California Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED. AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ 01/30/2013 CA220000060 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2043 19TH AVENUE** KINDRED NURSING AND REHABILITATION-NINETEE! SAN FRANCISCO, CA 94116 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) A 000 A 000 Initial Comments The following reflects the findings of the California Department of Public Health during a staffing visit: Representing the Department: Associate Governmental Program Analyst. Welfare and Institutions Code Section 14126.022 is attached hereto and incorporated herein as 'Attachment A.' The statute was met as evidenced by the following findings: Based on record review and interview, the above nursing facility was found in compliance with Health and Safety Code 1276.5, the requirement for a minimum of 3.2 nursing hours per patient day, for 24 randomly selected days from October 25, 2012 through January 23, 2013. However, documentation requirements set forth in All Facilities Letter (AFL) 11-19 were not met. In the future, failure to properly complete the CDPH 530 or CDPH 612 forms (or facility equivalent) will result in a deficiency in addition to a finding of non-compliance with the 3.2 minimum NHPDD requirement for each day that proper documentation is not provided. The following documentation requirements were not met as evidenced by AFL 11-19: Section II. Guidelines, Sub-Section 6: Documentation Facilities will be expected to meet the following documentation requirements no later than 14 days from the date of this All Facilities Letter. (b) Each facility shall maintain current, complete, and accurate personnel and payroll records for all employees in accordance with Title 22, Section

Licensing and Certification Division

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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TITLE EXECUTION ONSCION (X6) DATE

If continuation sheet 1 of 2

STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM  CA220000060			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  B. WING		СОМІ	(X3) DATE SURVEY COMPLETED 01/30/2013	
	ROVIDER OR SUPPLIER  NURSING AND REHAE		2043 197	DDRESS, CITY, STATE TH AVENUE ANCISCO, CA 941	, ZIP CODE		130/2013	
(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 (X5)  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY)			
A 000	72533. The facility documentation upon	shall provide the followi		A 000				

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