14155660148

PRINTED: 05/22/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER A BUILDING 01 05/17/2013 B. WING 055175 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1575 7TH AVENUE KINDRED TRANSITIONAL CARE & REHABILITATION-LAWTON SAN FRANCISCO, CA 94122 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION (X4) 10 TAG DEFICIENCY) PREFIX TAG This Plan of Correction is the center's credible 6/16/13 K 000 KOOD INITIAL COMMENTS allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the K3 BUILDING: 01 K6 PLAN APPROVAL: 1971 provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of K7 SURVEY UNDER: 2000 EXISTING correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 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 NFPA 101 LIFE SAFETY CODE STANDARD K 018 K 018 Doors protecting corridor openings in other than SS=D F018 NFPA 101 LIFE SAFETY CODE required enclosures of vertical openings, exits, or STANDARD hazardous areas are substantial doors, such as Corrective action for residents affected by those constructed of 1% inch solid-bonded core deficient practice: No residents were wood, or capable of resisting fire for at least 20 affected by the current practice. minutes. Doors in sprinklered buildings are only Identification of residents having potential to required to resist the passage of smoke. There is

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

no impediment to the closing of the doors. Doors

the door closed. Dutch doors meeting 19.3.6.3.6

are provided with a means suitable for keeping

19.3.6.3

TITLE

(X8) DATE 6/16/13

SXELVHIVE

be affected by deficient practice and

All residents have the potential to be

affected by the deficient practice.

corrective action to be taken;

Any deficiency statement enough with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that Any deficiency statement shows with an assertion to the patients, (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days other safeguards provide sufficient protection to the patients, (See instructions.) other sateguards provide sumicient protection to the petitions, today including the above findings and plans of correction are disclosable 14 following the date of survey whether or not a plan of porrection is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date of survey whether or not a plan of contestion to provided. For nothing notices, the above indings and plan of correction are disclosable to 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 days following the date these documents are made available to the facility. program participation. If continuation sheet Page 1 of 7

1 DRM CMS-7557(02 99) Previous Versions Obsolete

are permitted.

1 vers 10 SQNB21

Facility ID CARROUUSTO

14155660148

## PRINTED: 05/22/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLÉTED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING 01 AND PLAN OF CORRECTION 05/17/2013 B. WING 055175 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1575 7TH AVENUE KINDRED TRANSITIONAL CARE & REHABILITATION-LAWTON SAN FRANCISCO, CA 94122 PROVIDER'S PLAN OF CORRECTION COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE 10 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX IXAN ID REGULATORY OR LSC IDENTIFYING INFORMATION TAG CEFICIENCY) PREFIX TAG This Plan of Correction is the center's credible 6/6/13 K 018 K 018 Continued From page 1 allegation of compliance. Roller latches are prohibited by CMS regulations Preparation and/or execution of this plan of correction in all health care facilities 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 This STANDARD is not met as evidenced by: are free from impediments to closing doors. Based on observation, the facility failed to maintain their corridor doors. This was evidenced by a corridor door, that was obstructed from Monitoring the corrective action: The Maintenance Director/Designee will closing by a paper shredder. This affected one of two smoke compartments on the main level, and monitor all doors to make sure no obstructions from closing the door exist. could result in the passage of smoke from one The Executive Director/ Designee will area of the facility to another, in the event of a monitor for compliance during daily environmental rounds. Any instance of noncompliance will be corrected on the spot with 1:1 education. Results of all inspections will be discussed in the quality Findings: During a tour of the facility with staff, on 5/17/13. assurance meeting for 3 months and quarterly thereafter. The Executive Director the corridor doors were observed and or Designee are responsible for the At 10:32 a.m., the door to the therapy room was overall compliance. equipped with a self-closing device. The door was held open with a paper shredder that had been propped against the door. K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029

SS=D

One hour fire rated construction (with 3/4 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

STANDARD

K029 NFPA 101 LIFE SAFETY CODE

Corrective action for residents affected by

deficient practice: No residents were affected by the deficient practice.

