DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056345	A. BUILDING _____ B. WING _____	01/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the recertification survey visit from 1/12/15 to 1/20/15. Representing the Department: Health Facilities Evaluator Nurses: 33833; 25206 The resident census at the start of the survey was 53.	F 000	RECEIVED MAR 06 2015 Licensing & Certification East Bay District Office	
F 205 SS=B	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide written notice to three	F 205	1. HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE The 3 residents identified were now given a written notice of the seven day bedhold policy for those patients that were transferred to the hospital 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN The facility will now provide a written notice of the bedhold policy at the time of transfer to the hospital	2/20/15

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

Administrator 2/15/2015

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

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F 205 SS=B	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide written notice to three	F 205	**1. HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE** **The 3 residents identified were now given a written notice of the seven day bedhold policy for those patients that were transferred to the hospital** **2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN** **The facility will now provide a written notice of the bedhold policy at the time of transfer to the hospital**	

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F 205	Continued From page 1 (Resident 1, 3, and 8) of 14 sampled residents when they were transferred to hospital for evaluations. This failure potentially compromised the awareness of seven-day bedhold policy from residents and responsible parties when residents were transferred from the facility to hospitals for evaluations. Findings: 1. On 1/14/15, review of Bed Hold Policy, dated 9/1/2008, with Business Manager, showed that "At the time of transfer to acute care hospitalization or as soon as feasible afterwards, the licensed nurse/designee shall obtain a copy of the original bed hold form and complete the bottom portion, second notice of bed hold. The facility indicates how the resident/legal representative was notified and a copy of the form shall be sent to the representative and/or sent on transfer." 2. Record review showed nurses notes dated 1/14/15 at 8:43 a.m., that Resident 8 was transferred to the hospital for treatment of low breathing problems. There was no evidence of a bed-hold provided to the resident. 3. On 1/20/15 at 1:24 p.m. review of Resident 1's electronic medical record with DON showed that on 1/16/15 at 11 a.m., Resident 1 experienced respiratory problems and went to the dialysis center at 11:50 a.m. and then to the hospital at 2 p.m. There was no evidence of written notice of bed hold. 4. On 1/15/15 at 1:53 p.m., DON said that Business Manager was a designated staff to be responsible for bedhold notification when	F 205	**3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMATIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR** **In service will be provided to the Business Office staff and Nursing staff on the process of giving a written notice upon discharge** 2/20/2015 **4. HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED** **The IDT team will review the written process of informing residents/family on a quarterly basis. All corrections will be fixed immediately and reviewed.**	

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F 205	Continued From page 2 residents were transfered to hospitals. 5. On 1/15/15, the Business Manager said that she did not provide another resident (Resident 3) with any written notice of bedhold notification when Resident 3 was transferred to hospital on 11/30/14 and 12/20/14.	F 205		
F 323 SS=B	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to consistently maintain the wheelchair armrest of one of 14 sampled residents (1) and one additionally sampled resident (16) resulting in armrests having rough and cracked surfaces which could potentially cause residents' skin tears. Findings: 1. On 1/13/15 at 1:52 p.m., observation of Resident 1's wheelchair at Resident 1's bedside, with MS (maintenance supervisor) and MS 2, showed both armrests had rough and cracked surfaces 2. On 1/15/15 at 8:32 a.m., observation of the	F 323	**1. HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE** **The 2 broken wheelchair armrest have been replaced with new ones** **2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN** **The facility checked all wheelchair armrests t[o ensure that they are free from damage. Any of these that need to be fixed or replaced has been done** **3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMATIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR** **Maintenance supervisor or designee will frequently check all wheelchair armrests to ensure compliance. His findings will be sent to the IDT team. Any issues will be fixed.**	2/24/2015

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F 323	Continued From page 3 right armrest of Resident 16's wheelchair with the ADON(Assistant Director of Nurses) showed the armrest had torn rough surface exposing the foam underneath. 3. On 1/15/15 at 8:45 a.m., observation of Resident 1's both wheelchair armrests with the ADON showed that the armrests remained cracked and rough as observed during an environment tour with MS and MS 2 on 1/13/15 at 1:52 p.m.	F 323	**4. HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED** **The maintenance supervisor's findings will be reviewed monthly by the IDT team. Any actions based on the findings will be immediately taken**	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE 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, interviews, and record reviews the facility failed to ensure that the medication error rate was five percent or else, On 1/13/15 observation of 33 medication passes showed four errors resulting in an error rate of 12.12%. 1. Resident 7's Renvela and Resident 18's Calcuim Acetate (medications used to remove/control phosphorus levels in patients with end-stage renal disease on dialysis), was not given according to Physician's Order. 2. Resident 17 was almost given TUMS instead Calcium with Vitamin D. 3. Resident 7's Artificial Tears eye drop was not available. These failures had a potential to affect resident's health and safety and could cause other health	F 332	**1. HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE** **Licensed nurses were immediately instructed to give medications Renvela and Calcium Acetate to dialysis residents on the middle of their meal or before the end of their meal. They were also instructed to read the medication label properly when administering**	2/28/2015

