that the resident had claimed he "got it from pulling weeds by the west ramp." An activity note dated 9-13-05 indicated that gloves had been provided but that Resident 60 "declines to use it."

In spite of these incidents, review of the medical record, including the care plan relative to the risk for more falls, revealed the lack of discussion or evaluation regarding the amount and level of supervision required by Resident 60, and the manner this was to be provided. Review of the same care plan dated 5-22-05 also indicated the lack of consideration for the resident's cognitive impairment, aggressive, assultive and territorial behaviors, use of psychoactive drugs, seizure disorder, non-compliance with care and disregard
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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</thead>
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<td>F 324</td>
<td>Continued From page 197 for facility rules, desire to maintain his independence, poor relations with other residents, and his general inability for redirection. Further record review revealed that although quarterly interdisciplinary team meetings were held, discussions for the most part included the resident's status and behavioral problems, and did not always include consideration for the resident's supervision needs to prevent accidents and injuries, and how his behavior could be addressed to ensure the safety and security of other residents.</td>
<td>F 324</td>
<td>483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on staff interview, document review, and closed record review, the facility failed to ensure that one of 96 sampled residents maintained acceptable parameters of nutritional status and body weight. (Resident 69) Findings: A closed record review on 02/10/06 documented that Resident 69 was admitted on 10/05/05 and re-admitted on 11/01/05 with a diagnosis of Stage III heel ulcers (Stage III is full-thickness tissue loss extending through the dermis involving...</td>
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Continued From page 198

F 325

subcutaneous tissue). Her 01/12/06 MDS revealed that she had short-term memory problems, poor decision-making skills and needed supervision. She was restless, and making negative, self-deprecating statements, such as: "I'm worthless; I don't deserve it." She had unrealistic fears, insomnia, a sad appearance, loss of interest in activities and social interaction, and exhibited socially inappropriate and disruptive behaviors. She needed extensive staff assistance to transfer from bed to chair, for personal hygiene and bathing. The MDS also showed she had a weight loss of "five percent or more in the last 30 days," and the nutritional approaches included a planned weight change program. The record contained no documentation of a planned weight change program.

Review on 02/10/06 of Resident 69's Weight Record showed that her weight was 224 pounds on 11/06/05. On 12/09/05, her weight declined to 204 pounds, and declined to 195 pounds on 01/09/06, a weight loss of 29 pounds, or 13% in 65 days (from 11/06/05 to 01/09/06). There was no documentation to show that nutritional interventions to address her weight loss were implemented.

Review on 02/10/06 of Resident 69's 10/19/05 History And Physical Examination documented that Resident 69 had a history of "depression with psychotic features and/or schizoaffective disorder. She needs to be watched carefully." On the same date, the facility's 11/05 Monitoring Form documented that Resident 69 had a poor appetite since 11/19/05. There was no documented evidence that Resident 69's poor appetite was assessed, evaluated or monitored.
Review on 02/10/06 of Resident 69’s 11/01/05 Resident Care Plan revealed that she was also a diabetic.

According to Mosby’s 1992 Medical-Surgical Nursing, Assessment and Management of Clinical Problems: “Dietary Management is the cornerstone of therapy for diabetes. An individually calculated, balanced diet is of primary importance.”

The resident’s record contained no documented evidence that Resident 69’s diabetes was assessed, monitored, and dietary intervention planned.

Review on 02/10/06 of the 11/09/05 Resident Care Plan documented that Resident 69 had “decreased appetite secondary to depression, dizziness, and stomach sickness.” The care plan goal was “Will consume mostly 50-75 percent of meals.” There was no documented evidence of nutritional interventions to address Resident 69’s problem of reduced food intake relative to her diabetes.

In an interview on 02/05/06 at 10:00 a.m., a licensed nurse stated that 01/12/06, Resident 69 was 5150’d (involuntarily emergency transferred) to the hospital emergency room in grave condition due to her refusing food, fluids, and medications.

Review on 02/10/06 of the facility’s policies and procedures for unintended weight loss (revised on 1/05) revealed that the facility should do: “Implementation of interventions to improve intake, monitor weight status and resident satisfaction with meals, snacks, meal replacements and liquid nutrition supplements.”
### Statement of Deficiencies and Plan of Correction

**Laguna Honda Hospital & Rehabilitation Ctr D/P SNF**

**Address:**
375 Laguna Honda Blvd.
San Francisco, CA 94116

**Provider/supplier/CLIA Identification number:**
F 325

<table>
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<th>ID</th>
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<td>F 325</td>
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<td>Continued From page 200 Monitor hydration with intake/output records. &quot; The facility failed to address Resident 69's dietary needs, including her decreased appetite caused by her depression, and intervene to prevent her severe 29 lb. weight loss that occurred over 65 days in the facility. (Cross refer to F-250)</td>
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<td>F 328</td>
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<td>483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 1 of 96 sampled residents received the appropriate oxygen therapy when Resident 19 received oxygen at 4 L/min (liters per minute) instead of at 3 L/min for approximately a month. The facility further failed to ensure the proper storage of the resident's nasal cannula. (Resident 19) Findings: 1. Resident 19 was a 78 year old admitted to the</td>
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Facility on 5/29/28 with diagnoses including chronic obstructive pulmonary disease, coronary artery disease, and chronic renal failure.

On 2/6/06, the Resident was observed in his wheelchair in the hallway of unit E-4. He appeared alert, and he was pleasant and conversant. He was receiving oxygen via nasal cannula at 4 L/min.

During an interview on the same date and time, the licensed nurse told the surveyor: "The Resident is oxygen dependent because he only has one lung. He is on oxygen at 4 L/min."

A 2/6/06 review of his medical record revealed a 9/18/05 physician order for: "Oxygen at 3 L/minute by nasal cannula continuous."

A further review of the nurses' notes from 1/8/06 to 2/5/06 documented that the Resident had received oxygen at 4 L/minute every day during that period except for four days (1/9, 1/15, 1/19, and 2/1/06). The facility nursing staff failed to follow the 9/18/05 physician order for oxygen at 3 L/min.

2. During an observation of the Resident's living space on 2/6/06 at 3 p.m., an oxygen cannula was discovered hanging on the oxygen tank, undated and unprotected by a bag, a violation of the facility oxygen policy.

In an interview on the same date and time, the licensed nurse agreed that the cannula should have been dated and covered.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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**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

**ID PREFIX TAG**
F 329
SS=D

<table>
<thead>
<tr>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 329 Continued From page 202</td>
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Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

This REQUIREMENT is not met as evidenced by:

Based on interview, observation, and record review, the facility failed to insure that each resident was free from unnecessary drugs (excessive duration, without adequate monitoring; or without adequate indications for its use) for three (Residents 5, 20, and 33) of 96 sampled residents.

Findings:

1. Resident 33 was admitted to the facility on 07/11/2000 and has a diagnoses that includes dementia, schizoaffective D/O (disorder), S/P (status post) pacemaker placement, and H/O (history of) A-Fib (atrial fibrillation). On the physician's orders for January 2006 and February 2006, the physician had written four different prescriptions for Ativan:  a.) order number 11, dated 07/21/04 "Ativan (lorazepam) 0.25 MG PO (by mouth) BID (twice daily) Maint. (maintenance) Agit. (agitation),"  b.) order number 15, dated 12/12/05 "Ativan (lorazepam) 0.25 MG PO QHS (every hour of sleep) Maintenance,"  c.) order number 18 dated 11/16/04, "Ativan (lorazepam) 0.25 MG PO q (every) 8 hrs. PRN (when other necessary."
F 329  Continued From page 203

necessary) Agitation Maintenance, and d.) order number 17, dated 01/06/04 "Ativan 0.25MG PO or IM Give 30-60 min. prior to shower clinic visit or blood draw maintenance." The latter physician order did not state "prn (when necessary)" but was written to be given every time 30 minutes prior to shower, clinic visit, or blood draws. However, the January "Medication Record" had a handwritten statement "PRN" next to the listing of the medication and did not give any more information what behavior the medication might be targeted for. Below the medication was written "Bath M (Monday) & Th (Thursday)." Of the nine baths given to the resident during the month of January, the Ativan was only given 01/23/06, 01/26/06, and 01/30/06 as indicated by initials. On the back side of the sheet, the reason for giving the Ativan on each of these days was simply written as "AC (before) shower." There was no indication the resident was agitated on these three days prior to administering the Ativan nor was any reason given why the Ativan was not given on any of the other shower days. Due to the staff fluctuating in their interpretation of when and why to give the psychotropic medication prior to shower, clinic visit or blood draw, the facility was not monitoring use nor providing an adequate indication for its use. On 02/16/2006, the charge nurse for the Clarendon Hall 2-West station stated she called the physician and the order was changed to give the Ativan prior to shower on a when necessary basis.

F 329

2. Resident 5 was initially admitted to the facility on 11-21-03 following a stroke with residual right-sided hemiparesis and aphasia, and several other diagnoses including seizure disorder, hypertension, and depression. Review of the medical record revealed a quarterly assessment
F 329 Continued From page 204

dated 11-29-05 which described Resident 5 as having no short or long term memory deficits; and that he required “limited assistance” with transfer, and walking in his room and corridor.

Review of the medical record revealed a physician’s order dated 4-11-05 for Doxycycline (an antibiotic) 100 mgs orally twice daily. Review of the medication administration record (MAR) indicated that Resident 5 continued to receive the antibiotics as ordered.

Further record review however revealed the lack of documented indication for the administration of the antibiotic and the excessive duration of its use.

During an interview on 2-10-06, a licensed staff stated that Resident 5 may have been using the antibiotic for a longstanding dermatologic condition.

3. Resident 20 was admitted to the facility on 12-20-05 with several diagnoses including gout, hypertension, alcohol abuse, and diabetes mellitus. Review of the minimum data set (MDS) dated 12-30-05 revealed that Resident 20 had short term memory problems and required assistance with some activities of daily living (ADLs).

Review of the medical record revealed that on 12-20-05, a physician's order was written for the use of Trazodone 50 mgs at bedtime for sleep. Review the MAR revealed that Resident 20 did receive the drug nightly as ordered since her admission on 12-20-05. Further record review however revealed the lack of evaluation for the continued use of the Trazodone. In addition,
### SUMMARY STATEMENT OF DEFICIENCIES

#### F 329

Continued From page 205

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There was no documented indication of attempts made to determine the cause of insomnia prior to the use of the drug.

When asked during an interview if pain was a reason for her difficulty going to sleep at night (because of gout), Resident 20 stated that there was a particular resident on the unit who would scream and make other noises during the night. When asked if the Trazodone was effective, Resident replied that it wasn't but that she continues to take them because "they (medication nurses) keep giving it to me."

#### F 332

483.25(m)(1) MEDICATION ERRORS

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The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure that it is free of medication error rates of five percent or greater on 4 (Residents 95, 92, 96, and 88) out of 96 sampled residents.

Findings:

The survey team observed nine errors out of 132 medication passes for a medication error rate of 6.8%. The observed errors were as follows:

1.) During the 02/07/06 morning medication pass on the Second Floor South station of Clarendon Hall, the following five medication errors were...
Continued From page 206

observed for Resident No. 95 at approximately 08:30 AM:

a.) The resident was assisted in taking two puffs of the medication beclomethasone, an inhaled medication; however, the physician's order, dated 10/1/2003 reads: "beclomethasone FHA MDI 80 mcg/puff 1 puff bid (two times a day). The order further reads, "rinse mouth after use." The staff nurse did not instruct or assist the resident to rinse her mouth after taking the medication.

b.) The resident was assisted by the staff nurse in taking beclomethasone, a medication that is inhaled. During administration of the medication, the nurse did not provide the resident with instruction on the correct procedure for inhaling the medication. The resident sat in her wheelchair in a hunched-over position and did not exhale prior to the administration of the medication. When the push mechanism on the canister was depressed - releasing the medication, the resident was unable to inhale the medication and the spray of medication was observed to go out into the air surrounding the resident's face.

c.) The resident was assisted by the nurse in taking combivent, a medication that is inhaled. During administration of the medication, the nurse did not provide the resident with instruction on the correct procedure for inhaling the medication. The resident sat in her wheelchair in a hunched-over position and did not exhale prior to the administration of the medication. When the push mechanism on the canister was depressed - releasing the medication, the resident was unable to inhale the medication and the spray of medication was observed to go out into the air.
d.) The resident was assisted in taking Trusopt, an eye medication for glaucoma. During administration of the medication, the staff nurse did not place the eye drop in the resident's conjunctival sac and the eye drop fell onto the resident's lower eyelash. After the eye drop was administered, the resident was observed to wipe away the eye drop from her lower eyelash with the tissue that the nurse had given her; little, if any, of the eye medication went into the resident's eye.

e.) The resident was assisted in taking alphagen, an eye medication for glaucoma. During administration of the medication, the staff nurse was again observed not placing the eye drop in the resident's conjunctival sac. After the eye drop was administered, the resident was observed to wipe away the eye drop from her eyelash with the tissue that the nurse had given her; little, if any, of the eye medication went into the resident's eye.

