STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Surveyor: 31201 The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: 31201 The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census: 58	E 000		
K 000	INITIAL COMMENTS Surveyor: 31201 K3 BUILDING: 01 K6 PLAN APPROVAL: 2/1/1971 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY PLUS BASEMENT, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition.	K 000		

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

Electronically Signed | 09/24/2019

Approved 09/24/2019 per Cynthia Luc, SSM I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Representing the California Department of Public Health: 31201 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census = 58	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation, document review, and interview, the facility failed to maintain the exit signs. This was evidenced by the failure to perform the required monthly and annual functional test of the battery-powered emergency exit sign. This affected one of three smoke compartments, and could result in potentially delay evacuation. NFPA 101, Life Safety Code, 2012 Edition 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4.	K 293	The plan of correction is prepared in compliance with all applicable state and federal regulations and is intended as Lawton Skilled Nursing & Rehabilitation Center's credible evidence of compliance. The submission of the plan of correction is not an admission by the Facility that it agrees that the citations are correct or that it violated the law. Organization Minutes: The confidential and privileged minutes are being retained at the Facility for agency review and verification if required. Exhibits:	9/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 2 7.10.9.2 Testing. Exit signs connected to, or provided with, a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Findings: During document review, and interview with the Maintenance Staff on 9/10/19, the exit sign	K 293	All exhibits including revisions to medical staff bylaws, reviewed/revised or promulgated policies and procedures, documentation of staff and medical staff training education are retained at the Facility for agency review and verification upon request. Tag: K293 Exit Signage All residents residing in the facility have the potential to be affected by this practice. No specific resident was identified. Immediate Corrective Action(s): The Maintenance Supervisor immediately documented the functional testing that was performed. The battery-powered exit sign located by the Physical Therapy area is maintained and checked monthly with a minimum of 3 weeks and a maximum of 5 weeks for not less than 30 seconds; annually for 1 1/2 hours. Training: The Administrator and Director of Staff Development provided reeducation to the Maintenance Supervisor in regards to documenting the required monthly and annual testing of the batter-powered emergency exit sign located near the Physical Therapy area above an exit door. Monitoring: The Maintenance Supervisor will document visual inspections, functional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 3 documentation was requested. At 9:48 a.m., the facility failed to provide the required monthly and annual testing of the battery-powered emergency exit sign. The exit sign was located near the Physical Therapy area above an exit door. When interviewed, the Maintenance Staff stated that the monthly and annual testing were conducted but were not documented.	K 293	testing and monitoring of the battery-powered exit sign located by the Physical Therapy area, which is maintained and checked monthly with a minimum of 3 weeks and a maximum of 5 weeks for not less than 30 seconds; annually for 1 1/2 hours. The results of the functional testing of the emergency battery-powered exit sign will be submitted to the Administrator to ensure proper functionality is documented to ensure 100% compliance. The Administrator will complete monthly audits to ensure the Maintenance Supervisor is on track and complaint with the monthly and annual functional testing. Audits by the Administrator will be completed for a minimum of 3 months and until 100% compliance is met. The results of the monitoring will be presented quarterly at the Continuous Quality Improvement meeting. Responsible Person(s): Maintenance Supervisor Administrator Director of Staff Development	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited	K 324		9/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 4 cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation, document review, and interview, the facility failed to maintain the cooking equipment. This was evidenced by the failure to performed inspection and servicing at least annually for the cooking equipment in the Kitchen. This affected one of three smoke compartments. This could cause cooking equipment to malfunction, and could possibly cause a fire in the facility. NFPA 101, Life Safety Code, 2012 Edition 19.3.2.5 Cooking Facilities. 19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. 9.2.3 Commercial Cooking Equipment.	K 324	Tag: K324 Cooking Facilities All residents residing in the facility have the potential to be affected b the practice. No specific resident was identified. Immediate Corrective Action(s): The Maintenance Supervisor inspected the six gas burner stove, two ovens, and one griddle per manufacture's guidelines on 9/23/19. The Maintenance Supervisor will inspect, maintain, and document the performed inspection and servicing per manufacture's guidelines annually for the identified kitchen cooking equipment i.e. (1) six gas burner stove, (2) ovens, and (1) griddle.