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F 332	Continued From page 4 related problems. Findings: 1. During medication pass observation on 1/13/15 at 7:50 a.m., Licensed Vocational Nurse (LVN)1 poured the medications for Resident 18, and it includes Calcium Acetate 667 milligram(mg) capsule. LVN1 was not able to give the medication at that time because Resident 18 was having her morning care provided to her. LVN1 labeled the cup and placed it back in the drawer to be administered later. LVN returned back to Resident 18's bedside at 8:15 a.m. to administer the medications. At 8:30 a.m., LVN 1 poured Resident 7's medications that includes Renvela 800 mg tablet. Record reviews showed that Resident 7 and Resident 18 have a diagnosis of End-stage renal disease (ESRD - the last stage of chronic kidney disease. This is when the kidneys can no longer work to support the body's needs and remove waste and excess water). Both residents requires to have hemodialysis treatment (blood is removed from the body thorough vascular access site and sends it across a special filter with solutions. The filter helps remove harmful substances and then the blood is returned back to the body). Resident 7 and Resident 18 were on renal diet to help limit the intake of phosphorus. (Phosphorus job is to help your body use energy, and to build strong bones and teeth. When kidneys don't work, it cannot remove extra phosphorus. Phosphorus can build up in the body and in long-term can lead renal bone disease). Resident 7 and Resident 18 have to take the phosphate binder (Renvela or Calcium Acetate) medications with meals to remove extra phosphorus in their diet through the digestive system. Review Resident 7's Physician Orders showed	F 332	**2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN** **All residents have the potential to be affected . Licensed nurses were in-serviced and will be able to properly administer the Renvela and Calcium Acetate for dialysis residents, be able to order house stocks on timely manner and be able to read the medication label and administer the proper medication** **3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMATIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR** **In service was provided to Licensed Nurses regarding proper ordering of house stocks medications, proper adminis8tration of Renvela and Calcium Acetate for dialysis residents and proper reading of medication label**	2/20/2015

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F 332	Continued From page 5 (1) "Renvela tablet 800mg Give 1 tablet by mouth with meals every Mon, Wed, Fri related to END STAGE RENAL DISEASE". (2) "Renvela tablet 800mg give 1 tablet by mouth with meals every Sun, Tue, Thur, Sat related to END STAGE RENAL DISEASE" Review of Resident 18's Physician Orders showed (1)"Calcium Acetate Capsule Give 667mg by mouth with meals every Sun, Tue, Thur, Sat related to END STAGE RENAL DISIEASE" (2) "Calcium Acetate Capsule 667 Mg Give 1 capsule by mouth with meals very Mon, Wed, Fri related to END STAGE RENAL DISEASE." During an interview on 1/13/15 at 12:30 p.m., LVN1 stated that Renvela and Calcium Acetate have to be given with meals. When asked if LVN1 gave the medications for Resident 7 and 18 with meals this morning, LVN1 stated that they just had breakfast. When informed that it was observed that Resident 7 finished her breakfast at 7:35 a.m., and according to CNA1 Resident 18's breakfast was served at 7am and finished it at around 7:30 a.m. LVN 1 stated that it was supposed to be given at 7am, but they have a window of 1 hour before and 1 hour after to give the medications. LVN1 was unable to answer when informed that she gave the medication to Resident 17 at 8:15 a.m. and Resident 7 at 8:30 a.m. and purpose of those medications was to absorb/remove excess phosphorus in the diet. During an interview on 1/14/15 at 1:10 p.m., Director of Nursing (DON) stated that the Renvela and Phoslo have to be given right before the meals or within 15 minutes after the meal started. The medication will absorb the phosphorous from the diet so it won't accumulate in the blood stream. 2. During medication pass observation on 1/12/15	F 332	**4. HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED** **DON or designee will check the Licensed Nurses on how they do their med pass, how they administer the Renvela and Calcium Acetate for dialysis residents and will check the house stock supplies on regular basis to monitor compliance.**	2/20/2015

