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

PRINTED: 12/21/2017
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
	056394	A. BUILDING 02 B. WING ______	12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. FRANCIS CONVALESCENT PAVILION	99 ESCUELA DRIVE DALY CITY, CA 94015

(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 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	E 000	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.	
E 022 SS=D	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients,	E 022	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; a. Policy and procedure regarding sheltering clients, staff and volunteers was created and implemented into the emergency preparedness binder and plan. 12/15/17 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; a. Residents who reside at St. Francis Pavilion have the potential to be affected. New policy and procedure regarding the sheltering of clients, staff and volunteers was endorsed through in-service to staff on 12/28/17 during our monthly all staff meeting and presented to the Quality Assurance Performance Improvement committee on 12/29/17.	12/15/17 12/29/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 12-29-17

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.

1/3/18 - POC acceptable per Marian DeMene

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E 022	Continued From page 1 hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide policies and procedures for sheltering in place for staff and residents. This was evidenced by no documentation of shelter-in-place policies and procedures. This could result in an increased risk of harm to residents and staff in the event of an emergency that required sheltering-in-place for a given period of time. Findings. During document review with the Administrator on 12/14/17, the emergency preparedness plan was reviewed. 1. At 3:15 p.m., the facility's emergency preparedness plan failed to have policy and procedures to address a means to protect their clients, staff and volunteers when sheltering in place during a disaster. During interview with the Administrator, he stated he was not aware of this requirement of the emergency preparedness plan.	E 022	3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur; a. The facility Administrator will audit the emergency preparedness binder monthly to ensure all policies and procedures are current specifically the policy and procedure regarding sheltering of clients, staff, and volunteers. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system. a. Administrator will report findings to the monthly QAPI meeting for three months and thereafter as determined by QAPI committee.	
K 000	INITIAL COMMENTS K3 Building: 01 K6 Plan Approval: 7/16/1973 K7 Survey Under: 2012 EXISTING K12 Structure Type: TWO STORIES with PARTIAL BASEMENT, CONSTRUCTION TYPE III, FULLY SPRINKLERED The following reflects the findings of the California	K 000		

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K 000	Continued From page 2 Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.470 (a), National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 Edition, and NFPA 99, Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 31201 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. CENSUS: 227	K 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH 2018 JAN -2 PM 3:26 LICENSING & CERTIFICATION PROGRAM	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain its portable fire extinguishers. This was evidenced by a portable fire extinguisher that was obstructed from immediate access. This affected the basement and could result in staff's inability to readily access the portable fire extinguisher in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1	K 355	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; a. The two rolling carts were immediately moved to a new location not obstructing a fire extinguisher by Maintenance staff. 12/14/17 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; a. Residents who reside at St. Francis Pavilion have the potential to be affected. All other fire extinguishers in the facility were checked by maintenance staff to ensure they were not obstructed. No other obstructions were found. b. Employees were in-serviced to ensure fire extinguishers and all other fire protection system devices are not obstructed.	12/14/17 12/14/17 12/28/17

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K 355	Continued From page 3 9.7.4.1 Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition 6.1.3.3.1 Fire extinguishers shall not be obstructed or obscured from view. Findings: During a tour of the facility with staff on 12/14/17, the portable fire extinguishers were observed. 1. At 11:10 a.m., a portable fire extinguisher was obstructed from immediate access by two rolling carts placed in front of the fire extinguisher. The Maintenance Director confirmed the finding.	K 355	3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur; a. The Maintenance Director or Designee will make daily rounds to ensure no fire extinguishers are obstructed. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system. a. Maintenance Director will report findings to the monthly QAPI meeting for three months and thereafter as determined by QAPI committee.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms	K 920	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; a. The identified extension cords and power strips were immediately removed by maintenance staff on 12/14/17. 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;	12/14/17

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K 920	Continued From page 4 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the electrical wiring. This was evidenced by the use of and extension cords and power strips. This affected one of two floors and could result in the ignition of an electrical fire. NFPA 99, Health Care Facilities Code, 2012 Edition 10.2.3.6 Multiple Outlet Connection. Two or more power receptacles supplied by a flexible cord shall be permitted to be used to supply power to plug-connected components of a movable equipment assembly that is rack-, table-, pedestal-, or cart-mounted, provided that all of the following conditions are met: (1) The receptacles are permanently attached to the equipment assembly. (2)*The sum of the ampacity of all appliances connected to the outlets does not exceed 75 percent of the ampacity of the flexible cord supplying the outlets. (3) The ampacity of the flexible cord is in accordance with NFPA 70, National Electrical Code. (4)*The electrical and mechanical integrity of the assembly is regularly verified and documented.	K 920	a. Residents who reside at St. Francis Pavilion have the potential to be affected. Patient rooms were checked to see if there were any other extension cords or power strips. No other extension cords or power strips were found. b. DSD/Designee in-serviced Licensed Nurses, CNA's and other staff that medical equipment is not be plugged into powerstrips or extension cords and must plugged into the wall outlets as per Life Safety Code. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur; a. The Maintenance Director or Designee will make daily rounds randomly checking patient rooms for extension cords and power strips. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system. a. Maintenance Director will report findings to the monthly QAPI meeting for three months and thereafter as determined by QAPI committee.	12/14/17 12/28/17

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K 920	Continued From page 5 (5)*Means are employed to ensure that additional devices or non-medical equipment cannot be connected to the multiple outlet extension cord after leakage currents have been verified as safe. 10.2.4 Adapters and Extension Cords. 10.2.4.1 Three-prong to two-prong adapters shall not be permitted. 10.2.4.2 Adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. 10.2.4.2.1 All adapters shall be listed for the purpose. 10.2.4.2.2 Attachment plugs and fittings shall be listed for the purpose. 10.2.4.2.3 The cabling shall comply with 10.2.3. NFPA 70, National Electrical Code, 2011 Edition 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as	K 920		

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K 920	Continued From page 6 otherwise permitted in this Code (7) Where subject to physical damage Findings: During a tour of the facility and interview with staff on 12/14/17, the electrical wiring in the facility was observed and staff interviewed. First Floor: 1. At 10:10 a.m., an IV pole and a suction pump machine were plugged into a power strip near Bed A in Room 109. When interviewed, the Maintenance Director stated that there were not enough wall outlets. 2. At 10:40 a.m., an IV pole was plugged into a power strip by Bed C in Room 134. 3. At 10:46 a.m., an oxygen concentrator was plugged into a power strip near Bed C in Room 134. 4. At 10:51 a.m., a C-Pap Machine and a cell phone charger were plugged into a brown extension cord in Room 141. When interviewed, the Maintenance Director was not aware of the brown extension cord in use and stated a family member may have brought it into the facility.	K 920		

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