375 Laguna Honda Blvd., San Francisco, CA 94116-1411
Provider ID: 555020
Life Safety Code and Emergency Preparedness Survey
Date of Survey Completed 12/14/2022

Plan of Correction

E 000

This Plan of Correction is the response by Laguna Honda Hospital and Rehabilitation Center ("LHH" or “facility”) as required by regulation, to the Statement of Deficiencies and Plan of Correction (CMS-2567) issued by the California Department of Public Health on December 14, 2022, and received by the facility on December 21, 2022, via email as part of the third revisit survey and Life Safety Code and Emergency Preparedness Survey. The submission of this Plan of Correction does not constitute an admission of the deficiencies listed on the Summary Statement of Deficiencies or an admission to any statements, findings, facts, and conclusions that form the basis of the alleged deficiencies.

Plan of Correction

E 024

483.73(b)(6) Policies/Procedures – Volunteers and Staffing

[(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 every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]

> (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

CDPH concluded that this **REQUIREMENT** is not met based on document review and interview, the facility failed to maintain the emergency preparedness plan. The facility failed to provide a policy for the use of volunteers that included a process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

1. **The facility will update its policy and procedure LHHPP 70-01 B1 Emergency Response Plan under the section *Use of Volunteers* to include a process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.**
   Completion Date:
   January 13, 2023.
   Responsible Person:
   Administrative Director, Operations.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

2. **All LHH staff will receive an in-service on the updated Emergency Response Plan. The Department of Education and Training will monitor staff compliance.**
   Completion Date:
   January 13, 2023.
   Responsible Person:
   Nurse Director, Department of Education and Training.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

3. **The Emergency Preparedness Committee will review the Emergency Response Plan at a minimum annually to ensure all information is in accordance with Appendix Z of the State Operations Manual.**
   Completion Date:
   January 13, 2023.
   Responsible Person:
   Administrative Director, Operations.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #2

The Department of Education and Training will monitor the compliance with the completion of the in-service on the updated Emergency Response Plan. Any staff on leave will be required to complete this education on return and before any patient contact.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.
Completion Date:
January 13, 2023.
Responsible Person:
Nurse Director, Department of Education and Training.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

E 030

483.73(c)(1) Names and Contact Information

(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:]

(1) Names and contact information for the following:

(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians
(iv) Other [facilities].
(v) Volunteers.

CDPH concluded that this **REQUIREMENT** is not met based on document review and interview, the facility failed to maintain the emergency preparedness plan. This was evidenced by incomplete name and contact information. The facility's communication plan failed to include contact information for entities providing services under contract.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

4. **The facility will update its policy and procedure LHHPP 70-01 B1 Emergency Response Plan under the section *Communication Plan* to include contact information of entities providing services under contract.**

   Completion Date:

   January 13, 2023.

   Responsible Person:

   Administrative Director, Operations.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

5. **All LHH staff will receive an in-service on the updated Emergency Response Plan. The Department of Education and Training will monitor staff compliance.**

   Completion Date:

   January 13, 2023.

   Responsible Person:

   Nurse Director, Department of Education and Training.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

6. **The Emergency Preparedness Committee will review the Emergency Response Plan at a minimum annually to ensure all information is in accordance with Appendix Z of the State Operations Manual.**
   Completion Date:
   January 13, 2023.
   Responsible Person:
   Administrative Director, Operations.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #5

The Department of Education and Training will monitor the compliance with the completion of the in-service on the updated Emergency Response Plan. Any staff on leave will be required to complete this education on return and before any patient contact.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.
Completion Date:
January 13, 2023.
Responsible Person:
Nurse Director, Department of Education and Training.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

E 031
483.73(c)(2) Emergency Officials Contact Information

(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:

(2) Contact information for the following:
- (i) Federal, State, tribal, regional, and local emergency preparedness staff.
- (ii) The State Licensing and Certification Agency.
- (iii) The Office of the State Long-Term Care Ombudsman.
- (iv) Other sources of assistance.

CDPH concluded that this **REQUIREMENT** is not met based on document review and interview, the facility failed to maintain the emergency preparedness plan. This was evidenced by the failure to include contact information for emergency officials. The emergency preparedness plan failed to include contact information for the State Long-Term Care Ombudsman.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

7. **The facility will update its policy and procedure LHHPP 70-01 B1 Emergency Response Plan under the section *Emergency Contact List* to include contact information for the State Long-Term Care Ombudsman.**
   Completion Date:
   January 13, 2023.
   Responsible Person:
   Administrative Director, Operations.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

8. **All LHH staff will receive an in-service on the updated Emergency Response Plan. The Department of Education and Training will monitor staff compliance.**
   Completion Date:
   January 13, 2023.
   Responsible Person:
   Nurse Director, Department of Education and Training.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

9. **The Emergency Preparedness Committee will review the Emergency Response Plan at a minimum annually to ensure all information is in accordance with Appendix Z of the State Operations Manual.**

   Completion Date:

   January 13, 2023.