2.) During the 02/07/06 morning medication pass on the Second Floor South station of Clarendon Hall, the following two medication errors were observed for Resident 92 at approximately 08:20 AM:

a.) The licensed nurse took one tablet of Lexapro 10 mg from the packet and gave it to resident 92 with his other oral medications. During record reconciliation, the physician's order dated 08/03/04 stated, "Lexapro 20mg PO (by mouth) daily maintenance (compulsive behavior)." At 09:15 AM on the same morning the surveyor asked to see the Lexapro container again. The licensed nurse then counted the remaining
Continued From page 208

b.) Resident 92's latest Physician Orders sheet on this resident's medical record (dated Jan. 01, 2006) stated, "Rosiglitazone 4mg. PO Daily Maintenance (Diabetes)" with an order date of 05/06/04. This medication was not observed to have been given during the aforementioned 02/07/06 drug pass. At approximately 09:15 AM the surveyor asked the licensed nurse to open the resident's current Medication Administration Record. There was a blank space for 02/07/06 where the nurse signs her initials when the medication is given. The licensed nurse apologized for missing the medication.

3.) During a medication observation on Ward K7 on 2/7/06 at approximately 8:20am, the licensed nurse was observed to administer KCl 20 mEq 7.5 cc (Potassium chloride 20 mEq) via gastronomy tube. Medical record review of Resident 96 documented a doctor's order for the potassium chloride 7.5 cc last written on 9/21/05. The nurse manager concurred that there was no current doctor's order for the administration of the medication.

4.) Resident 88 was admitted to the facility with several diagnoses including diabetes mellitus and hypertension. During the medication pass observation at 8:40 a.m. on 2-7-06, Resident 88 was observed given several oral medications including one each of the following: Toprol XL 50 mgs; Lasix 20 mgs; ASA 81 mgs; Synthroid 0.025 mg; Gabapentin 300 mgs; DSS 100 mgs; and Diltiazem ER 60 mgs.
Continued From page 209

Following the observation, reconciliation of the drugs administered to Resident 88 with the current physician's orders revealed another physician's order dated 12-27-05 for Resident 88 to receive Niacin 500 mgs orally daily, a drug that was not observed administered but should have been given with the rest of the medications.

Review of the medication administration record (MAR) revealed that the schedule for administration of the Niacin 500 mgs was the same as those of the other drugs observed given during the pass.

F 333 483.25(m)(2) MEDICATION ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:

Based on observation, medical record review and interview, the facility failed to ensure that the resident was free of any significant medication errors when the correct dose of insulin was not administered as ordered by the physician. The licensed nurse used a tuberculin syringe (a syringe used for administering T.B. test), instead of an insulin syringe (a syringe used specifically for administering insulin to diabetic patients) to administer 0.9 Units of Regular Insulin instead of the physician order of 9 Units, to one out of 96 sampled residents. (Resident 16) The Resident was at risk for hyperglycemia as a result of the error. The facility further failed to develop and
F 333 Continued From page 210

implement a policy for the safe administration of insulin, which put all insulin dependent diabetics in the facility at risk for medication errors when insulin was administered.

Findings:

Resident 16 was admitted to the facility on 6/06/95 and re-admitted on 6/21/05 with diagnoses of diabetes mellitus type II, hypertension, aphasia, and cerebrovascular accident.

A review of the 1/02/06 Minimum Data Set (MDS-assessment tool) revealed that he had short-term and long-term memory problems and his decision making was moderately impaired. He was also aphasic (non-verbal).

Further record review on the same date and time revealed that the 9/12/01 care plan indicated:

"Non-insulin Dependent R/T Diabetes Mellitus. The interventions were to check blood glucose before breakfast and dinner. 7/21/05 - Offer sugar free beverage with medications and snacks." Resident 16 had physician orders for:

11/25/03 - Insulin Sliding Scale: For blood glucose (BG):
- 250-300 Give Regular Insulin SQ - 3 Units
- 301-350 = 5U
- 351-400 = 7U
- 401-450 = 9U
- > (Above) 450 call MD

10/25/05 - NPH Insulin 15 Units subcutaneous (SQ) every AM Pre-breakfast for Insulin Dependent Diabetes Mellitus (IDDM)."

Review of the Medication Administration Record

F 333
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

**Address:** 375 LAGUNA HONDA BLVD., SAN FRANCISCO, CA 94116

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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>F 333</td>
<td>Continued From page 211 (MAR) on the same date and time documented:</td>
<td>F 333</td>
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<td>&quot;2/04/06 - 7:00 a.m. BG level - 248. There was no documentation in the medical records or in the Medication administration Record that 0.9 Insulin was given. 7:30 a.m. - he was given 15 Units of NPH Insulin. 11:30 a.m. - BG level 422 - 9 units Regular Insulin SQ (subcutaneous route) was given&quot;.</td>
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<td>On 2/04/06 at 11:45 a.m. the MAR documented:</td>
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<td>&quot;FSBS every 15 min for 4 hours - Notify MD if &lt; (less) 100 mg/dl. If &lt; 100 mg/dl, admin OJ (orange juice).</td>
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<td>11:45 a.m. - BS 429</td>
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<td>12:00 p.m. - BS 480</td>
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<td>The 2/04/05 12:p.m Physician's progress notes indicated: &quot;Reported patient was given regular insulin SQ 90 units earlier by RN by mistake. Patient BS (blood sugar) remain over 450 range. Also given orange juice by RN, earlier reported. Will continue observe BS every 15 minutes for 6 hours.&quot;</td>
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<td>Resident 16's BS level did not decrease to 100 mg/dl as it was documented in the MAR during the following hours.</td>
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<td>12:15 p.m. - 279</td>
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<td>12:30 p.m. - 245</td>
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<td>12:45 p.m. - 185</td>
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<td>1:00 p.m. - 167</td>
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<td>1:15 p.m. - 142</td>
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<td>1:30 p.m. - 124</td>
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<td>1:45 p.m. - 105</td>
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<td>On 2/04/06 at 2:00 p.m, the physician documented: &quot;Patient still alert, no symptoms, but BS down to 105 in 2 hours. Pt has no signs of</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
LAGUNA HONDA HOSPITAL & REHABILITATION CTR DIP SNF

STREET ADDRESS, CITY, STATE, ZIP CODE
375 LAGUNA HONDA BLVD.
SAN FRANCISCO, CA 94116

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<td>F 333</td>
<td>Continued From page 212 hypoglycemia yet but expected until further BS will decrease. Cannot get IV access yet reported.&quot;</td>
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On the night of 2/04/06 Resident 16 was transferred back to the facility. The 2/05/06, 1:00 a.m. nursing notes documented he was "easily awakened" when staff went to check him. "Incontinent of urine. Able to follow instructions. Vital signs (VS) 96.9, 84, 20, B/P 175/86."

The 2/06/06 physician's progress notes (Medicine On-call Notes) documented: "Patient is alert and oriented to self. B/P 162/66. 2/4/06 insulin overdose. (There was no documented explanation by the Physician why he thought there was an overdose of Insulin). Did not affect insulin------ related to BPH (benign prostatic hypertrophy) + renal failure. Will increase Cardura to 4 mg. every HS (bedtime). No evidence hypoglycemia."

In an interview on 2/07/06 at 2:55 p.m., the Nurse Manager for O7 stated: "On Saturday the LVN (Licensed Vocational Nurse) checked the BS of the Resident at 7:00 a.m. and the BS was 248. The nurse administered 0.9 Units of regular (insulin) given through a tuberculin syringe. She immediately realized the error, called the on-call physician, and notified the charge nurse.

The Physician ordered FBS (fasting blood sugar) sticks every 15 minutes. The11:30 a.m. BS was 422. BS never dropped below 100." This Surveyor brought to Staff 2's attention that the physician documented that 90 units was given to the
Resident by the licensed nurse although the MAR indicated 9 units. Staff 2 said it was a documentation error by the physician.

On 2/16/06 at 11:00 a.m., during the Quality Assurance Committee interview, Staff 3 acknowledged that the facility did not have a current system in place for insulin administration but they would be giving in-services to the licensed staff. She also said they would be implementing a system where two licensed staff would check the dosage of insulin to be administered to diabetic residents.

Staff 1 administered Regular Insulin 0.9 Units SQ to Resident 16 using a Tuberculin syringe when his BS level was 248. The Resident's BS level went up, and did not go down to 100mg./dl.

The facility's failure to have a policy/procedure for the administration of insulin placed all residents at risk.

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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

SUMMARY STATEMENT OF DEFICIENCIES
(Each deficiency must be preceded by full regulatory or LSC identifying information)

Continued From page 214
Excerpt when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Excerpt when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, the facility failed to provide sufficient staff to enable ten of 96 sampled residents on six different wards to attain their highest practicable mental and psychosocial well-being. (Residents 2, 8, 26, 45, 47, 55, 65, 66, 68, 84)

(1.) The facility failed to have enough staff to protect Resident 84 from the assaults of other residents on K-6.
(2.) The facility failed to have enough staff to prevent Resident 65 from assaulting three residents on K-6.
(3.) The facility failed to have enough staff to prevent Resident 66 from assaulting three residents on K-6.
(4.) The facility failed to have enough staff on K-7 to answer the call-light of Resident 45 to help her with her dinner tray and to prevent a fall that rendered her blind.
(5.) The facility failed to have enough staff to protect Resident 26 from another resident's assault on L-6.
(6.) The facility failed to have enough staff to protect Resident 55 on CH S-300 from inappropriate touching by another resident.
(7.) The facility's failure to have sufficient staff on
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### PROVIDER/SUPPLIER/CWA IDENTIFICATION NUMBER:

555020

### 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

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<td>L-6 to provide Resident 47 with 1:1 supervision while they passed breakfast trays resulted in her fractured hip after she slipped, unsupervised, on the shower room floor.</td>
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<td>(8.) Resident 2 was restricted to his ward (C-3) because the facility did not have enough staff to supervise him off the ward.</td>
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<td>(9.) Facility staff said they were unable to supervise Resident 68 at &quot;all times&quot;, especially when he left the unit (C-3) to join social activities and/or smoke.</td>
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<td>(10.) Before Resident 8 had a near death drowning on 9/26/05, the physician's order for a sitter was cancelled the next day by administration because of facility policy to &quot;never&quot; write a doctor's order for a sitter because, if Nursing can't find the staff, then Nursing is not able to meet a doctor's order. Nursing staff said their unit (E-6) did not have enough staff if Resident 8 did not have a sitter.</td>
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### PROVIDER'S PLAN OF CORRECTION

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### DATE SURVEY COMPLETED

02/21/2006

### SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

### ID PREFIX TAG

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| 1. Resident 84 was originally admitted to the facility on 1/20/93 and readmitted on 2/1/01 with diagnoses including subdural hematoma, seizure disorder, and altered mental status. His 11/28/05 MDS indicated he had short and long-term memory problems, severely impaired decision-making ability, and was not oriented to person, place or time. He was rarely able to make himself understood, and sometimes understood what others said to him. He had the behavioral symptoms of daily wandering not easily altered, verbally abusiveness several days a week that was easily altered, socially inappropriate/disruptive behavior, and resisted care daily. He needed only supervision to get out of bed, walk, eat, and use the toilet; and required

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If continuation sheet Page 216 of 274

**Event ID:** 09ME11  **Facility ID:** CA22000512  **Previous Versions Obsolete**
Review of his Integrated Progress Notes revealed that on 9/18/05 at 6:45 am: "Resident was punched in the chest by resident (Resident 66)-sustained skin redness on the chest." The RN Assessment on 9/18/05 at 8am stated: "Resident is at risk for being injured by others related to his sudden outburst of yelling, verbally abusive using "F" word and using obscene hand gesture which provoke other residents. Resident is advised to stop such behavior so he won't get hurt." Review of his care plan revealed that he was "at risk for injury by others," he had "episodes of shouting, yelling, screaming," and "in dining area he should sit by self to prevent altercations."

