PRINTED: 05/22/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. BUILDING 01 B. WING	05/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHABILITATION-LAWTON	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	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1971 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: TYPE (V) 111, FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code re-certification survey. The findings are in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes. Representing the California Department of Public Health: 27254 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 51	K 000	*This Plan of Correction is the center's 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	6/16/13
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3	K 018	**F018 NFPA 101 LIFE SAFETY CODE STANDARD** Corrective action for residents affected by deficient practice: No residents were affected by the current practice. Identification of residents having potential to be affected by deficient practice and corrective action to be taken: All residents have the potential to be affected by the deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 6/16/13

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.

6/13/13 Poc acceptable per Marion DeMeure, HFEIS

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K 018	Continued From page 1 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their corridor doors. This was evidenced by a corridor door, that was obstructed from closing by a paper shredder. This affected one of two smoke compartments on the main level, and could result in the passage of smoke from one area of the facility to another, in the event of a fire. Findings: During a tour of the facility with staff, on 5/17/13, the corridor doors were observed. At 10:32 a.m., the door to the therapy room was equipped with a self-closing device. The door was held open with a paper shredder that had been propped against the door.	K 018	*This Plan of Correction is the center's 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Systematic changes to ensure deficient practice does not reoccur: The paper shredder propping the door open was removed. The Administrator / Designee will in-service staff to ensure that all doors are free from impediments to closing doors. Monitoring the corrective action: The Maintenance Director/Designee will monitor all doors to make sure no obstructions from closing the door exist. The Executive Director/ Designee will monitor for compliance during daily environmental rounds. Any instance of non compliance will be corrected on the spot with 1:1 education. Results of all inspections will be discussed in the quality assurance meeting for 3 months and quarterly thereafter. The Executive Director and or Designee are responsible for the overall compliance.	6/6/13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029	**K029 NFPA 101 LIFE SAFETY CODE STANDARD** Corrective action for residents affected by deficient practice: No residents were affected by the deficient practice.	

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K 029	Continued From page 2 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their hazardous areas, as evidenced by a door to a hazardous area that was not equipped with a self-closing device. This affected one of two smoke compartments on the basement level and could result in the passage of smoke from one area to another, in the event of a fire. Findings During a tour of the facility with staff, on 5/17/13, the hazardous areas were observed. Combustible storage rooms greater than 50 square feet in size are considered hazardous areas, and require self-closing doors. At 10:48 a.m., the door to the kitchen storage room was not equipped with a self-closing device. The storage room measured approximately 12 feet by 7 feet and contained combustible storage and supplies.	K 029	*This Plan of Correction is the center's 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Identification of residents having potential to be affected by deficient practice and corrective action to be taken: All residents have the potential to be affected. Systematic changes to ensure deficient practice does not reoccur: The kitchen storage room was equipped with a self-closing device. Monitoring the corrective action: The Maintenance Director/Designee will monitor the kitchen door to ensure that door closer remains intact and in good working condition. The Executive Director/ Designee will monitor for compliance during daily environmental rounds. Any instance of non compliance will be corrected on the spot with 1:1 education. Results of all inspections will be discussed in the quality assurance meeting for 3 months and quarterly thereafter. The Executive Director and or Designee are responsible for the overall compliance.	6/16/13
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	K 054	**K054 NFPA 101 LIFE SAFETY CODE STANDARD** Corrective action for residents affected by deficient practice: No residents were	