   Responsible Person:

   Administrative Director, Operations.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #8

The Department of Education and Training will monitor the compliance with the completion of the in-service on the updated Emergency Response Plan. Any staff on leave will be required to complete this education on return and before any patient contact.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Nurse Director, Department of Education and Training.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 000

This Plan of Correction is the response by Laguna Honda Hospital and Rehabilitation Center ("LHH" or “facility”) as required by regulation, to the Statement of Deficiencies and Plan of Correction (CMS-2567) issued by the California Department of Public Health on December 14, 2022, and received by the facility on December 21, 2022, via email as part of the third revisit survey and Life Safety Code and Emergency Preparedness Survey. The submission of this Plan of Correction does not constitute an admission of the deficiencies listed on the Summary Statement of Deficiencies or an admission to any statements, findings, facts, and conclusions that form the basis of the alleged deficiencies.

Plan of Correction

K 163
NFPA 101 Interior Nonbearing Wall Construction

Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 19.1.6.4, 19.1.6.5

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the building construction. This was evidenced by an unsealed penetration in the wall. This affected one of three buildings and could result in the spread of fire and smoke in the event of a fire.

1. Approximately 4-inch diameter penetration located underneath a sink in the Staff Restroom, adjacent to Room PM061 located on the Mezzanine floor.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

10. **Facility Services will repair the approximately 4-inch diameter penetration located underneath a sink in the Staff Restroom, adjacent to Room PM061 located on the Mezzanine floor (Work Order #174456).**
    Completion Date:
    January 6, 2023.
    Responsible Person:
    Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

11. **A communication will be sent to a LHH staff via the Daily Situation Status (DSS) for work orders to be submitted for any wall penetration repairs.**
    Completion Date:
    January 6, 2023.
    Responsible Person:
    Director of Facility Services.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

12. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**

    Responsible Person:

    Administrative Director, Operations.

    Completion Date:

    January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #12

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 211
NFPA 101 Means of Egress - General

Means of Egress – General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the means of egress. This was evidenced by unattended carts in the corridors and obstructed egress. This affected one of three buildings and could result in delayed evacuation in the event of an emergency.

1. A metal food cart was observed in the 8 feet corridor next to Resident Room N644. The food cart was obstructing the width of egress down to approximately 30 inches.
2. An unattended janitorial cart and a soiled linen cart were observed against the corridor wall between Resident Rooms N546 and N544.
3. A food cart was observed along the East corridor wall and a soiled linen cart was observed along the West corridor wall near Resident Room NM44. The width of the corridor was 8 feet. The carts were obstructing the width of egress down to approximately 40 inches.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

13. **The metal food cart observed in the 8 feet corridor next to Resident Room N644 was immediately removed.**
14. **The unattended janitorial cart and soiled linen cart observed against the corridor wall between Resident Rooms N546 and N544 was immediately removed.**
15. **The food cart observed along the East corridor wall and a soiled linen cart observed along the West corridor wall near Resident Room NM44 was immediately removed.**

    Completion Date:

    December 14, 2022.

    Responsible Person:

    Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

16. **LHH staff will receive education on appropriate locations for storing carts in resident care areas via the DSS and Town Hall.**

    Completion Date:

    January 13, 2023.

    Responsible Person:

    Acting Director of Fire Life Safety.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

17. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**

    Responsible Person:

    Administrative Director, Operations.

    Completion Date:

    January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #17

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 281
NFPA 101 Illumination of Means of Egress

Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the illuminated means of egress. This was evidenced by a light fixture that was not illuminated. This affected one stair tower located in the North Tower. This could result in decreased visibility in the event of an evacuation.

1. The light fixture on the fourth-floor landing of stairwell N2 in the North tower was not illuminated.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

18. **The light fixture on the fourth-floor landing of stairwell N2 in the North tower was repaired.**
    Completion Date:
    December 16, 2022.
    Responsible Person:
    Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

19. **The Environment of Care (EOC) checklist will be updated to reflect illumination means of egress.**
    Completion Date:
    January 6, 2023.
    Responsible Person:
    Administrative Director, Operations.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

20. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**
    Responsible Person:
    Administrative Director, Operations.
    Completion Date:
    January 13, 2023.

Plan of Correction

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #19 & #20

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 321
NFPA 101 Hazardous Areas - Enclosure

Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the hazardous area enclosures. This was evidenced by a door not equipped with a self-closing device within the hazardous area enclosure. This affected one of three buildings and could result in the spread of smoke and fire.