Review of Resident 84's Integrated Progress Notes on 10/15/05 at 6:20 am revealed: "Heard that resident saying the word "fuck you" to resident (Resident 65) and returned incident (sic) resident (Resident 65) put his hands on his (Resident 84's) neck and slapped him on his left cheek."

Review of Resident 84's Integrated Progress Notes revealed that on 12/17/05 at 5:50 pm, Resident 84 "was struck by resident (Resident 65) on his face/punches with an open hand (after) he made an obscene gesture and cursed this resident." The RN Assessment included: "Residents were separated and closely watched....Has history of being loud and verbally abusive." Two hours later, on 12/17/05 at 7:55 am, the notes stated: "Staff heard loud voices at the back ward. When checked CNA saw resident (Resident 65) hitting Resident 84 on his (L) temporal area (the left side of his head) 1x with a fist and 1x with an open hand. Resident 84 was
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<td>F 353</td>
<td>Continued From page 217 sitting on his own bed at the time.</td>
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Observation on 2/16/06 at 2 pm revealed Resident 84 sitting on the edge of his bed near the window. His shoulders were slumped, and he shrank back when approached by the surveyor. He seemed frail, and had trouble answering when asked how he was, mumbling something unintelligible in almost a whisper.

In another interview on 2/17/06 at 8:15 am, a staff nurse stated: “Sometimes it’s just not possible to prevent them from hitting each other. Things happen and they can be so quick.” She stated that the CNAs can’t watch them all the time because they are busy giving care, or have to go to inservice. She said having another staff person would help.

The facility failed to have enough staff to protect Resident 84, diagnosed with subdural hematoma and seizure disorder, from being struck in the face, hit in the head with a fist, slapped in the face, and struck on the back of the head by other residents on his unit. (Cross-reference F-224, F-279)

2. Closed record review on 2/8/06 revealed that Resident 65 was admitted to the facility on 6/8/05 with diagnoses of traumatic brain injury secondary to motor vehicle accident, diabetes, cataracts and glaucoma. His 9/5/05 MDS indicated he had short and long-term memory problems, moderately impaired decision-making ability, and was not oriented to person, place or time. He was easily distracted, had altered perception, restlessness, and repetitive physical movement. He required limited assistance to get out of bed, walk, and use the toilet, and extensive...
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/COLA IDENTIFICATION NUMBER:</th>
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| (X2) MULTIPLE CONSTRUCTION                      |
| A. BUILDING                                     |
| B. WING                                        |

| (X3) DATE SURVEY COMPLETED                      |
| 02/21/2006                                     |

#### 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

#### SUMMARY STATEMENT OF DEFICIENCIES

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<tr>
<th>ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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</thead>
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| F 353         | Continued From page 218
F 353         | assistance to bathe and dress.                                                                                   |                 |

Record review on 2/8/06 revealed that Resident 65 had a care plan, dated 9/10/05, for: "At risk for aggressive behavior toward others related to resistiveness to care, agitation, restlessness, being verbally loud, kicking, punching staff during care." On 10/15/05 the care plan included "altercation with other resident with the above behavior." The interventions included: "staff will separate Resident 65 from resident (Resident 84) related to resident's(Resident 84's) verbally abusive behavior which provokes Resident 65 to hurting him." On 12/12/05 the care plan included monitoring the other resident, and "direct resident to the front away from other residents."

Review of the nurses' notes on 2/8/06 revealed that Resident 65 went to Resident 84's bedside at 7:55 pm on 12/17/05 and hit him in the head with his fist and again with his open hand. His December 2005 Medication Administration Record (MAR) documented that on 12/18/05 he required Ativan 0.5mg at 3:40 pm, Seroquel 25mg at 4:30 pm, Seroquel 25mg at 6:30pm, Seroquel 25mg at 8:50 pm, all by mouth (p.o.). On 12/19/05 he received Seroquel 50mg p.o. at 5pm, and Seroquel 25mg at 11:40 pm for "attempting to hit when redirected."

On 12/20/05 5:55 pm, his nurses notes disclosed he "was coming out of the 2nd bathroom with a sitter behind him when, without provocation, he elbowed another resident who was coming into the bathroom....then attempted to hit resident (a third resident) who was motioning for him to get out of his bed. Was subdued by CNA to prevent him from hitting resident." On 12/20/05 at 8:15 pm he was seen by the psychiatrist and involuntarily
transferred (5150'd) to the hospital psychiatric emergency service (PES.)

In an interview on 2/8/06 at 2:45 pm, a licensed nurse stated that on 11/25/05, Resident 65 had broken the glass window in the bathroom door after a staff person redirected him away from banging on the back door, and was subdued by two CNAs. In another interview on 2/17/06 at 8:15 am, another licensed nurse stated: "Sometimes it's just not possible to prevent them (the residents on the ward) from hitting one another. They can be so quick. We try but things happen. We can't always be there because staff might be busy giving care to residents, or they have to go to inservice. We could use one more person."

The facility failed to have enough staff to prevent Resident 65 from assaulting three residents. (Cross-reference F-224.)

3. Resident 66 was originally admitted to the facility on 3/11/98, and readmitted on 7/5/05 with diagnoses of dementia, diabetes, and seizure disorder. His 11/27/05 MDS indicated he had short and long-term memory problems, moderately impaired decision-making skills, and was not oriented to person, place or time. He wandered daily, and resisted care. He needed supervision to get out of bed, walk, eat, use the toilet, and dress, and needed extensive assistance to bathe. He had a 7/6/05 physician's order for Ativan (an antianxiety medication) 0.5mg every six hours for anxiety, and restlessness.

Record review on 2/10/06 revealed that Resident 66's 7/5/05 care plan stated he had the "potential for restlessness, agitation, aggressive behavior, may hit others, territorial, intolerable of residents..."
who may be loud, talking, pacing." The goal was, "will not hit others." The interventions were: "Staff will report any signs of restlessness. When noted to be restless, agitated, staff will redirect from others, or others away from resident to prevent possible altercation," and "staff will immediately redirect other residents away from his space (Ex. bedside) or other residents who may be loud or pacing."

Record review on 2/10/06 of Resident 66's Integrated Progress Notes revealed that on 9/18/05 at 6:45 am, "resident punched (Resident 84) in the chest." (The same resident struck by Resident 65.)

Record review on 2/10/06 of Resident 66's Integrated Progress Notes revealed that on 12/19/05 at 9 am, "Resident got very upset when (Resident 84) turned to him, was verbally abusive to him, yelling at him, using his middle finger. Resident 66 angrily reacted to this, stood up, approached him, ran after him after (Resident 84) tried to get away. He hit him at the back of his head." The notes stated the incident was witnessed by a CNA who "was not able to break (sic) the fight related to his distance."

Record review on 2/10/06 of Resident 66's Integrated Progress Notes revealed that on 1/4/06 at 5 am, Resident 66 "got upset and irritated with (another) resident, went to his bed and pushed him on his (L) shoulder. Resident apparently was irritated when (the other) resident kept moving around his (own) bed and fixing it." At 11 am the same day, the notes stated Resident 66: "remains confused and disoriented except his name."
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<th>(X4) ID PREFIX TAG</th>
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</table>
| F 353             | Continued From page 221 Record review on 2/10/06 of Resident 66's Integrated Progress Notes revealed that on 1/29/06 at 6 pm, "he (Resident 66) try (sic) to hit (a third resident) in his face that he deflected it and it landed on his shoulder." Observation on 2/10/06 at 12 pm revealed Resident 66, a tall man dressed in blue sweat-shirt and sweat-pants sitting in a chair at his bedside. His bed was in the far corner of the ward, and the bed that would have been near it had been removed. He answered simple questions with "yes" or "no." He appeared confused, seemed unable to formulate an answer to a question, and his face took on an irritated, threatening expression. In an interview on 2/17/06 at 8:15 am, a staff person stated: "Sometimes it (Resident 66's assault) happens very quick. He's very territorial. We moved beds away. We tried to move a very quiet resident next to him but he hit him too. We have one CNA in front and one CNA in back (of the ward), but the CNAs have to do patient care, and then there's only the licensed staff to watch. And today we have inservice and 2 CNAs have to go. If (only) we had another staff person it would help. Sometimes it's just not possible to prevent them from hitting other residents. We try, but unfortunately things happen." The facility failed to have enough staff to prevent Resident 66 from assaulting three residents. (Cross-reference F-224) 4. Record review on 2/9/06 revealed that Resident 45, age 92, was admitted to the facility on 1/3/06 and with diagnoses including hip fracture after a fall on 12/14/05 at home, arthritis,
atrial fibrillation, cataracts, history of breast cancer with right mastectomy, and depression. Her 1/9/06 MDS indicated her memory was O.K., she was alert and oriented to person, place, and time, had modified independence in decision-making, and impaired vision. She required extensive staff assistance to turn in bed, get out of bed to a chair, move around her unit, toilet and hygiene. She did not walk, and was totally dependent on staff to dress, and bathe. She needed one staff person’s limited assistance to eat.

Record review on 2/9/06 revealed that Resident 45’s 1/11/06 care plan stated: “Resident is at risk for fall. One of the interventions was: "Anticipate needs of resident by checking or asking her what she needs."

Record review on 2/9/06 revealed that Resident 47’s 1/18/06 Integrated Progress Notes at 6 PM revealed: "Resident sitting in her bed eating her dinner with set-up tray.” At 6:45 PM the notes stated: "Passed by resident and I saw her standing at the foot part of her bed and fixing her dinner tray. I attended to her and told her that we will take care of her dinner tray and I assisted her back to sit on her bed.”

In an interview on 2/9/06 at 11:20 am, a supervisory nurse on K-7 stated that Resident 45 had been in a low bed in the front part of the ward at bed #28 before she fell on 1/18/06 at 7 PM. She said: "The PM nurse saw her. She was there when the resident got up, and told her to sit down. The nurse went to the back ward and was passing medications. She saw her stand up and started walking. The nurse couldn’t get there quickly enough. The resident hit her eye on the..."
Continued From page 223

Observation on 2/14/06 at 11:30 am revealed Resident 45 dressed and sitting in her wheelchair. Her eye-patch was in place, her head was bent down, and she was mumbling to herself in a non-English language.

In a telephone interview on 2/15/06 at 1:45 PM, Resident 45’s daughter stated her mother told her that on 1/18/06: “She kept pushing the buzzer but no-one came and her food was sitting there. She wanted to reach for the food. She got up and hit the corner. She was waiting a long time, maybe a half hour, for someone to help her. Her food got cold, and she was tired.”

The facility failed to have enough staff to meet the needs of Resident 45 to prevent her injury. When she turned on her call light for help with her dinner tray at 6:45 PM on 1/18/06, she waited a long time (she told her daughter a half-hour) and no staff came to help her. Because the facility did not have enough staff to help her, she stood up from her bed to reach for her food, fell, and hit her head on the corner of the next bed, sustaining a blow-out fracture of her one good eye, her right, that rendered her blind. (Cross-reference: F-241, F-272, F-324, F-463.)

5. Resident 26 was originally admitted to the facility on 1/10/05 and readmitted on 4/29/05 with diagnoses including dementia, congestive heart failure and hypotension. Her 1/10/06 MDS indicated she had memory and severely impaired cognitive (reasoning) problems. She had mood and behavior problems of restlessness, wandering, physical abusiveness, and resisting
Continued From page 224

care. She was able to get out of bed, walk and eat, but needed extensive assistance to dress and bathe.