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F 332	Continued From page 6 at 9:15 a.m., Registered Nurse (RN1) was pouring the medication for Resident 17. RN 1 opened the medication cart (med cart) drawer to get a house stock medication. RN 1 looked the electronic Medication Administration Record (eMar) and compared the house stock medication that she obtained from the drawer. RN1 looked at the front and back of the bottle multiple times, and then she took a medication cup and poured 1 tablet from the bottle. The bottle had a manufacturer's label and pharmacy label showing Calcium Antacid 500mg Chewable (substitute for TUMS), while eMar, showed an order for Calcium Carbonate 500 (milligram)mg with Vitamin D 200 (International Unit)IU. The RN1 proceeded to pour the other medications for R17 in a separate cup, and then RN1 brought all the medications that she poured to Resident 17's room. Just before RN1 was to administer the medication cup that contains TUMS, the surveyor had to interrupt the medication administration. RN1 was asked to review and compare the eMar to the TUMS bottle, when asked if she had a right medication, RN1 answered that it's Calcium Carbonate 500mg. RN1 opened her drawer to look for other Vitamin supplements in the med cart. RN1 pulled another bottle of house stock medication from the med cart with label Oyster Shell Calcium 500mg with Vitamin D 200IU, RN1 stated that's Oyster Shell Calcium and not Calcium carbonate. RN1 documented that Calcium carbonate with Vitamin D "Unable to give the medication is not available". Review of the 17's Physician orders dated 1/2/15 showed an order for Calcium Carbonate -Vitamin D tablet 500mg-200unit. 3. During medication pass observation and concurrent interview on 1/13/15 at 8:30 a.m., LVN 1 was preparing Resident7's medication that	F 332		2/20/2015

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F 332	Continued From page 7 includes an eye drops called Artificial Tears. LVN 1 opened her drawer where the eye drops were stored; she looked at several eye drop boxes but was not able to find the Artificial Tears for Resident 7. LVN1 stated the she needs to obtain the medications for the med storage. LVN1 asked RN2 to get her a bottle of Artificial Tears from the med storage room. RN2 came back from the med storage room and stated that they were out stock of Artificial Tears. RN2 stated that they will order it from the pharmacy. LVN 1 stated that yesterday she had the bottle of Artificial Tears in her drawer and was not sure what happened to it. LVN 1 stated that they were the responsible of checking the supplies of medication in the med cart. A review of Resident 7's Physician's Orders dated 11/19/14 showed Artificial Tears Solution 0.4 % Instill 1 drop in both eyes four times a day for dry eyes. Review of the facility's policy and procedure titled "Medication Administration" dated 9/1/2008, showed that "To accurately administer medications to residents. Medications shall be administered as ordered by a licensed nurse upon the order of a physician/licensed independent practitioner."	F 332		2/20/2015
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the	F 458	**1. HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE** **The facility will complete a waiver form for those rooms and send it to the Department for approval**	

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F 458	Continued From page 8 facility failed to maintain 80 square feet per resident space in 18 (Resident Room 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25) out of 24 resident rooms. This failure has the potential to affect the resident's quality of life and care due to a lack of sufficient space for the provision of care by facility staff and for the lack of sufficient space for residents to have personal belongings at the bedside. Findings: During an environmental tour from 1:52 p.m. to 2:58 p.m., the following room size measurements were observed and verified with MS 2, excluding the areas, such as restrooms, closets, wardrobes, and alcoves. 1. In Resident Room 7 (four-bed room), the area was 12 feet 9 and a half inch by 22 feet and 4 inches. The resident space was 71.42 square feet per resident. 2. In Resident Room 8 (four-bed room), the area was 12 feet 7 inches by 22 feet 4 inches. The resident space was 70. 256925 square feet per resident. 3. In Resident Room 9 (four-bed room), the area was 12 feet 7b inches by 22 feet 4 inches. The resident space was 70.2569 square feet per resident. 4. In Resident Room 10 (four-bed room), the area was 12 feet 6.75 inches by 22 feet 4 inches. The resident space was 70.140625 square feet per resident. 5. In Resident Room 11 (two-bed room), the area was 12 feet 5.5 inches by 11 feet 7 inches. The	F 458		2/20/2015

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F 458	Continued From page 9 resident space was 72.1545 square feet per resident. 6. In Resident Room 12 (two-bed room), the area was 12 feet 5 inches by 11 feet 9 inches. The resident space was 72.94791 square feet per resident. 7. In Resident Room 14 (two-bed room), the area was 12 feet 5 inches by 11 feet 9 inches. The resident space was 72.947915 sqaure feet per resident. 8. In Resident Room 15 (two-bed room), the area was 12 feet 5.5 inches by 11 feet 9 inches. The resident space was 73.1927 square feet per resident. 9. In Resident Room 16 (two-bed room), the area was 12 feet 5.5 feet by 11 feet 9 inches. The resident space was 73.1927 square feet per resident. 10. In Resident Room 17 (two-bed room), the area was 12 feet 5.5 inches by 11 feet 9 inches. The resident space was 73.1927 square feet per resident. 11. In Resident Room 18 (two-bed room), the area was 12 feet 4.5 inches by 11 feet 9 inches. The resident's space was 72.703125 square feet per resident. 12. In Resident Room 19 (two-bed room), the area was 12 feet 4.5 inches by 11 feet 8.5 inches. The resident's space was 72.4453 square feet per resident. 13. In Resident Room 20 (three-bed room), the	F 458		2/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056345	A. BUILDING _____ B. WING _____	01/20/2015