1. The door to the storage room P2236 in the kitchen was observed missing a self-closing device. The room was approximately 88 square feet and contained cases of printer paper.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

21. A self-closing device was installed on the door to the storage room P2236 in the kitchen.

Completion Date:

December 20, 2022.

Responsible Person:

Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

22. The Environment of Care (EOC) checklist will be updated to reflect self-closing device within the hazardous area enclosure.

Completion Date:

January 6, 2023.

Responsible Person:

Administrative Director, Operations.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

23. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**

    Responsible Person:

    Administrative Director, Operations.

    Completion Date:

    January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #22 & #23

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 324
NFPA 101 Cooking Facilities

Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:

- residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2
- cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3,
  or
- cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.

Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the cooking equipment. This was evidenced by the failure to maintain the discharge nozzle caps for the ANSUL system. This affected the Main Kitchen in one of three buildings. This could result in grease build up in the ANSUL discharge nozzle, which could cause the fire suppression system to malfunction in the event of an emergency.

1. The kitchen hood ANSUL suppression system over the cook top and deep fryer were observed. Two of 11 blow-off caps were not attached to the suppression nozzles.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

24. **The two blow-off caps were replaced and attached to the suppression nozzles on the kitchen hood ANSUL suppression system.**
    Completion Date:
    December 13, 2022.
    Responsible Person:
    Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

25. **Food and Nutrition staff will be trained on checking the blow-off caps are attached to the suppression nozzles after cleaning. If replacements are required, staff will be trained to complete a work order for Facility Services to address the need.**
    Completion Date:
    December 31, 2022.
    Responsible Person:
    Director of Food and Nutrition Services.

Plan of Correction

26. **The Food and Nutrition Services staff will update their daily rounding checklist to include the ANSUL suppression system and blow-off caps.**
    Completion Date:
    January 6, 2023.
    Responsible Person:
    Director of Food and Nutrition Services.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

27. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**
    Responsible Person:
    Administrative Director, Operations.
    Completion Date:
    January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #26 & #27

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.
Completion Date:
January 13, 2023.
Responsible Person:
Administrative Director, Operations.

Plan of Correction

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 344
NFPA 101 Fire Alarm - Control Functions

The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the fire alarm system. This was evidenced by trouble conditions on the fire alarm control panels (FACP). This affected three of three buildings and could result in a delay in emergency forces notification, in the event of a fire.

1. The main FACP located on the first floor of the South Tower was observed in trouble mode. The supervisory and trouble indicator lights were illuminated, and the screen displayed a fault with the beam smoke detector near the Therapy Pool in the Pavilion on the ground level. Upon interview, ES1, ES2, and ES3 stated that the beam type smoke detector near the Therapy Pool had been malfunctioning for approximately a week.
2. The main FACP located on the first floor of the South Tower was observed in trouble mode. The supervisory and trouble indicator lights were illuminated, and the screen displayed a supervisory fault with the existing hospital MXL panel. The existing hospital and the new hospital were separated by a three-hour fire separation construction. Upon interview, ES1, ES2, and ES3 stated that the new hospital building, and the old hospital building have separate FACPs but both panels communicate with each other. The fault displayed on the screen was from the existing hospital FACP due to smoke detectors in Wards M and O wings that had been taken offline for about five or six months. The smoke detectors were taken offline due to a roof leak that caused a trouble code which was transmitted to the new hospital FACP. ES1, ES2, and ES3 further explained that Wards M and O wings were not occupied and there were smoke detectors approximately every six feet along the ceiling.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

28. **The beam type smoke detector near the Therapy Pool was repaired.**
    Completion Date:
    December 9, 2022.
    Responsible Person:
    Director of Facility Services.

29. **The main FACP located on the first floor of the South Tower was fixed to clear the trouble mode.**
    Completion Date:
    December 9, 2022.
    Responsible Person:
    Director of Facility Services.

Plan of Correction

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

30. **The Watch Engineer will round once per shift per day to review the fire alarm panels and ensure proper functionality.**
    Completion Date:
    January 6, 2023.
    Responsible Person:
    Director of Facility Services.

31. **The beam type smoke detector near the Therapy Pool was added to the annual fire alarm device report and will be tested annually.**
    Completion Date:
    December 9, 2022.
    Responsible Person:
    Director of Facility Services.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

32. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**
    Responsible Person:
    Administrative Director, Operations.
    Completion Date:
    January 13, 2023.

Plan of Correction

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #30 & #31

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 345
NFPA 101 Fire Alarm System - Testing and Maintenance

A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the fire alarm system (FAS).