She had a 7/26/05 care plan for: "At risk for being a target of others' aggression as evidenced by wandering into other resident's physical space, handling other resident's belongings without their permission." One of the interventions was for staff to: "Maintain line-of-sight by staff."

Review of the Integrated Progress Notes, dated 10/24/05 at 8:30 PM, revealed: "Res. was lying on her bed when another resident went to her and was heard by CNA talking and arguing and both were tugging along the comforter. Both of them were separated. Resident 26 stayed at her bed with her privacy curtains drawn while the other resident was redirected to her bed. After approx. 5 minutes, CNA heard both residents arguing again. This time Resident 26 was sitting on the floor 2 ft. to (sic) her bed while the other resident was standing next to her holding the comforter. Resident 26 was found with a bump on her (L) jaw with 2 superficial cuts about 0.5 cm each with minimal bleeding. She also sustained a bruise with purplish discoloration on her forehead 3 x 2 cm and a bump at the back of her head 4 x 5 cm with purplish discoloration. Resident was pointing at her left jaw and grimacing."

Observation on 2/7/06 at 11:45 am revealed Resident 26 sitting in a chair beside the bed of another resident and another resident sitting in a chair near a TV.

In an interview on 2/15/06 at 4 PM, a licensed nurse was asked about Resident 26's altercation with another resident on 10/24/05 at 8:30 PM
Continued From page 225

when Resident 26 sustained bruises on her jaw and back of her head. The nurse stated: "No-one witnessed it. Staff were putting residents to bed."

The facility failed to have enough staff to "maintain line-of-sight supervision" per Resident 26's care plan, and to intervene to protect her from another resident's assault, causing her to have a bumped and bleeding left jaw, a purple bruise on her forehead, and a bruise on the back of her head on 10/24/05. (Cross reference F-223.)

6. Resident 55 was admitted to the facility on 12/17/91 with diagnoses of seizure, hemiplegia, alcohol and substance abuse. The MDS, dated 1/10/06, documented she was alert, oriented x3, verbally responsive, and had behavior problems of verbal and physical abuse of other residents.

The 9/27/06 nursing notes documented that the housekeeping supervisor reported that a porter witnessed a male resident from Clarendon Hall South-300 touching Resident 55's breasts in the day room on the first floor. "Accoring to the report Resident 55 said this has been happening everyday in the dayroom while playing the computer. Asked if she wants to press charges & she said 'no.' 'I just want him to stop.'" The nursing notes also indicated that Resident 55 did not want to press charges and just wanted the male resident to stop. She stated she was embarrassed about the incident.

Review of the revised Behavioral Plan, dated 11/09/05, documented: "Resident 55 sometimes engages in excessive physical intimacy in public areas with her man friend. Goal: Resident 55 will not engage in excessive physical intimacy with..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<td>F 353</td>
<td>Continued From page 226</td>
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- Others while in public areas. She will go to more private areas, such as outside the building, to do so. **Plan:** She will be redirected to a more private area, such as outdoors.

Observation during the survey on 2/05/06, 2/08/06, and 2/15/06 revealed Resident 55 in a wheelchair going in and out of the unit. She was alert, verbally responsive, and continually wheeled herself back and forth when talking to the staff or other residents. When asked how the staff monitored Resident 55 when she went out of the unit, the nurse said: "she usually tells the nursing staff where she goes."

- Resident 55 was inappropriately touched several times by another resident in the presence of other residents and stated it made her feel embarrassed. The facility failed to have enough staff to supervise and monitor Resident 55, and prevent her physical abuse by another resident. (Cross reference F-223, F-224, F-250.)

7. Record review on 2/9/06 revealed that Resident 47 was originally admitted to the facility on 7/26/05 with diagnoses of organic brain disease, hypertension, and falls. Her 8/1/05 MDS indicated she had memory problems, moderately impaired decision-making, restlessness, anger, daily wandering, physically abusive symptoms, and resisted care. She required extensive assistance to get out of bed, dress, bathe and toilet, but could feed herself and needed supervision to walk. She had a 7/26/05 care plan for "at risk for elopement" due to cognitive impairment and asking to leave. The interventions were: "Staff to supervise whereabouts of resident and provide redirection if resident is getting confused or wandering," and "1:1 close
Review on 2/9/06 of her 10/9/05 Interdisciplinary Notes revealed: "At 7:55 am (Resident 47) was found sitting on the floor in the shower room, calling for help as she was in pain, could not move. She went there as she was redirected to dining area for breakfast, but confused she got into shower room (next area). She stated that she slid (sic) and fell on her buttocks." The RN Assessment at the same time stated: "Patient sat on the floor, both legs straight forward with slippers on, partly on pad and floor. She c/o pain at (L) hip, but (L) leg and foot rotated outward.... She stated that she slid and fell. Area around dry, well-lighted, but there are 2 pads on the floor." She was transferred to the hospital at 9:40 am, on 10/9/05. Later that day at 3:10 PM, the notes stated that the hospital called and informed the facility that Resident 47 "had (L) hip fracture and will be scheduled for surgery today."

In an interview on 2/9/06 at 11:30 am, a licensed nurse said that on Sunday morning, 10/9/05 about 8 or 9 am, Resident 47: "was in bed and got up to go to the table for breakfast. She was confused and went to the shower room while staff were passing breakfast trays." The nurse said she heard staff calling from the shower room, and "found Resident 47 in a sitting position on the floor with her PJs and sandals on saying she was having pain."

The facility failed to have sufficient staff to supervise Resident 47 while they were passing breakfast trays to provide the 1:1 supervision her care plan stated she needed. Because of lack of sufficient staff, Resident 47 went into the shower room, slipped on the floor, and fractured her left hip.
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Continued From page 228

hip. (Cross reference F-353.)

8. A 2/5/06 record review revealed that Resident 2 was admitted on 03/02/05 and re-admitted on 07/28/05 and 12/04/05 with diagnoses including alcohol withdrawal, urinary tract infection, and failure to thrive.

Resident 2's 01/30/06 MDS documented that he had no cognitive problem with daily decision-making, was able to understand others and could make himself understood. The MDS also documented that he had persistent anger with himself and others, and exhibited physically abusive behavior.

The Resident was observed lying in bed on 02/16/06 at 2:00 p.m. During an interview on the same date and time, Resident 2 stated that he was restricted to his ward. He stated that he was being punished after a resident-to-resident altercation that occurred a month ago. He was also not allowed to leave the ward to join any social activity, smoking, or to visit any other resident outside of his ward. He stated: "I feel like a prisoner."

A further 2/6/06 record review of the 01/14/06 Integrated Progress Notes revealed that Resident 2 was instead placed on ward restriction and had been grounded since 01/14/06 after he hit another resident.

Review of the 01/14/06 Care Plan indicated that Resident 2 had admitted hitting another resident. The care plan interventions included: "Ward Restriction for safety pending IDT (Inter-disciplinary Team) review." However, there was no documented evidence that the ward.
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Restriction was used only for a limited period of time, or was serving the purpose of a therapeutic intervention.

During an interview 2/16/06 at 2:30 p.m., licensed nursing staff stated that Resident 2 was restricted to the ward so that he could be supervised and monitored. The licensed nurse added that if he was outside the ward, there was no staff to supervise or to monitor him.

(Cross reference F-223, F-324, F-353.)

9. Record review on 02/10/06 documented that Resident 68 was admitted on 02/01/93 and re-admitted on 04/20/05 for heart problems, old stroke with right side weakness, seizure disorder, traumatic brain injury in 1987 after a motor vehicle accident, hypertension, and depression with visual hallucinations and suicidal ideation.

His 01/18/06 MDS disclosed that Resident 68 had short-term and long-term memory problems, poor decision-making, was able to understand others, usually able to make himself understood, had persistent anger with self and others, sad, repetitive anxious complaints, and was physically abusive. He also needed extensive assistance from the staff with transfers from his bed to chair, dressing, toilet use, grooming, and bath.

Review on 02/10/06 of 08/31/05 Integrated Progress Notes indicated that that when Resident 68 was sitting in his wheelchair in the dining room at 2:00 p.m. and another resident asked him to move over, Resident 68 responded, "You F---ing n-----er" and then he swung his right arm to hit the other resident on the stomach.

A 02/10/06 review of the 09/17/05 Integrated Progress Notes indicated that Resident 68 was seated in his wheelchair in the dining room at 2:00 p.m. and another resident asked him to move over. Resident 68 responded, "You F---ing n-----er" and then he swung his right arm to hit the other resident on the stomach.
Progress Notes at 3:35 p.m. revealed that during the social activity, Resident 68 said "F--- you" very loudly to another resident and threw a playing "Pokeno" chip at the resident. When the activity staff tried to intervene, Resident 68 yelled, "F--- bitch."

A 02/10/06 review of the 09/21/05 Integrated Progress Notes documented that at 10:55 a.m., Resident 68 poured hot coffee on his own left hand. Ice was applied immediately to the left hand. "Skin abrasion" was reported.

A 02/10/06 of the 10/15/05 Integrated Progress Notes documented that at 11:40 a.m., Resident 68 hit another resident while passing-by another resident in the hallway, without any provocation.

A 02/10/06 of the 10/29/05 Integrated Progress Notes documented that at 7:30 p.m. when Resident 68 was passing-by another resident, they hit one another.

During an interview on 02/10/06 at 9:00 a.m., Resident 68 stated that he sometimes becomes upset and he could not control himself. He also stated that he hits other people when he becomes "mad."

During an interview on 02/10/06 at 10:00 a.m., licensed nursing staff stated that they were unable to monitor and to supervise Resident 68 at "all times", especially when he left the unit to join social activities and/or to smoke. There was no supervision and no monitoring of Resident 68's behavior when he was outside the ward. (Cross reference F-223.)

10. Resident 8 was readmitted to the facility on
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<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 353</td>
<td></td>
<td></td>
<td>Continued From page 231</td>
<td></td>
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<td>F 353</td>
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10/3/05 after a near death drowning experience on 9/26/05.

Review of the resident's medical record from 2/2/05 through 2/11/06 revealed that the resident had been stable until around the middle of the year (2005). Cross reference F224. The discharge summary, dictated by the primary care doctor, documents that "we had many, many meetings and discussions about how to manage this patient. At this point I recommended a sitter from 5 p.m. to 9 p.m. to prevent problems; however, this was unable to be arranged."

In a surveyor interview with the primary care physician on 2/10/05 at 9:40am, the doctor described the resident as "he is a six year old in a forty year-old body with nothing to do" and "he needs something to keep him occupied when he gets back to the hospital from his day programs."

The doctor further stated that she had written an order for a sitter and on the next day it was cancelled by administration.

Review of doctors' orders noted an order written on 6/16/05 for a sitter.

On 6/17/06 an order was written to discontinue the sitter.

Interview with licensed staff on 2/10/05 revealed that there are two nursing assistants assigned to provide resident care for potentially thirty residents on the evening shift. When the surveyor asked if they thought that was enough staff, one responded, "yes, when there is a sitter for Resident 8"; the other stated, "they work very, very hard and are busy-I wouldn't want to do it".
In an interview with the Medical Director on 2/10/06, the surveyor was informed that it is hospital policy to "never" write a doctor's order for a sitter because if Nursing can't find the staff, then Nursing is not able to meet a doctor's order.

In an interview with the Director of Quality Management on 2/17/06, the surveyor was told that he believed that Nursing had actually arranged for a sitter when Resident 8's behaviors escalated, although the order had been discontinued because of the policy. The Director did not provide any documentation that a sitter had been assigned until after the incident of the near death drowning. [Cross reference F-224]

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility failed to ensure that food was nutritious, attractive and at the proper temperature. By not having food that was appealing, palatable and at proper temperature, there were the potentials for diminished interest and intake as well as not meeting residents' nutritional needs. The facility also failed to ensure that six residents on the second floor of Clarendon Hall received food at the proper temperature. There were no microwave ovens in the dining areas of the
F 364 Continued From page 233

second floor to reheat residents' food.