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PRINTED: 05/22/2013

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES DENTIFICATION NUMBER A BUILDING 01 AND PLAN OF CORRECTION 05/17/2013 B WING 055175 STREET ADDRESS, CITY, STATE, ZIP COCE NAME OF PROVIDER OR SUPPLIER 1575 7TH AVENUE KINDRED TRANSITIONAL CARE & REHABILITATION-LAWTON SAN FRANCISCO, CA 94122 PROVIDER'S PLAN OF COFRECTION (XS) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE (X4) ID PREFIX TAG DIEFICIENCY) TAG 6/16/13 K 029 This Plan of Correction is the center's credible K 029 ' Continued From page 2 allegation of compliance. option is used, the areas are separated from other spaces by smoke resisting partitions and Preparation and/or execution of this plan of correction doors. Doors are self-closing and non-rated or does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions field-applied protective plates that do not exceed set forth in the statement of deficiencies. The plan of 48 inches from the bottom of the door are correction is prepared and/or executed solely hecause it is required by the provisions of federal and state law. permitted 19.3.2.1 Identification of residents having potential to be affected by deficient practice and corrective action to be taken: This STANDARD is not met as evidenced by: Based on observation, the facility failed to All residents have the potential to be maintain their hazardous areas, as evidenced by affected. a door to a hazardous area that was not equipped Systematic changes to ensure deficient with a self-closing device. This affected one of practice does not reoccur: two smoke compartments on the basement level The kitchen storage room was equipped with and could result in the passage of smoke from a self-closing device. one area to another, in the event of a fire. Monitoring the corrective action: The Maintenance Director/Designee will Findings monitor the kitchen door to ensure that door During a tour of the facility with staff, on 5/17/13, closer remains intact and in good working the hazardous areas were observed condition. The Executive Director/ Designee Combustible storage rooms greater than 50 will monitor for compliance during daily square feet in size are considered hazardous environmental rounds. Any instance of non areas, and require self-closing doors. compliance will be corrected on the spot with 1:1 education. Results of all At 10:48 a.m., the door to the kitchen storage inspections will be discussed in the quality room was not equipped with a self-closing device. assurance meeting for 3 months and The storage room measured approximately 12 quarterly thereafter. The Executive Director feet by 7 feet and contained combustible storage and or Designee are responsible for the overall compliance. and supplies K 054 NFPA 101 LIFE SAFETY CODE STANDARD K 054 All required smoke detectors, including those K054 NFPA 101 LIFE SAFETY CODE SS=D activating door hold-open devices, are approved STANDARD maintained, inspected and tested in accordance Corrective action for residents affected by with the manufacturer's specifications. 9.6.1.3 deficient practice: No residents were

PRINTED: 05/22/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER A BUILDING 01 05/17/2013 B. WING 055175 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1575 7TH AVENUE KINDRED TRANSITIONAL CARE & REHABILITATION-LAWTON SAN FRANCISCO, CA 94122 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE (IVX) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX DEFICIENCY) TAG This Plan of Correction is the center's credible K 054 K 054 Continued From page 3 allegation of compliance Preparation and/or execution of this plan of correction 6/14/13 does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions This STANDARD is not met as evidenced by: set forth in the statement of deficiencies. The plan of Based on observation, the facility failed to correction is prepared and/or executed solely because maintain their smoke detectors, as evidenced by it is required by the provisions of federal and state law, one smoke detector that failed to alarm when tested. This affected one of two smoke affected by the current practice. compartments and could result in a delay in Identification of residents having potential to be affected by deficient practice and notification, in the event of a fire. corrective action to be taken; practice does not reoccur; Findings: All residents have the potential to be During fire alarm testing with staff, on 5/17/13, all affected. The smoke detector in front of room 107 was repaired and is now working the smoke detectors were tested. properly. At 10 a.m., Smoke Detector 12 failed to activate Monitoring the corrective action: the fire alarm system when tested. The smoke The Maintenance Director/Designee will detector was located in front of Resident Room monitor smoke detectors quarterly to ensure 107 and was tested three times with aerosol they work properly. Any instance of failed compliance will be corrected immediately. smoke K D62 NFPA 101 LIFE SAFETY CODE STANDARD Results of all inspections will be discussed K 062 in the quality assurance. The Executive Required automatic sprinkler systems are Director and or Designee are responsible for SS=D continuously maintained in reliable operating the overall compliance. condition and are inspected and tested 19.7.6, 4.6.12, NFPA 13, NFPA 25, K 062 NFPA LIFE SAFETY CODE periodically. STANDARD 9.7.5 Corrective action for residents affected by deficient practice: No residents were affected by the deficient This STANDARD is not met as evidenced by: practice. Based on observation, the facility failed to maintain the automatic sprinkler system. This Identification of residents having potential to was evidenced by a sprinkler head with less than be affected by deficient practice and 18 inch clearance around the deflector. This corrective action to be taken:

affected one of two smoke compartments on the

main level, and could create an obstruction of the

affected.