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 5 Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition 11.7.1 Inspection and servicing of the cooking equipment shall be made at least annually by properly trained and qualified persons. 11.7.2 Cooking equipment that collects grease below the surface, behind the equipment, or in cooking equipment flue gas exhaust, such as griddles or charbroilers, shall be inspected and, if found with grease accumulation, cleaned by a properly trained, qualified, and certified person acceptable to the authority having jurisdiction. Findings: During a tour of the facility, document review, and interview with the Maintenance Staff on 9/10/19, the cooking equipment were observed and document was requested. At 10:27 a.m., the kitchen cooking equipment were observed and inspection documents were requested. The facility failed to provide inspection and servicing documents at least annually for the cooking equipment. The kitchen was observed with six gas burner stove, two ovens, and one griddle. When interviewed, the Maintenance Staff confirmed the finding.	K 324	Training: The Administrator and Director of Staff Development provided reeducation to the Maintenance Supervisor on the need to inspect, maintain and document the performed inspection and servicing annually for the identified kitchen equipment i.e. (1) six gas burner stove, (2) ovens, and (1) griddle. Monitoring: The Maintenance Supervisor will inspect, maintain, and document the performed inspection and servicing per manufacture's guidelines annually for the identified kitchen cooking equipment i.e. (1) six gas burner stove, (2) ovens, and (1) griddle. The annual documented inspection of the kitchen cooking equipment will be submitted to the Administrator to ensure proper functionality and documentation is met to ensure 100% compliance. The Administrator will complete monthly audits to ensure the Maintenance Supervisor is on track and complaint with the annual inspection, maintenance and documentation. Audits by the Administrator will be completed for a minimum of 3 months and until 100% compliance is met. The results of the monitoring will be presented quarterly at the Continuous Quality Improvement meeting. Responsible Person(s): Maintenance Supervisor Administrator Director of Staff Development	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 6 This is a repeat deficiency from the last Life Safety survey on 10/29/18.	K 324		
K 325 SS=D	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation and interview, the facility failed to maintain the location of the alcohol based hand rub dispenser (ABHR). This was evidenced by the ABHR that was installed over an	K 325	Tag: K325 Alcohol Based Hand Rub Dispenser (ABHR) All residents residing in the facility have the potential to be affected by this practice. Room 114 was identified.	9/19/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 325	Continued From page 7 ignition source. This affected one of three smoke compartments, and could result in the increased risk of fire. Findings: During a tour of the facility and interview with the Maintenance Staff and Administrator on 9/10/19, the ABHR was observed. At 11:12 a.m., the ABHR in Room 114 was observed. The ABHR was installed directly over a light switch. The Ethyl Alcohol content of the ABHR was 70 percent. When interviewed, Administrator confirmed the finding.	K 325	Immediate Corrective Action(s): The Maintenance Supervisor immediately removed and relocated the identified Alcohol Based Hand Rub Dispenser (ABHR) on 9/10/19, that was installed directly over a light switch. The Administrator and Director of Staff Development observed and validated that the identified ABHR was relocated in room 114, to another wall away from an ignition source on 9/19/19. Training: The Administrator and Director of Staff Development provided education to the Maintenance Supervisor to ensure that no ABHR are install over light switches or other sources of ignition. Monitoring: The Maintenance Supervisor completed an audit of all clinical and non-clinical areas at the facility and found that no other location other than the identified room 114 was affected. The Maintenance Supervisor will complete monthly audits to ensure that no ABHR will or has been installed over a source of ignition i.e. light switch, etc. The audits will be completed for 3 month or until 100% compliance is achieved. The results of the audits/monitoring will be submitted to the Continuous Quality Improvement meeting quarterly. Responsible Person(s): Maintenance Supervisor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 325	Continued From page 8	K 325	Administrator Director of Staff Development	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on document review and interview, the facility failed to maintain the integrity of the automatic fire sprinkler system. This was evidenced by the failure to provide two of four quarterly sprinkler system inspections. This affected three of three smoke compartments, and could result in the ineffective operation of the automatic fire sprinkler system in the event of a fire.	K 353	Tag: K353 Sprinkler System - Maintenance and Testing All residents residing in the facility have the potential to be affected by this practice. No specific resident was identified. Immediate Corrective Action(s): The Administrator did locate evidence of compliance with the Sprinkler System maintenance and testing for the 4th Quarter of 2018, identified as missing.	9/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 9 NFPA 101 Life Safety Code, 2012 Edition. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7 Automatic Sprinklers and Other Extinguishing Equipment. 9.7.1 Automatic Sprinklers. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. Chapter 5 Sprinkler Systems. 4.3 Records. 4.3.1* Records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. 