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K 054	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their smoke detectors, as evidenced by one smoke detector that failed to alarm when tested. This affected one of two smoke compartments and could result in a delay in notification, in the event of a fire. Findings: During fire alarm testing with staff, on 5/17/13, all the smoke detectors were tested. At 10 a.m., Smoke Detector 12 failed to activate the fire alarm system when tested. The smoke detector was located in front of Resident Room 107 and was tested three times with aerosol smoke.	K 054	*This Plan of Correction is the center's 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* affected by the current practice. Identification of residents having potential to be affected by deficient practice and corrective action to be taken: practice does not reoccur: All residents have the potential to be affected. The smoke detector in front of room 107 was repaired and is now working properly. Monitoring the corrective action: The Maintenance Director/Designee will monitor smoke detectors quarterly to ensure they work properly. Any instance of failed compliance will be corrected immediately. Results of all inspections will be discussed in the quality assurance. The Executive Director and or Designee are responsible for the overall compliance.	6/14/13
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the automatic sprinkler system. This was evidenced by a sprinkler head with less than 18 inch clearance around the deflector. This affected one of two smoke compartments on the main level, and could create an obstruction of the	K 062	**K 062 NFPA LIFE SAFETY CODE STANDARD** Corrective action for residents affected by deficient practice: No residents were affected by the deficient practice. Identification of residents having potential to be affected by deficient practice and corrective action to be taken: All residents have the potential to be affected.	

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K 062	Continued From page 4 sprinkler water spray pattern, in the event of a fire. NFPA 13, Installation of Sprinkler System, 1999 Edition 5-5.6 Clearance to Storage. The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. Findings During a tour of the facility with staff, on 5/17/13, the sprinkler heads were observed. At 11:10 a.m., the sprinkler head in the South Hall, in front of the oxygen storage room, had less than 18 inch clearance around the sprinkler deflector. The sprinkler deflector diverts the water supply, when a sprinkler is activated, creating the water spray pattern. A light fixture was installed next to the sprinkler head. There was approximately 2 inches between the light fixture and the sprinkler head.	K 062	*This Plan of Correction is the center's credible allegation of compliance.* 6/18/13 *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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Systematic changes to ensure deficient practice does not reoccur: The light fixture adjacent to the sprinkler in front of the oxygen storage room has been removed so that the sprinkler has 18 inch clearance. Monitoring the corrective action: The fire sprinkler system will be tested and monitored quarterly. Any evidence of less than 18 inch clearance will be acted and corrected immediately. Results of all fire sprinkler reviews tests will be communicated during the monthly quality assurance committee. The Executive Director and or Designee is responsible for the overall compliance.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their portable fire extinguishers, as evidenced by a fire extinguisher that was	K 064	**K064 NFPA 101 LIFE SAFETY CODE STANDARD** Corrective action for residents affected by deficient practice: No residents were affected by the deficient practice. Identification of residents having potential to be affected by deficient practice and corrective action to be taken: All residents have the potential to be	

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K 064	Continued From page 5 obstructed. This affected one of two smoke compartments on the main level, and could result in a delayed access to a fire extinguisher, in the event of a fire. NFPA 10 Standard for Portable Fire Extinguishers, 1998 Edition 1-6.6 Fire extinguishers shall not be obstructed or obscured from view. Exception: In large rooms, and in certain locations where visual obstruction cannot be completely avoided, means shall be provided to indicate the location. 4-3.2 Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place Findings: During a tour of the facility with staff, on 5/17/13, the fire extinguishers were observed.	K 064	*This Plan of Correction is the center's credible allegation of compliance.* 6/14/13 *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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* affected by the deficient practice. Systematic changes to ensure deficient practice does not reoccur: Items blocking the fire extinguisher were moved. The Executive Director and or Designee will in-service staff that all fire extinguishers need to be visible and not obstructed. Monitoring the corrective action: The Maintenance Director will monitor the fire extinguisher and check to make sure no equipment is blocking the extinguishers during his daily rounds. The Executive Director/ Designee will monitor for compliance daily during environmental rounds. Any instance of non-compliance will be corrected on the spot with 1:1 education. Results of all inspections will be discussed in the quality assurance meeting for 3 months and quarterly thereafter.	

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K 064	Continued From page 6 At 10:34 a.m., the fire extinguisher outside of the dining room was obstructed by walkers that were stored along the corridor wall. During an interview, Maintenance Staff reported that the walkers were kept in the corridor during the day for easy access during physical therapy treatments.	K 064	*This Plan of Correction is the center's 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	6/14/13