All residents have the potential to be

SOCIAL SERVICES

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PRINTED: 05/22/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER A BUILDING 01 AND PLAN OF CORRECTION 05/17/2013 B WING 055175 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1575 7TH AVENUE KINDRED TRANSITIONAL CARE & REHABILITATION-LAWTON SAN FRANCISCO, CA 94122 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL. PREFIX DATE (X4) ID REGULATORY OR I.SC IDENTIFYING INFORMATION) TAG PREFIX DEFICIENCY) TAG This Plan of Correction is the center's credible K D62 K 062 Continued From page 4 allegation of compliance. sprinkler water spray pattern, in the event of a 6/10/13 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the fire. provider of the truth of the facts alleged or conclusions NFPA 13, Installation of Sprinkler System, 1999 set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because 5-5.6 Clearance to Storage. The clearance It is required by the provisions of federal and state law. between the deflector and the top of storage shall be 18 in. (457 mm) or greater. Systematic charges to ensure deficient Findings practice does not reoccur; During a tour of the facility with staff, on 5/17/13, The light fixture adjacent to the sprinkler in front of the oxygen storage room has been the sprinkler heads were observed. removed so that the sprinkler has 18 inch At 11:10 a.m., the sprinkler head in the South clearance. Hall, in front of the oxygen storage room, had less Monitoring the corrective action: than 18 inch clearance around the sprinkler The fire sprinkler system will be tested and deflector. The sprinkler deflector diverts the monitored quarterly. Any evidence of less water supply, when a sprinkler is activated, than 18 inch clearance will be acted and creating the water spray pattern. corrected immediately. Results of all fire sprinkler reviews tests will be communicated A light fixture was installed next to the sprinkler during the monthly quality assurance head. There was approximately 2 inches committee. The Executive Director and or between the light fixture and the sprinkler head. Designee is responsible for the overall

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

FORM CMS-2587(02-99) Provious Versions Obsolete

K 064 NFPA 101 LIFE SAFETY CODE STANDARD

SS=D

9741

Portable fire extinguishers are provided in all

health care occupancies in accordance with

This STANDARD is not met as evidenced by:

as evidenced by a fire extinguisher that was

Based on observation and interview, the facility

failed to maintain their portable fire extinguishers,

19,3.5.6, NFPA 10

Event IO: SONB21

Facility ID: CA220000020

compliance.

If continuation sheet Page 5 of 7

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/22/2013 FORM APPROVED

CENTERS FOR MEDICAR	E & MEDICAID SERVICES				A A T. (8), 707	0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 05/17/2013	
NAME OF PROVIDER OR SUPPLIES KINDRED TRANSITIONAL C	ARE & REHABILITATION-LAWTOR	N	1575 7T	DDRESS, CITY, STATE, ZIP CODE TH AVENUE RANCISCO, CA 94122			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S IPLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DIFFICIENCY)	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE		
compartments on in a delayed accelevent of a fire.  NFPA 10 Standa Extinguishers, 19 1-6,6 Fire exting or obscured from Exception: In land locations where we completely avoid indicate the location in decay and facing outward (a) No obstruction (b) No obstruction (c) Operating instand facing outward (d) Safety seals a facing outward (e) Fullness detection (f) Examination corrosion, leakage (g) Pressure gale operable range of (h) Condition of nozzle checked (ii) HMIS label in Findings:	affected one of two smoke the main level, and could result iss to a fire extinguisher, in the  rd for Portable Fire 98 Edition puishers shall not be obstructed view. ge rooms, and in certain risual obstruction cannot be ed, means shall be provided to ion  spection of fire extinguishers eck of at least the following esignated place on to access or visibility structions on nameplate legible and tamper indicators not broken ermined by weighing or "hefting" for obvious physical damage, ge, or clogged nozzle uge reading or indicator in the or position tires, wheels, carriage, hose, and (for wheeled units)			This Plan of Correction is the center's a allegation of compliance.  Preparation and/or execution of this plat does not constitute admission or agreen provider of the truth of the facts alleged set forth in the statement of deficiencies correction is prepared and/or executed it is required by the provisions of federal and the facts alleged and the provisions of federal actions are described by the deficient practice. Systematic changes to ensure described does not reoccur: tems blocking the fire extinguismoved. The Executive Director Designee will in-service staff the extinguishers need to be visible obstructed.  Monitoring the corrective action The Maintenance Director will requipment is blocking the extinguisher and check to me equipment is blocking the extinguisher compliance daily during environ compliance daily during environ rounds. Any instance of non-cowill be corrected on the spot with education. Results of all inspections of a months and quarterly therefore the form of the provision of the quality assurant for 3 months and quarterly therefore.	an of correctionent by the dor conclusion. The plan of solely becaused and state late.  Efficient sher were and or at all fire and not monitor the nake sure no guishers secutive a for a sure the late of the lat	7.5	

PRINTED 05/22/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION A BUILDING 01 055175 B WING 05/17/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE. 1575 7TH AVENUE KINDRED TRANSITIONAL CARE & REHABILITATION-LAWTON SAN FRANCISCO, CA 94122 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4)(D (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) K 064 Continued From page 6 K 064 6/14/13 This Plan of Correction is the center's credible At 10:34 a.m., the fire extinguisher outside of the allegation of compliance. dining room was obstructed by walkers that were Preparation and/or execution of this plan of correction stored along the corridor wall. does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions During an interview, Maintenance Staff reported set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because that the walkers were kept in the corridor during it is required by the provisions of federal and state law. the day for easy access during physical therapy treatments