Findings:

1. On 2/6/06 at 12:50 p.m. an interview with Dietetic Service Manager 1 during inspection of the main kitchen holding unit revealed that hot foods for both regular and cafeteria service had been held there since 11 a.m. and that as needed, would be pulled from the holding unit until 1:30 p.m. These foods were: pork chops, beef barley soup, gravy, rice, cheese enchiladas, Chinese mixed vegetables, and "porridge" (aka juk, a Chinese food made of rice). The pork chops, the rice items and enchiladas were dry, the soup had foam at the edges, the gravy had a filmy top layer and the Chinese mixed vegetables were limp. Given the prolonged holding time, there was a probable loss of heat-sensitive nutrients, e.g. B-vitamins and vitamin C.

2. On 2/6/06 at 1:25 p.m. just prior to cafeteria lunch service break-down at the hot food service counter, cheese enchiladas in a nearly filled pan were at 124.5 degrees F and rice in a nearly filled pan was at 126 degrees F. Dietetic Service Manager 1 said these foods should be discarded due to uncertainty "to time below 140 degrees F" and end of service. In the absence of documented temperature during service, residents receiving foods from the cafeteria could have had foods that were not palatable because they had not been kept warm.

3. On 02/08/06, the first Clarendon Hall Group Interview consisted of six residents representing a combination of the second and third floor resident areas. During this interview, residents stated the food served in the second floor dining areas
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<td>F 364</td>
<td>Continued From page 234 sometimes is served too cold. They attributed the problem to the lack of an available microwave oven to reheat the food. Instead, reheating a resident's meal would require the dish to be taken to one of the three nurses stations where microwave ovens were present. The distance between the two dining rooms and any of the second floor nurses stations prohibited this activity from easily happening. On 02/15/2006, at approximately 11:20 AM, during the surveyor led tour of the general environment of Clarendon Hall with the facility's Director of Quality Management, Interim Director of Facilities Operations, General Services Manager and the Associate Administrator of Operations, both of the second floor dining rooms were observed. There were no microwave ovens in either the Paradise West and Woods dining areas of the second floor. However, earlier on the tour, two microwave ovens were located in the first floor dining area.</td>
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<tr>
<td>F 368</td>
<td>483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a</td>
<td>F 368</td>
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</tbody>
</table>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

F 368  Continued From page 235
resident group agrees to this meal span, and a
nourishing snack is served.

This REQUIREMENT is not met as evidenced by:
Based on interview with residents the facility
failed to offer snacks at bedtime daily throughout
Clarendon Hall.

Findings:

Sixteen cognitively alert residents attended either
either one of two Group Interviews conducted on
02/08/06. These interviews had residents
representing each of Clarendon Hall's three
resident floors. The residents stated snacks were
not offered at bedtime, but were only available in
the evening hours if a resident went to one of the
nurses stations and asked for one.

F 371  483.35(h)(2) SANITARY CONDITIONS - FOOD
PREP & SERVICE

The facility must store, prepare, distribute, and
serve food under sanitary conditions.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record
review the facility failed to store, prepare,
distribute and serve food under sanitary condition.
By not having safe operations there were
potentials for cross-contamination and food-borne
illness.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**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

<table>
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 371 | Continued From page 236 | **Findings:**

1.) During the initial tour at 11:13 A.M. on February 5, 2006 the following observations were made:

   a. A resident from G-4 was observed in the main kitchen on the third floor. Dietary staff stated that this was somewhat dangerous for the resident. Dietary staff stated that they try to keep residents out of the kitchen and call the nursing unit when a resident is seen in the kitchen.

   b. The paper towel disposal receptacle at the hand washing station for employees when covered required touching of the receptacle - a likely means of cross-contamination.

   c. In refrigerator #5, two five pound open containers of chicken base and one open five pound container of beef base were not labeled with the dates they were opened, and a 2 pound 48 ounces of almonds was undated after opening as directed by the Laguna Honda Hospital - Nutrition Services Policy and Procedure of Nutrition Care.

   d. In refrigerator #5, two to three pounds of diced carrots, 1 pound of diced onions and 10 pounds of beef patties were undated and not closed to the air to prevent contamination.

   e. In refrigerator #5, there was one hotel size serving pan containing cooked rice which was dated 2/1/2006. At 11:30 A.M. on 2/5/2006, the Senior Food Service Supervisor stated that the facility had a 3 day maximum holding policy on retaining cooked prepared foods that were unserved leftovers.

   f. Nine 15 ounce open cans of puree chicken were observed on the shelf in refrigerator #5. Dietary staff stated that this puree chicken was left over from dinner on 2/2/2006. When asked
## Statement of Deficiencies and Plan of Correction

### (X1) Provider/Supplier/CLA Identification Number:

<table>
<thead>
<tr>
<th>ID</th>
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<tr>
<td>F 371</td>
<td>Continued From page 237</td>
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</table>

### (X2) Multiple Construction

- **A. Building:**
- **B. Wing:**

### (X3) Date Survey Completed:

<table>
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<tr>
<th>Date Survey Completed</th>
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<tr>
<td>02/21/2006</td>
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</table>

### Name of Provider or Supplier:

**Laguna Honda Hospital & Rehabilitation CTR D/P SNF**

**Address:**

375 Laguna Honda Blvd.
San Francisco, CA 94116

### Summary Statement of Deficiencies

**ID Prefix Tag:**

**F 371**

- **On 2/10/2006 at 1:30 P.M., an assistant administrator stated that this puree chicken was out of the facility date and time range for keeping. He stated that they would have only served this within 48 hours of opening on 2/2/2006. The Assistant administrator went on to explain a chef would have disposed of this puree chicken when he reported to go work on 2/6/2006. Laguna Honda Hospital - Nutrition Services Policy and Procedure of Nutrition Care Policy number #11.4 entitled Food Supply/Food Storage stated: "Food that is outdated, spoiled or contaminated will be properly identified with a sign and removed from the general stores area. " This food did not have a sign and had not been removed from the general refrigerated storage area.**

- **g. Opened containers of cheese were not dated in the salad refrigerator. These included 120 slices of Swiss cheese, 4 pounds of cheddar cheese and 1 pound of American cheese.**

- **h. Refrigerator #9 contained a one pound bag of cilantro which was dated 1/20/2006 on 2/5/2006.**

- **i. The chef’s walk in freezer tested 12 degrees F. The State of California requires freezer temperatures to be 0 degrees F. or below.**

### Provider's Plan of Correction

**ID Prefix Tag:**

**F 371**

**Plan of Correction:***

- **On 2/15/06 during an inspection of the medication room located on K-5, beginning at 14:05; a can opener was found attached to the sink area by a dirty string. This can opener was soiled with dried crusty food particles present. According to the nursing staff on duty, this is occasionally used to open containers for resident usage. In the refrigerator, located in the dining room across from the medication room, a drawer was filled with bags of unlabeled personal food items. The charge nurse identified these as resident food items.**
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tr>
<td>F 371</td>
<td>3.) On 02/15/2006, at approximately 9:45 AM, during the surveyor led tour of the general environment of Clarendon Hall with the facility's Director of Quality Management, Interim Director of Facilities Operations, General Services Manager and the Associate Administrator of Operations, both microwave ovens located in the residents' first floor dining room were observe with food residue on all interior sides. In particular, the &quot;Sharp Carousel&quot; microwave had large amounts of solidified brown residue on its interior top and interior base areas. The touring staff stated they would notify an appropriate individual to clean the interiors of both microwave ovens. Later on 02/15/2006, between 2:20 PM and 3:00 PM, in the presence of nursing staff the following food items were found in the &quot;resident food refrigerators&quot; in Clarendon Hall: a.) Two East, an unlabeled bottle dated 01/06/06 that containing meat looking like chicken and an undated, unlabeled Ziploc plastic bag also containing chicken-like meat. The certified nurses assistant stated he would remove the items immediately, and b.) Two West, an undated and unlabeled bag containing a sandwich. 4.) On 2/6/06 between 11:37 a.m. and noon inspection of the main kitchen dry goods and bakery storage areas revealed unsanitary, cross-contaminating conditions. a. In dry storage there was a #10 can of applesauce with a case-cut on the top lid. Case-cuts are the result of vigorous box cutting such that cans have deep cut marks which ruin the protection of the metal of the canned good, increasing the possibility of deterioration,</td>
<td>F 371</td>
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F 371 Continued From page 239
perforation and contamination of food. Dietetic Service Manager 1 said that staff should not have retained this canned good and said it would be removed from use.

b. In a bakery drawer a dietetic service staff member had co-mingled recipes with used ear plugs. As the used ear plugs were proximate to the recipes which would be used during food preparation, there was the potential for cross-contamination.

c. In the bakery there was a bin of brown sugar with dark matter of uncertain origin on the exterior. As such there was the potential for cross-contamination during procurement of the sugar.

5.) On 2/6/06 between approximately 11:40 a.m. and 1:20 p.m., there were unsanitary, cross-contaminating conditions in both the main kitchen and in ancillary kitchen refrigerators.

a. In walk-in refrigerator #4 there was a wet box of thawing, boxed frozen juices set less than one foot from the floor. Dietetic Service Manager 1 said that the box had become wet during the cleaning of the floor. While inspection revealed that the contents had not been soaked, the practice of having stored foods near the floor while cleaning could result in inadvertent contamination.

b. In a walk-in refrigerator #7 there was flaking paint on a pipe above nourishments, milk and panned prepared foods. Also, in walk-in refrigerator #8 there was flaking paint on the ceiling, just above packages of cheese. Dietetic Service Manager 1 acknowledged the conditions.
<table>
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<tr>
<td>F 371</td>
<td>Continued From page 240 and potentials for contamination.</td>
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<tr>
<td>c. In walk-in refrigerator #5 there was dirty ice on top of a box of bagged broccoli. Dietetic Service Manager 1 said he did not know if the ice had come with a delivery or was from a departmental source. The manager added that he did not know why staff had kept the broccoli stored in this manner, given potential for leakage and contamination.</td>
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<td>6.) On 2/6/06 at approximately 12:30 p.m. in the Formula Room there was an uncovered box of used gloves stored atop an opened case of formula. Dietetic Service Manager 2 acknowledged the potentially cross-contaminating condition and removed the box of soiled gloves.</td>
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<td>7.) On 2/6/06 at approximately 1:20 p.m. following the dishmachine sanitation trial in the main kitchen dishroom, food debris remained on the dishrack and scoops. Dietetic Service Manager 2 acknowledged the need for more effective cleaning and the need to re-run the items.</td>
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<td>8.) On 2/6/06 between approximately 1:20 p.m. and 2:10 p.m. there were unsanitary, cross-contaminating conditions in the cafeteria.</td>
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<td>a. At approximately 1:25 p.m. just prior to lunch service break-down, cheese enchiladas were at 124.5 degrees F and rice was at 126 degrees F. Dietetic Service Manager 1 said that the items would have to be discarded given uncertain time &quot;below 140 degrees F&quot;.</td>
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<td>b. At 1:30 p.m. the top of the dishmachine was soiled with brown and black matter of unknown</td>
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<td>F 371</td>
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<td>origin. Dietetic Service Manager 2 acknowledged the potential for cross-contamination.</td>
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<td>c. At approximately 1:35 p.m. near the cafeteria service area there was a soiled scoop retained in drawer. Dietetic Service Manager 1 acknowledged the unsafe retention and potential to contaminate food during service.</td>
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<td>9.) On 2/6/06 at approximately 2:20 p.m. in the Volunteer kitchen there was a microwave with a soiled interior. Dietetic Service Manager 1 acknowledged the potential for contamination during use.</td>
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<td>10.) On 2/6/06 between approximately 2:40 p.m. and 2:55 p.m., there were unsanitary, cross-contaminating conditions in the Room 404 kitchen as there was a build up of cooked food debris in the drip pans of the range burners and a microwave with a soiled interior. Dietetic Service Manager 2 acknowledged the lack of clean equipment and potential for contamination.</td>
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<td>11.) On 2/6/06 between approximately 2:45 p.m. and 2:50 p.m. there were unsanitary, cross-contaminating conditions in the M-4 kitchen.</td>
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<td>a. In a pull-out cabinet there were three cartons of yogurt which had been retained for uncertain time there, instead of refrigeration. Dietetic Service Manager 2 said that the person responsible and the retention time were unknown. The manager removed the yogurt from the cabinets for discard.</td>
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<td></td>
<td>b. In another cabinet for equipment there were brown stains of uncertain origin on the frame and</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

**F 371** Continued From page 242

door. Dietetic Service Manager 2 acknowledged the conditions and potential for cross-contamination.

c. In a drawer there was a grimy, worn metal spatula. Dietetic Service Manager 2 acknowledged the conditions as well as the need for replacement.

d. There was a build-up of cooked food debris in the drip pans of the range burners and a microwave had a soiled interior. Dietetic Service Manager 2 acknowledged the lack of clean equipment and potential for contamination.

e. In an upper cabinet, there was a hole of approximately one-inch diameter which could become an entry for contaminants which could spill onto items stored there.