4.3.2 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 5.1.1 Minimum Requirements. 5.1.1.1 This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. 5.2.5 Waterflow Alarm and Supervisory Devices. Waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are	K 353	The facility contracted company completed the inspection, testing and maintenance of the facility's sprinkler system on 11/7/18. The Facility did investigate and find that the inspection, testing and maintenance for 1st Quarter of 2019 was completed 4/11/19. The sprinkler system inspection for the Second Quarter of 2019 was completed on 6/11/19 and the Third Quarter of 2019 was completed on 8/29/19. The Maintenance Supervisor will schedule Sprinkler inspection, testing and maintenance for the first month of each Quarter, as scheduling and company availability permits to ensure no Quarterly inspection is missed or late. If the contracted company does not come on the assigned date scheduled, the Maintenance Supervisor will escalate this to the facility's Administrator to ensure completion of this required quarterly inspection, testing and maintenance is met. The Maintenance Supervisor will ensure the Facility receives the documented results of the inspection, testing and maintenance which includes a.) date sprinkler system last checked, b.) who provided system test, c.) water system supply source; timely after each scheduled inspection. Training: The Director of Staff Development provided education to the Maintenance Supervisor in regards to scheduling, time	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 10 free of physical damage. Findings: During document review and interview with the Maintenance Staff on 9/10/19, the automatic fire sprinkler system was observed and maintenance records were requested. 1. At 9:31 a.m., the facility failed to provide documentation for two of four quarterly sprinkler system inspections. The facility failed to provide the first quarter (January/February/March) of 2019; and fourth quarter (October/November/December) of 2018. When interviewed, the Maintenance Staff confirmed the finding. The facility was given the opportunity to email the quarterly sprinkler reports on 9/11/19 by 10 a.m. On 9/11/19, at 10 a.m., no e-mail was received from the facility regarding the missing sprinkler inspections.	K 353	management and escalation processes. The education included a focus on the required quarterly inspection, testing, and maintenance of the sprinkler system. Ensuring a schedule of the required quarterly inspection, testing and maintenance of the sprinkler system and ensuring an escalation process is in place will ensure that no quarterly inspections are missed moving forward. Furthermore the Maintenance Supervisor will ensure the Facility receives the documented results of the inspection, testing and maintenance timely after each scheduled inspection. Monitoring: The Maintenance supervisor will monitor & audit the upcoming scheduled inspection, testing and maintenance of the sprinkler system to ensure that the scheduled inspections are followed. Once the scheduled inspections are completed the Maintenance Supervisor will ensure the company performing the testing will provide the report back to the Facility timely. The documented audits will be completed for a minimum of 3 months or until 100% compliance is met. The results of the monitoring will be presented to the Continuous Quality Improvement Meeting. Responsible Person(s): Maintenance Supervisor Administrator Director of Staff Development	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101	K 363		9/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 11 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 12 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation and interview, the facility failed to maintain corridor doors to resist the passage of smoke and/or fire. This was evidenced by doors that failed to latch. This affected one of three smoke compartments and could result in the passage smoke and flames in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition 19.3.6.3* Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 13?4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes 19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7. 19.3.6.3.10* Doors shall not be held open by devices other than those that release when the	K 363	Tag: K363 Corridor - Doors All residents have the potential to be affected by this practice. No specific resident was identified. The Janitor's closet by room 102 and the door to Physical Therapy room were both identified. Immediate Corrective Actions: The Maintenance Supervisor inspected the two identified doors at the Janitor's closet on the North hallway by room 102 and the Physical Therapy room door. The Maintenance Supervisor found that the door strike (a metal plate affixed to a doorjamb with a hole for the bolt of the door. When the door is closed, the bolt extends into the hole in the strike plate and holds the door closed) on the door frame needed to be secured to ensure full latch of the door lock. This project was completed on 9/16/19. The Director of Staff Development tested and validated that the two identified doors (the Janitor's closet on the North hallway by room 102 and the Physical Therapy room door)were compliant and able to latch when fully opened and released on 9/22/19. The Director of Staff Development repeated this test three times and all three times the doors were able to latch when fully opened and released. Training: The Administrator and Director of Staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 13 door is pushed or pulled. 7.2.1.8 Self-Closing Devices. 7.2.1.8.1* A door leaf normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2, unless otherwise permitted by 7.2.1.8.3. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic-closing, provided that all of the following criteria are met: (1) Upon release of the hold-open mechanism, the leaf becomes self-closing. (2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes self-closing, or the leaf can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door leaf becomes self-closing. (5) The release by means of smoke detection of one door leaf in a stair enclosure results in closing all door leaves serving that stair. 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. 7.2.1.5.2* The requirement of 7.2.1.5.1 shall not	K 363	Development provided in-service education to the Maintenance Supervisor in regards to a system to periodically check and maintain the two identified doors (the Janitor's closet on the North hallway by room 102 and the Physical Therapy room door) and all other applicable corridor doors to ensure that the corridor doors latch when fully open and released. Monitoring: The Maintenance Supervisor will check and maintain the two identified doors (the Janitor's closet on the North hallway by room 102 and the Physical Therapy room door) and other applicable corridor doors monthly by opening the door identified doors fully and releasing them to ensure they fully latch. Audits will be completed for a minimum of 3 months and until 100% compliance is met. The results of the monitoring will be presented quarterly at the Continuous Quality Improvement Meeting. Responsible Person(s): Maintenance Supervisor Administrator Director of Staff Development	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 14 apply to door leaves of listed fire door assemblies after exposure to elevated temperature in accordance with the listing, based on laboratory fire test procedures. 7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. 7.2.1.5.4 The requirements of 7.2.1.5.1 and 7.2.1.5.3 shall not apply where otherwise provided in Chapters 18 through 23. Findings: During a tour of the facility and interview with the Maintenance Staff and Administrator on 9/10/19, the corridor doors were observed. 1. At 11:16 a.m., the door to the Janitor's closet by Room 102 was equipped with a self-closing device that failed to latch when fully opened and released. The door was tested three times and failed. The finding was confirmed by the Maintenance Staff and Administrator. 2. At 11:21 a.m., the door to the Physical Therapy room was equipped with a self-closing device that failed to latch when fully opened and released. When interviewed, the Maintenance Staff confirmed the finding and stated that he will adjust the self-closure device.	K 363		
K 914 SS=D	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional	K 914		9/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 15 testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on document review and interview, the facility failed to maintain the electrical systems. This was evidenced by the failure to test the non-hospital grade receptacles in the resident care rooms annually. This could result in failure to provide electrical power to emergency equipment. This affected three of three smoke compartments. NFPA 99, Health Care Codes, 2012 Edition. 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals	K 914	Tag: K914 Electrical Systems All residents have the potential to be affected by this practice. No specific resident was identified. Immediate Corrective Action(s): The Maintenance Supervisor completed the annual inspection, maintenance and documentation of testing of the non-hospital grade receptacles in the resident care rooms on 9/23/19. Training: The Administrator and Director of Staff Development provided in-service education to the Maintenance Supervisor in regards to Electrical systems. The in-service focused on the annual inspection, maintenance and documentation of testing of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING **02** B. WING _____	**09/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWTON SKILLED NURSING & REHABILITATION CENTER	**1575 7TH AVENUE** **SAN FRANCISCO, CA 94122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 16 defined by documented performance data. 6.3.4.l.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. 6.3.4.1.4 The LIM circuit shall be tested at intervals of not more than 1 month by actuating the LIM test switch (see 6.3.2.6.3.6). For a LIM circuit with automated self-test and self calibration capabilities, this test shall be performed at intervals of not more than 12 months. Actuation of the test switch shall activate both visual and audible alarm indicators. 6.3.4.1.5 After any repair or renovation to an electrical distribution system, the LIM circuit shall be tested in accordance with 6.3.3.3.2. 6.3.4.2 Record Keeping. 6.3.4.2.1* General. 6.3.4.2.1.1 A record shall be maintained of the tests required by this chapter and associated repairs or modification. Findings: During document review and interview with the Maintenance Staff on 9/10/19, the receptacle test was requested. At 10:29 a.m., the receptacles in the resident rooms were not tested annually. The last test was done on 1/3/18. When interviewed, the Maintenance Staff confirmed the finding.	K 914	non-hospital grade receptacles in the resident care rooms. Monitoring: The Maintenance Supervisor will complete annual inspection audits and any need for maintenance or replacement of electrical receptacles and document the findings. Audits of the non-hospital grade receptacles in the resident care rooms will be completed for a minimum of 3 months and until 100% compliance is met. The results of the monitoring will be presented quarterly at the Continuous Quality Improvement meeting. Responsible Person(s): Maintenance Supervisor Administrator Director of Staff Development	