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F 458	Continued From page 10 area was 11 feet 8.5 inches by 18 feet 2 inches. The resident's space was 70.900333 square feet per resident. 14. In Resident Room 21 (three-bed room), the area was 11 feet 9 inches by 18 feet 1 inch. The resident's space was 70.8263 square feet per resident. 15. In Resident Room 22 (three-bed room), the area was 11 feet 9 inches by 18 feet 1 inch. The resident's space was 70.82633 square feet per resident. 16. In Resident Room 23 (three-bed room), the area was 11 feet 9 inches by 18 feet 1 inch. The resident's space was 70.82633 sqaure feet per resident. 17. In Resident Room 24 (three-bed room), the area was 11 feet 10 inches by 18 feet 1 inch. The resident's space was 71.3287 square feet per resident. 18. In Resident Room 25 (three-bed room), the area was 11 feet 9 inches by 18 feet 1 inch. The resident's space was 70.8263 square feet per resident. During observations on 1/12/15, 1/13/15, 1/14/15, 1/15/15 and 1/20/15, during initial tour at 7:37 a.m. on 1/12/15 and throughout the remaining survey dates, the useful living space in each of the affected resident rooms provided sufficient space to move about (including wheelchair movement) without obstruction or interference from furniture or closets. Residents in affected rooms had privacy as well as storage space for personal possessions. There were no resident	F 458		2/20/2015

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F 458	Continued From page 11 complaints from the affected rooms. During observations, on 1/12/15, 1/13/15, 1/14/15, 1/15/15, and 1/20/15, staff were able to provide nursing services to meet the individual needs of each resident within these affected rooms. The affected rooms were maintained in a reasonable, uncluttered manner. There were no negative consequences attributable to the decreased space in any of the rooms, neither were any safety concerns noted.	F 458		
F 518 SS=B	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate training for three out of nine staff members in disaster preparedness, to ensure a continuing state of readiness in an event of an emergency. This failure had the potential to threaten the safety and well-being of all the residents, in the event of an emergency. Findings: In an observation and concurrent interview on 1/13/14 at 2:40 p.m., Registered Nurse (RN)2 stated that in case of disaster, the water and gas shut off valves were located outside of the building . When asked to locate the water shut off	F 518	**1. HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE** **The facility conducted an inservice on 3 people identified that did not know where the water and gas shut off were located** **2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN** **The facility will conduct an inservice for staff in regards to the water and gas shut off**	2/20/2015

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F 518	Continued From page 12 valve, RN 2 walked outside and identified a large pipe on the side of the building as water shut off valve and pointed to lever on the right side of the pipe to turn of the water supply. RN 2 stated that the gas shut off valve should be nearby as she was reviewing the instructions on the reminder card. RN 2 was not able to locate the gas shut off valve and called the Director of Staff Development (DSD). The DSD identified the large pipe as the gas shut off valve and stated that you need the wrench that was hanging on chain to shut off the gas in emergency. The DSD was not able to locate the water shut off valve and called the Maintenance/Housekeeping staff (M/HS) for assistance. The M/HS identified the large pipe on the side of the building as water shut off valve and stated you need to wrench to shut it off and once the wrench was attached to the valve it needs to be turned to the right. M/HS was unable to locate the gas shut off valve. M/HS called the Maintenance Supervisor (MS) for assistance. MS stated that the water shut off valve was along the side walk with plate cover and marked EBMUD (East Bay Municipal Utility District), he stated that you need to remove the cover to reach the shut off valve and turn it to the right. MS identified the large pipe on the side of the building as gas shut off valve and it needs the wrench to shut it off. After attaching the wrench to the valve, it needs to be turned to the left to shut off the gas supply. According to the facility's emergency and disaster instructions showed "Gas Shut-off - Outside bldg. Water Shut-off - Close by the Gas Shut-off". The instructions did not indicate the process of shutting both water and gas in an event that a disaster happens. According to the Federal Emergency	F 518	**3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMATIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR** **The facility will conduct frequent interviews on disaster preparedness which will include gas and water shut off . The facility will also randomly test employees on these issues** **4. HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED** **These inservices and random tests will given to the IDT team quarterly for review. Any actions needed will be immediately taken.**	2/20/2015

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F 518	Continued From page 13 Management Agency (FEMA), "Natural gas leaks and explosions are responsible for significant number of fires following disasters. It is vital that all household members know how to shut off natural gas. Water quickly becomes a precious resource following many disasters. Cracked lines may pollute the water supply to your house. It is wise to shut-off your water supply until you hear form authorities that it is safe for drinking". [http://www.ready.gov/utility-shut-safety]	F 518		2/20/2015