12.) On 2/6/06 between approximately 2:50 p.m. and 2:55 p.m. there were unsanitary, cross-contaminating conditions in the M-5 kitchen.

a. There was grimy fry pan stored on a cabinet shelf. Dietetic Service Manager 2 said that it would have to be cleaned.

b. There was a drawer containing plates and three dusty cans of waterchestnuts. Dietetic Service Manager 2 said that he did not know why the dusty canned goods had been stored with previously cleaned plates.

c. There was a soiled oven mitt and a soiled potholder stored with partially uncovered disposable bowls. Dietetic Service Manager 2 acknowledged the potential for
### Summary Statement of Deficiencies

#### 483.35(h)(3) Sanitary Conditions - Garbage Disposal

The facility must dispose of garbage and refuse properly.

This **requirement** is not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure that garbage and refuse were properly disposed.

**Findings:**

During the initial tour at approximately 11:45 A.M. on February 5 2006, the following observations were made:

Refuse was allowed to accumulate on the ground outdoors between the building and the grease...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 555020 |
| A. BUILDING | |
| B. WING | |

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

(A) BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE

SUMMARY STATEMENT OF DEFICIENCIES

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<tr>
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<tr>
<td>F 372</td>
<td>Continued From page 244 trap. This refuse, including paper waste, trash and rubbish, was not contained in regular garbage containers to prevent the attraction of pests. This refuse was next to the large open loading dock both inside and outside the building located close to the bulk food storage area. When observed, dietary staff verified that this opening to the building is left standing open when unattended. The facility did not guard against physically preventing pests from entering this building or prevent hiding places for mice in this rubbish next to the food delivery area.</td>
<td>F 372</td>
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</tr>
<tr>
<td>F 426</td>
<td>483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview with licensed nursing staff, the facility failed to provide pharmaceutical services to meet the needs of each resident at three nurses stations (F5 and K5 in the main building and One East in Clarendon Hall). Findings: 1.) During the environmental tour on 2-15-06, the following drug storage observations were made on F-5:</td>
<td>F 426</td>
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</tbody>
</table>
F 426 Continued From page 245

a. A plastic container labeled "Vi-Daylin Multivitamin liquid" was noted to have an expiration date of 9-1-05. The medication, described by staff as "house supply," was observed stored in the same medication cabinet with other non-expired drugs.

b. Two vials of regular Humulin insulin were noted inside the medication refrigerator. Although labeled when both were first opened, the vials however were stored with other non-expired medications past their discard date of 28 days (after being opened). One vial, for example, had a first-open date of 12-26-05 and a labeled discard date of 1-26-06.

Another vial of regular Humulin insulin was observed undated as to when it was first opened and did not indicate a discard date.

In addition, discard dates for multidose vials, according to pharmacy policy, was 28 days after the vials were first opened. In light of this however, staff had been noting discard dates of 30 days after the vials were first opened. One vial of regular Humulin insulin, for example, was noted as having a first-open date of 1-17-06. The discard date of this vial was observed to be 2-17-06, a period of 30 days (instead of 2-14-06).

2.) On 2/15/06 during an inspection of the medication room located on K-5, beginning at 14:05; an open bottle of Aluminum Hydroxide was found on the medication cart. This medication expired on 12/05. In a drawer in the medication room, 8 vials of sterile water for injection were found with an expiration date of 09/05.
### STATEMENT OF DEFICIENCIES

#### 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

#### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

- **(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 555020
- **(X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:**
  - A. BUILDING
  - B. WING
- **(X3) DATE SURVEY COMPLETED:** 02/21/2006

#### SUMMARY STATEMENT OF DEFICIENCIES

**483.60(c)(1) DRUG REGIMEN REVIEW**

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility did not ensure that the drug regimen of each resident was reviewed at least monthly on 2 (Residents 5 and 20) of 96 sampled residents.

#### Provider's Plan of Correction

- **(X4) ID PREFIX TAG:** F 426
- **(X5) COMPLETION DATE:**

**F 426**

Continued From page 246

3.) On 2/15/2005, at approximately 2:00 PM, in the presence of the registered nurse, another surveyor observed a 16 ounce bottle of Docusate Sodium Liquid at the One East nurses station in Clarendon Hall. The expiration date on the bottle was listed as 12/05.

**F 428**

483.60(c)(1) DRUG REGIMEN REVIEW

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility did not ensure that the drug regimen of each resident was reviewed at least monthly on 2 (Residents 5 and 20) of 96 sampled residents.

Findings:

1. Resident 5 was initially admitted to the facility on 11-21-03 following a stroke with residual right-sided hemiparesis and aphasia, and several other diagnoses including seizure disorder, hypertension, and depression.

Review of the medical record revealed a physician's order dated 4-11-05 for Doxycycline (an antibiotic) 100 mgs orally twice daily. Review of the medication administration record (MAR) indicated that Resident 5 continued to receive the antibiotics as ordered. Further record review however revealed the lack of documented indication for the administration of the antibiotic and for the excessive duration of its use. During
F 428 Continued From page 247

During a separate interview at 10:30 a.m. on 2-7-06, a pharmacy staff was requested evidence of completed drug regimen review records for Resident 5 as none could be found in the medical record and on the unit. After this request, a drug regimen review dated 2-7-06 was presented regarding the resident's continuing use of the Doxycycline.

2. Resident 20 was admitted to the facility on 12-20-05 with several diagnoses including gout, hypertension, alcohol abuse, and diabetes mellitus. Review of the minimum data set (MDS) dated 12-30-05 revealed that Resident 20 had short term memory problems and required assistance with some activities of daily living (ADLs).

Review of the medical record revealed that on 12-20-05, a physician's order was written for the use of Trazodone 50 mgs at bedtime for sleep. Review the MAR revealed that Resident 20 did received the drug nightly as ordered since her admission on 12-20-05. Further record review however revealed the lack of evaluation for the continued use of the Trazodone. In addition, there was no written indication available of attempts made to determine the cause of insomnia prior to the use of the drug.

When asked during an interview if pain was a reason for her difficulty going to sleep at night (because of gout), Resident 20 stated that there was a particular resident on the unit who would
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F 428</td>
<td>Continued From page 248 scream and made other noises during the night. When asked if the Trazodone was effective, Resident replied that it wasn't but that she continues to take them because &quot;they (medication nurses) keep giving it to me.&quot; During the same interview at 10:30 a.m. on 2-7-06, completed drug regimen reviews were requested from the pharmacy staff for Resident 20. Thereafter, a document was presented indicating a drug regime review completed on 1-6-06 but did not include a review for the use of the Trazodone.</td>
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<tr>
<td>F 430 SS=C</td>
<td>483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview with facility pharmacy staff and the facility's Director of Nursing, the facility failed to ensure that the pharmacists' report of any irregularities were acted upon. Findings: On 02/16/06 between 1:00 PM and 2:00 PM, the surveyor discussed with the facility's pharmacists and Director of Nursing the facility's method of reporting of any medication irregularities to the attending physician and director of nursing. The pharmacists provided exhibits of monthly computerized reports of the irregularities divided into Nursing findings and Physician findings. The</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>(X3)COMPLETION DATE</td>
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<td>F 430</td>
<td>Continued From page 249 facility's Director of Nursing assured the surveyor that she read each monthly report. However, there was no mechanism for either the attending physician or Director of Nursing to indicate acceptance or rejection of each report.</td>
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<tr>
<td>F 432 SS=D</td>
<td>483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to store drugs and biologicals in a locked compartment when the crash cart was left unlocked and unattended in the hallway close to Residents' rooms. Findings: During the tour at Clarendon Hall West 200 on 2/6/06 at 8:20 a.m., a red metal crash cart</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
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</table>
| F 432 | | Continued From page 250 located in the hallway between Residents' rooms was observed with a broken lock. The second drawer contained medications such as Lidocaine, Epinephrine, Atropine Sulfate and others. The lower drawer contained metal instruments, Betadine Solution, syringes and forceps. This observation was brought to the licensed staff's attention. She said, "It was not used by the night shift and it should have been locked."

In an interview on 2/6/06 at 8:45 a.m., the licensed nurse said the crash cart was checked every shift and that the morning shift had not done it yet. Review of the crash cart monitoring log indicated the night shift licensed nurse signed the log indicating that it has been checked. There was no documentation that the cart was opened and used by the night shift. The morning shift licensed nurse checked the drawer with the medications and found that the plastic bag that enclosed the medications had not been opened. There was no explanation by the staff why the cart was left unlocked and unattended in the hallway.

The crash cart was left unlocked through the night and the contents were made accessible to unauthorized persons. | F 432 | | |
| F 441 | SS=E | 483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as | F 441 | | |
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<th>ID PREFIX</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<tr>
<td>F 441</td>
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<td>isolated should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</td>
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This REQUIREMENT is not met as evidenced by:

Based on observation, record review and interview, the facility did not maintain an infection control program designed to provide a safe, sanitary and comfortable environment, and prevented the transmission of disease and infection for four of 96 sampled residents. (Residents 5, 20, 39, 90)

Findings:

1. Resident 20 was admitted to the facility on 12-20-05 with several diagnoses including gout, hypertension, alcohol abuse, and diabetes mellitus. Review of the minimum data set (MDS) dated 12-30-05 revealed that Resident 20 had short term memory problems and required assistance with some activities of daily living (ADLs). An interdisciplinary note dated 12/29/05 further documented that Resident 20 "needs supervision" and that she "desires discharge."

Review of the medical record revealed a Record of Tonometry (a measurement of the intraocular pressure of the eye) and Immunizations (RTI) which noted that Resident 29 had refused the influenza vaccine on 11-6-00. Further record review however revealed the lack of documented evidence as to why the vaccine was not thereafter offered, or why it was not indicated for Resident 20.

During an interview on 2-7-06, Resident 20 stated...
Continued From page 252

that she did not know why she did not receive the influenza vaccine, and does not remember if it was offered to her.

2. Resident 39 was admitted to the facility on 10-25-05 with several diagnoses including pneumonia, organic brain disease with dementia, diabetes mellitus, and hypertension. A quarterly assessment dated 2-7-06 described Resident 39 as having short and long-term memory problems, cognitively impaired, and dependent on staff for all activities of daily living.

Review of the medical record revealed that Resident 39 was bed-bound, had a slow-healing pressure sore on her right heel, and received enteral feedings by nasogastric tube.

Review of the RTI revealed that while Resident 39 was given the influenza vaccine on 10/11/05, there was no documentation in the medical record that attempts were made to verify when the last pneumococcal vaccine was administered, if at all. Review of the same RTI indicated that Resident 39 last received the pneumococcal vaccine on "11/8/09 (sic)," a date which, according to a nurse manager interviewed on 2/16/06, was not accurate and in need of verification.

3. Resident 5 was initially admitted to the facility on 11-21-03 following a stroke with residual right-sided hemiparesis and aphasia, and several other diagnoses including seizure disorder, hypertension, and depression. Review of the medical record revealed a quarterly assessment dated 11-29-05 which described Resident 5 as having no short or long term memory deficits; and that he required "limited assistance" with transfer,
Continued From page 253

and walking in his room and corridor. The same assessment noted that the resident was continent of both bowel and bladder functions.

Review of the Record of Tonometry and Immunizations (RTI) revealed that a physician's order dated 10-12-05 was made to give Resident 5 the influenza vaccine. Further record review revealed that the influenza vaccine was subsequently administered but there was no indication in the medical record as to why the pneumococcal vaccine was not offered or considered for administration. While the RTI noted that the "pneumococcal vaccine was not recommended at less than 5-year intervals," there no notation on the RTI as to when Resident 5 last had pneumococcal vaccine, or if he ever did receive it.

Review of a memorandum dated 10-3-05 entitled "Influenza Vaccine & Pneumococcal Vaccine Campaign 2005" from the facility's infection control and medical director revealed a directive to "administer flu shots to all residents who do not have contraindications," and that "all new admissions to (the facility) from now until mid-February should receive influenza vaccine on admission unless previously given or unless there is a medical contraindication." In addition, a guideline on the administration of the pneumococcal vaccine attached to the same memorandum noted, among others, that "all nursing home residents, regardless of their age, should receive the Pneumococcal Polysaccharide Vaccine (PPV) upon admission to the facility (if there is no prior vaccination history or unclear vaccination status)," and "a second booster dose should be given to persons 65 years or older if they received the first dose of vaccine more than
5 years earlier and were less than 65 years old at the time."

The memorandum further noted that the "Pneumococcal Polysaccharide Vaccine is required for all residents of nursing facilities except those with allergic reaction to vaccine component(s) and a physician order not to immunize ..."

4. During observation of wound care on 2-14-06 at 10:25 a.m., involving Resident 39 who was described in the medical record as having a slow healing pressure sore on the right heel, a licensed staff with gloves on both hands was observed to cut through the old dressings, remove, and then discarded them in a plastic receptacle.

Without changing gloves, the same staff proceeded to rearrange the resident's bed sheet and touched the side rail while waiting for the treatment nurse to begin. When the resident's tube feeding pump began to alarm, the staff, using the same gloves, pressed the power button on the pump to turn it off.

5. On 02/05/2006 during the initial tour of the 300 West and 300 East units of Clarendon Hall, washing machines and dryers were observed. When asked, the Program Manager of 300 West stated that the machines were used to wash the residents' personal clothing. She said the linens were sent out of the building and done by a professional cleaning service. When asked, the Program Manager also stated that they used warm water when washing the clothing. When asked if she knew at what temperature the water was when the clothing was washed on the unit, the Program Manager stated they did not
measure the water temperature. When asked if there were ever any residents on the unit who were isolated with infectious organisms, the Program Manager stated that it had happened on a few occasions. It was also observed that the laundry detergent being used in the washing machines was "Sure Brite." In reviewing the directions on the boxes of detergent, there were no instructions regarding how hot the temperature of water needed to be when using this particular detergent.

Policies and procedures were requested from the facility on the use of the washing machines with the Sure Brite detergent. A policy from the CDC (Centers for Disease Control) was given to the survey team. In part, it states under "IV. Laundry Process: A. If hot-water laundry cycles are used, wash with detergent in water > (greater than or equal to) 160 (degree symbol) F [71 (symbol for degrees) C] for > (greater than or equal to) 25 minutes."

6.) On 2/5/2006 at 11:45 A.M., during the entrance tour of the Hospice Unit, C-2, Resident 90 was observed as she dropped her pink plastic drinking cup on the floor. A staff nurse picked up the plastic cup and gave it back to the resident for her use.

7.) On 2/15/06 during an inspection of the medication room located on K-5, beginning at 14:05; a closet labeled to identify sterile supply storage had a variety of items stored directly on the floor, to include a box of gloves, two 24 hour urine collection containers, 3 storage-type metal cans and a set of bolt cutters. The floor was extremely dirty with both loose and embedded debris.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<td>F 444</td>
<td>SS=D</td>
<td>483.65(b)(3) PREVENTING SPREAD OF INFECTION</td>
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The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility failed to ensure that a staff member on Clarendon West washed her hands between residents when providing direct care and services; failed to ensure that proper procedure was used by Hospice staff while performing Resident 85's wound care; and failed to ensure that Resident 55 was provided with the necessary supplies to self administer her medicines hygienically (two of 96 sampled residents).

**Findings:**

1. On 2/14/06 at 9:15 A.M. a lab technician on the Clarendon West unit was observed removing her gloves at the nurses' station, using the addressograph stamping machine, then going into another Resident's room where she put on another pair of gloves without first washing her hands.

During an interview on the same date and time, the technician said she had not washed her hands because the Resident's bathroom was occupied when she entered the room.

On 2/15/06, a review of the facility policy number C4 titled "Hand Hygiene" revealed that:
F 444 Continued From page 257

"Health care workers must practice hand hygiene prior to beginning their work shifts. The most important times for subsequent handwashing are:

AFTER DIRECT CONTACT WITH RESIDENT SECRETIONS (even if gloves have been worn). BEFORE INVASIVE PROCEDURES (even if gloves are to be worn).

Health care providers must also practice hand hygiene:
   a. Between resident contacts
   b. After contact with a source likely to contain microorganisms in high quantity (i.e. body fluids, mucous membranes, non-intact skin and inanimate objects likely to be contaminated).
   c. Immediately after removing gloves...."

2. Resident 85 was admitted to the M-5 unit of the facility on 10/25/2005 with diagnoses that included pressure sores and SDAT (brain condition); the resident was subsequently transferred to the Hospice Unit at C-2.

On 02/07/06 at 10:15 A.M. in the Hospice unit, a CNA was observed completing care for Resident 85, which included peri care; she had gloves on her hands. The CNA then provided assistance to the staff nurse during wound care; however, the CNA did not change her gloves prior to the start of the wound care procedure.
### Statement of Deficiencies and Plan of Correction

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<td>F 444</td>
<td>Continued From page 258</td>
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The staff nurse performed wound care to the coccyx area for this resident according to physician orders. When the surveyor asked to observe the right heel of the resident, the CNA lifted the Resident's right heel for observation. There was a blister on the resident's right lateral heel. The CNA then took her gloved hand and ran a finger over the blister at which time the blister broke and fluid from the blister oozed from the area. The CNA then opened the chest of drawers next to the resident's bed and reached in and dipped her finger into a jar of vaseline and scooped some of the vaseline out of the jar. She then proceeded to apply the vaseline onto the open blister of the right heel. The staff nurse then used a piece of sterile Kerlix to wipe the vaseline from the wound; however, this procedure did not remove all of the vaseline from the now opened area. The staff nurse then proceeded to dress the wound with polymen, taped the polymen in place, then covered the polymen with gauze, wrapped the heel with Kerlix and taped the dressing in place.

The physician's order for wound care is dated 11/07/05 and reads: "Wounds: Dilute ioprep wash/polymer." The staff nurse did not use the dilute ioprep when cleansing the wound of the vaseline and before applying the polymen.

The unit charge nurse was interviewed regarding the wound care procedure that was done by the staff nurse. She agreed that it was not the right procedure.

The resident's care plan, dated 10/25/05 includes as a goal: "Altered skin integrity re: Stage II - R heel," the goal: "will have no signs of infections,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<td>F 444</td>
<td>Continued From page 259 no complications.</td>
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<td>3. Resident 55 had a Physician's order dated 11/21/05 for &quot;Self administration of Drugs.&quot;</td>
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<td>During a medication administration observation at Clarendon Hall on 2/8/06 at 9:05 a.m., Resident 55 was observed in a wheelchair in the dining room, finishing her breakfast. The licensed nurse stood beside her as the resident opened medicine bottles with her teeth, and removed the medications from the bottles with her unwashed hands. Resident 55 was not provided with a spoon to take the medications from the containers. This observation was brought to the licensed staff's attention who said, &quot;We trained her many times to open the medication bottles with her right hand. Her left hand is paralyzed.&quot;</td>
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<tr>
<td></td>
<td>Facility staff did not provide Resident 55 with tools or equipment to open medication bottles or to remove medications from the containers in a manner that would prevent cross contamination. Also, the staff person did not remind Resident 55 to wash her hands, nor did the nurse provide the resident with supplies to wash or sanitize her hands before she self-administered her medications. (Cross reference F-176.)</td>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 454</td>
<td>483.70 PHYSICAL ENVIRONMENT</td>
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<td>The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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Based on observation, the facility failed to maintain equipment to protect the health and safety of personnel for one walk in freezer in the Main Kitchen.

Findings:

During the initial tour at approximately 11:25 A.M. on February 5, 2006 the chef's walk in freezer in the Main Kitchen, on the third floor of the main building, tested 12 degrees F. The State of California requires freezer temperatures to be 0 degrees F. or below. There was a build up of ice on the floor in some areas of this freezer which was a safety hazard for the staff.

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, the facility failed to ensure that essential mechanical, electrical, and patient care equipment was functional and maintained in safe operating condition. By not having functional thermometers in the dietetic service there was initial confusion regarding the safety of chilled foods and reliability of the refrigeration.

Findings:

1. On 2/6/06 at approximately noon, during inspection of main kitchen walk-in refrigerator #5,
there were foods that had been stored for more
than four hours which were above 41 degrees F (Fahrenheit), the maximum safe holding
temperature for chilled foods) according to a
facility thermometer. These were: one batch of juk (a Chinese rice porridge) --which registered
45-46 degrees F, and two batches of rice, one at
46 degrees F and another at 47 degrees F. Also,
there was roast beef which registered 48 degrees
F and turkey roll at 47 degrees F.

Concerned that the foods should have been
better chilled, given that the gauge registered 39
degrees F and the internal thermometers, 36
degrees F and 38 degrees F, Dietetic Service
Manager 2 re-checked the thermometer for
calibration as well as another facility thermometer
via the ice-bath method, finding that the first
thermometer was unreliable.

When foods were re-tested using the reliable
thermometer, batches of rice and juk were at 41
degrees, roast beef was at 39.4 degrees F and
turkey roll at 34-39 degrees F. Dietetic Service
Manager 2 acknowledged that the first
thermometer was inaccurate and that it needed
either repair or replacement.

2. On 2/9/06 during dinner tray line which
commenced at approximately 4:42 p.m., there
were indications of inaccurate internal
thermometers in refrigerators.

a. On the A-line, at 4:48 p.m. there was a
reach-in refrigerator which had an internal
thermometer registering 52 degrees AF while a
tuna fish sandwich registered 44 degrees AF
when probed. Also, in another reach in
refrigerator, there was an internal thermometer
Continued From page 262

registering 54 degrees AF while custard was at 42.6 degrees AF. As the thermometer used to test the sandwich and custard had been evaluated for accuracy at noon and the location of the sandwich and custard was within six inches of the respective internal thermometers, the inaccuracy of the internal thermometer was probable. Dietetic Service Manager 2 concurred.

b. On the B-line, at 5:06 p.m. there was a reach-in refrigerator which had an internal thermometer registering 50 degrees AF while a tuna fish sandwich less than six inches away, registered 44.4 degrees AF when probed. As the thermometer used to test the sandwich had been evaluated for accuracy at noon, Dietetic Service Manager 2 said that the internal thermometer in question would have to be replaced.

C. At approximately 5:10 p.m. in the walk-in milk box there were two internal thermometers. Although one registered 42 degrees AF, the other was at 46 degrees AF even though milk, stored next to the thermometer registered 42.1 degrees AF. As the thermometer used to test the milk had been evaluated for accuracy at noon, Dietetic Service Manager 2 said that the internal thermometer in question would have to be replaced.

3. On 02/15/2006, at approximately 9:45 AM, during the surveyor led tour of the general environment of Clarendon Hall with the facility’s Director of Quality Management, Interim Director of Facilities Operations, General Services Manager and the Associate Administrator of Operations, a combination refrigerator and freezer was opened in the the "inactive kitchen" area of the first floor dining room. There was no
Continued From page 263

thermometer in either compartment. The freezer section was full of frost to the point of making it necessary to carve out the ice in order to place even a small item. The refrigerator section had pooling water in both "crisper" sections. When asked what the refrigerator was used for, the accompanying facility staff members asked for the registered nurse from the One East Nurses Station to come to the dining room. When she arrived, she stated the refrigerator was used to store all resident laboratory specimens requiring refrigeration for the entire resident population of Clarendon Hall. The refrigerator was not storing any resident laboratory specimens at the time of this observation.

F 457

Bedrooms must accommodate no more than four residents.

This REQUIREMENT is not met as evidenced by:

Based on observation, confidential group interview, family interviews, resident and staff interviews, the facility failed to provide bedrooms which accommodated no more than four residents.

Findings:

Observation on 02/05/06 revealed that the facility had open wards with more than 20 residents in each ward, and bedrooms with more than four residents throughout the facility.

In an interview on 02/05/06 at 9:00 a.m. an
Continued From page 264

administrative staff person stated that the facility had been accommodating the residents in this manner since the 1920's.

In interviews during the survey from 02/05/06 to 02/21/06, residents and family members had no complaints about their bedroom accommodations, and the less than required square footage appeared to have no adverse effect on their health and safety.

During the survey, in a confidential group interview, and also individual resident and family interviews, there was no indication that the open wards and rooms with more than four residents had adversely affected the residents' health and safety.

This REQUIREMENT is not met as evidenced by:

Based on observation, confidential group interviews, family interviews, resident and staff interviews, and record review, the facility failed to provide bedrooms that measured at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

Findings:

Observation on 02/05/06 revealed that the facility
F 458 Continued From page 265

had open wards with more than 20 residents in each ward, 17 two-resident bedrooms had less than the required 80 square feet per resident, and one single resident room measured less than the required 100 square feet, as follows:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Room #</th>
<th>Square feet</th>
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<tr>
<td>Two-resident Rooms</td>
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<td></td>
</tr>
<tr>
<td>0-7 715</td>
<td>132</td>
<td>66</td>
</tr>
<tr>
<td>0-7 716</td>
<td>132</td>
<td>66</td>
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<tr>
<td>L-7 703</td>
<td>147</td>
<td>73.5</td>
</tr>
<tr>
<td>K7 716</td>
<td>142</td>
<td>71</td>
</tr>
<tr>
<td>0-6 616</td>
<td>132</td>
<td>66</td>
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<tr>
<td>M6 615</td>
<td>129</td>
<td>64.5</td>
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<tr>
<td>L-6 603</td>
<td>139</td>
<td>69.5</td>
</tr>
<tr>
<td>F-6 614</td>
<td>126</td>
<td>63</td>
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<tr>
<td>E-6 618</td>
<td>130</td>
<td>65</td>
</tr>
<tr>
<td>E-5 500</td>
<td>126</td>
<td>63</td>
</tr>
<tr>
<td>F-5 502</td>
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<tr>
<td>L-5 518</td>
<td>127</td>
<td>62.5</td>
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<tr>
<td>M5 517</td>
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<td>F-4 403</td>
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<td>C-4 416</td>
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<td>F-3 302</td>
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<td>F-3 316</td>
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Private Room

F-6 613 | 91 | 91 |

In an interview on 02/05/06 at 9:00 a.m. an administrative staff person stated that the facility had been accommodating the residents in this manner since the 1920's.

In interviews during the survey from 02/05/06 to 02/21/06, and the confidential group interviews,
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 458</td>
<td>Continued From page 266 Residents and family members had no complaints about their bedroom accommodations, and the less than required space appeared to have no adverse effect on their health and safety. During the survey, in a confidential group interview, and also individual resident and family interviews, there was no indication that the open wards and rooms with more than four residents had adversely affected the residents' health and safety.</td>
<td>F 458</td>
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<td>F 463</td>
<td>483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all portions of their call light and buzzer system were functioning for one of 96 sampled residents. (1.) The buzzer in the nurses' station on K-7 failed to continually buzz after Resident 45 put on her call light to obtain help with her dinner tray. (2.) The facility failed to ensure that each nurses' station was equipped to receive resident calls through a communication system from resident rooms, toilet and bathing facilities for two rooms at Clarendon Hall 1 West. Findings: 1. Record review on 2/9/06 revealed that</td>
<td>F 463</td>
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Resident 45, age 92, was admitted to the facility on 1/3/06 and with diagnoses including hip fracture after a fall on 12/14/05 at home, arthritis, atrial fibrillation, cataracts, and depression. Her 1/9/06 MDS indicated her memory was O.K., she was alert and oriented to person, place, and time, had modified independence in decision-making, and impaired vision. She required extensive staff assistance to turn in bed, get out of bed to a chair, move around her unit, toilet and hygiene. She did not walk, and was totally dependent on staff to dress, and bathe. She needed one staff person's limited assistance to eat, had limited range of motion and partial loss of use of one foot and leg, and was frequently incontinent of bowel and bladder. The 1/13/06 RAP Summary stated: "Speaks (non-English language) Translator needed for communication."

Record review on 2/9/06 revealed that Resident 45 had a 1/3/06 physician's order for: "Metoprolol 12.5 mg po (by mouth) BID (twice a day) (hold for SBP (systolic blood pressure) below 110." (Metoprolol is a blood pressure medication with a common side-effect of hypotension, or excessively low blood pressure)

Record review on 2/9/06 revealed that Resident 45's 1/11/06 care plan stated: "Resident is at risk for fall R/T (related to) history of fall and use of BP (blood pressure) meds." The goal was: "Resident will have no fall in 3 months." One of the interventions was: "Anticipate needs of resident by checking or asking her what she needs."

Record review on 2/9/06 revealed that Resident 47's 1/18/06 Integrated Progress Notes at 7 PM, the notes stated: "Per witness, Resident stood up..."
FROM PAGE 268

Continued from her bed (#28) took a few steps in between her bed and bed #29 then she swayed and fell and hit her head at the corner of bed #29.

Record review on 2/14/06 revealed that Resident 45's returned to the facility on 1/24/06 from the hospital where she was taken after having a fall on K-6. During that fall, she struck her head and was sent urgently to the hospital. A CT scan showed a "blowout" fracture of the (right) eye, and subdural hematoma. The patient has no vision at her right eye.

In an interview on 2/9/06 at 11:20 am, a supervisory nurse on K-7 stated that Resident 45 had been in a low bed in the front part of the ward at bed #28 before she fell on 1/18/06 at 7 PM. She stated: "The PM nurse saw her. She was there when the resident got up, and told her to sit down. The nurse went to the back ward and was passing medications. She saw her stand up and started walking."

Observation on 2/14/06 at 11:30 am revealed Resident 45 dressed and sitting in her wheelchair on the ward where she was relocated, G-5. Her eye-patch was in place, her head was bent, and she was mumbling to herself in a non-English language. She did not respond when the surveyor attempted a greeting in the resident's language.

In a telephone interview on 2/15/06 at 1:45 PM, Resident 45's daughter stated her mother told her that on 1/18/06: "She kept pushing the buzzer but no-one came and her food was sitting there. She wanted to reach for the food. She got up and hit the corner. She was waiting a long time, maybe a half hour, for someone to help her. Her food got cold, and she was tired."
Continued From page 269

Observation of the resident's call-light on 2/15/06 at 2:30 PM revealed that pressing the button on the call-light cord at bed #28 caused a light to go on over the resident's bed, at the entry to the ward, and in the nurses' station, but the buzzer only rang once in the nurses' station and not out on the ward when the button was first pressed, and it did not continue to sound.

In an interview at the same time on 2/15/06, a supervisory nurse stated that the buzzer sounds when the call-light button is first pressed, but the resident must hold and continue to press the button for the buzzer to continually sound. Simply turning on the call-light does not cause the buzzer to continually sound.

Resident 45, who was alert and oriented with no memory problems, told her daughter she put her call light on for help with her dinner tray. A nurse who saw her standing up told her to sit down and went into the back ward to pass her medications. Since the resident's call-light buzzer only sounded once briefly in the nurses' station, the nurse who was in the back of the ward, and any other staff near-by, could not hear that the resident was attempting to summon help. Because no staff came to help her, Resident 45 stood up from her bed to reach for her food, fell, hit her head, and sustained a subdural hematoma and blow-out fracture of her one good eye, rendering her blind.

(Cross reference F-241, F-272, F-324, F-353)

2. On 02/08/2006, at 09:10 AM at Station One West in Clarendon Hall the alert resident occupying bed 100-A was observed sitting with an unopened breakfast tray. When the surveyor asked the resident why she was not eating she
Continued From page 270

stated, "They will come," referring to the nursing staff. Above the resident's doorway the light was illuminated indicating the call light had been turned on. Due to an angle in the hallway, the light was not visible from either the nurses station or most of the rest of the Station One West area. When the surveyor approached the nurses station, there was not the usual audible buzzard sounding to indicate the resident's call light had been turned on. Although the switchboard had a small light illuminated to indicate the resident had applied the call light, the switchboard was placed in a small alcove against the south wall of the nurses station, out of view of anyone sitting at the desk at the nurses station. When asked, the station's registered nurse (RN) stated the call system had not been working well and the facility's maintenance department had tried to repair it the previous week. The RN dispatched a certified nurses assistant to help the resident and then helped the surveyor test all the room and bathroom call lights at Station One West. The call lights for 100-B and 101 (a private room) also were not functioning as intended (no buzzard at the nurses station). The RN put in place frequent monitoring of the residents until the call system could be repaired.

On 02/15/2006, at approximately 11:00 AM, the surveyor, while on tour of the general environment of Clarendon Hall with the facility's Director of Quality Management, Interim Director of Facilities Operations, General Services Manager and the Associate Administrator of Operations, returned to the One West Station. The call system for rooms 100 and 101 was again tested. This time, only the call light/buzzer for bed 100-A did not function as intended. Again there was no audible buzzer. The accompanying
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>DATE COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 463</td>
<td>Continued From page 271</td>
<td>facility staff members stated they would get it fixed that day. As before, the attending licensed staff member stated they would frequently monitor the resident until the call system was restored.</td>
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<tr>
<td>F 465</td>
<td>483.70(h) OTHER ENVIRONMENTAL CONDITIONS</td>
<td>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</td>
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This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview the facility failed to ensure that there were safe, sanitary conditions in the main kitchen and ancillary areas. By not having such, there was the risk of staff accidents and contamination.

**Findings:**

1. On 2/6/06 at approximately 12:45 p.m. there was an unsafe condition in the main kitchen Pot Room (where there is the washing, rinsing and sanitizing) of large wares. There was a large hose with a frayed mesh exterior looped onto the wet floor. As such, dietetic service staff could trip and fall and the frayed mesh was a concern as the hose was in contact with contaminants.

2. On 2/6/06 at approximately 12:50 p.m. there were unsafe conditions in the main kitchen hot food production area as there were worn floor skids (treads). As such, given that the floor was wet due to the amount of steam produced in the
<table>
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<tr>
<td>F 465</td>
<td></td>
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<td>Continued From page 272 area as well as the drainage from the large kettles, there was the risk for dietetic service staff to slip and fall.</td>
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<td>F 517</td>
<td>483.75(m)(1)</td>
<td>DISASTER AND EMERGENCY PREPAREDNESS</td>
<td>The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review the facility failed to have detailed written plans specific to foodservice during emergencies and disasters. By not having detailed plans, there was potential for errors in foodservice operations, inclusive of special diet, preparation and alternative dishwashing. Finding: On 2/9/06 between 11:00 a.m. and 11:30 a.m. review of the emergency and disaster plans and departmental policies and procedures specific to foodservice with Dietetic Service Manager 1, Dietetic Service Manager 2 and Dietitian 1 revealed that in the written plan there were no emergency and disaster menus and no plan for alternative dishwashing. During an interview on 2/9/06 Dietitian 1 said that the menus for therapeutic diets had been liberalized, but retained in the automated system. Also, Dietitian 1 said that there was guidance for</td>
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<td>F 517</td>
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<td>the preparation of modified diets which should have been inserted following approval and review.</td>
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When the method for alternative dishwashing was reviewed, Dietetic Service Manager 1 said that the Pot Room (which had a smaller dishwashing set-up than the dishroom) and the bain-marie (a hot water holding-bath) could be used in lieu of the main dishmachine, but found that these two alternatives had not been written, approved and incorporated in the plan.