This was evidenced by the failure to provide documentation for replacement of the failed FAS batteries and incomplete inspection and test of the FAS. This could lead to a malfunction of the fire alarm system in the event of an emergency, and affected the South Tower and Pavilion Building.

1. The annual inspection and testing report provided dated 5/13/22, did not indicate if the beam detector located in the Therapy Pool area in the Pavilion Building was tested. The record titled, "Summary of Findings" indicated "Did not test beam detector because it is tied to the heat detector adjacent and we were not aware it was a separate address. Found it was separated when we replaced the failed reset relay". When interviewed, the ES2 confirmed the finding and stated that the beam detector was not tested during the annual inspection and testing.
2. The FAS batteries on the 4th floor of the South Tower had failed the discharge test. The record titled, "Annual Battery Charger Test" dated 12/17/21 was reviewed. The record indicated "Battery 1" "AMP HRS AFTER" "1.96 in the South Tower, 4th Floor Panel, in Room "Telecom S4046" "Device B PS 9", "Battery 1", "AMP HRS AFTER" "3.04" in the South Tower, 4th Floor Panel in the "Electrical S4023" "Device BPS 8".

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

33. A discharge test of the FAS batteries on the on the 4th floor of the South Tower was completed.
Completion Date:
December 28, 2022.
Responsible Person:
Director of Facility Services.

34. The beam smoke detector located in the Therapy Pool area in the Pavilion Building was tested.
Completion Date:
December 9, 2022.
Responsible Person:
Director of Facility Services.

Plan of Correction

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

35. **The fire alarm vendor will modify the report to include a 30-minute discharge test with start-end time and voltage drop.**
    Completion Date:
    December 28, 2022.
    Responsible Person:
    Director of Facility Services.

36. **The beam smoke detector near the Therapy Pool was added to the annual fire alarm device report and will be tested annually.**
    Completion Date:
    December 9, 2022.
    Responsible Person:
    Director of Facility Services.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

37. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**
    Responsible Person:
    Administrative Director, Operations.
    Completion Date:
    January 13, 2023.

Plan of Correction

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring for item #37

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 353
NFPA 101 Sprinkler System - Maintenance and Testing

Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the fire sprinklers. This was evidenced by foreign materials on the sprinklers and an obstructed sprinkler. This could result in the malfunction of the sprinklers in the event of a fire and affected two of three buildings.

1. A balloon was observed approximately 10 inches away from a sprinkler on the ceiling of Resident Room N243 at Bed B.
2. An upright sprinkler head was observed with paint on the sensing bulb in storage room NM017.
3. A foreign material was observed on the sensing bulb of freezer 3 in the Kitchen.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

38. **The balloon observed approximately 10 inches away from a sprinkler on the ceiling of Resident Room N243 at Bed B was removed.**
    Completion Date:
    December 14, 2022.
    Responsible Person:
    Director of Facility Services.

39. **The paint on the sensing bulb of an upright sprinkler head in storage room NM017 was determined to not be paint, but a particle which was cleaned.**
    Completion Date:
    December 14, 2022.
    Responsible Person:
    Director of Facility Services.

40. **The foreign material observed on the sensing bulb of freezer 3 in the Kitchen was cleaned.**
    Completion Date:
    December 14, 2022.
    Responsible Person:
    Director of Facility Services.

Plan of Correction

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

41. **All sprinkler heads will be checked within the facility to ensure there are no obstructions.**
    Completion Date:
    January 6, 2023.
    Responsible Person:
    Director of Facility Services.

42. **The Environment of Care (EOC) checklist will be updated to reflect inspection of sprinkler heads for obstructions.**
    Completion Date:
    January 6, 2023.
    Responsible Person:
    Administrative Director, Operations.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

43. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**
    Responsible Person:
    Administrative Director, Operations.
    Completion Date:
    January 13, 2023.

Plan of Correction

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #41, #42, & #43

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 355
NFPA 101 Portable Fire Extinguishers

Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by a fire extinguisher that was not inspected at a minimum of 30-day intervals. This could result in a delayed notification of malfunctioning portable fire extinguisher and affected one of three buildings.

1. The fire extinguisher in the Main Electrical Room located on the Ground floor was observed. The annual service was conducted on 5/16/22. The tag attached to the extinguisher failed to indicate monthly inspections were completed in June and July of 2022.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

44. The fire extinguisher in the Main Electrical Room located on the Ground floor was replaced.
Completion Date:
December 9, 2022.
Responsible Person:
Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

45. Monthly visual inspections of all fire extinguishers will be conducted by Facility Services. The Safety Engineer is responsible for monitoring completion of inspections and any needed repair work.
Completion Date:
January 6, 2023.
Responsible Person:
Director of Facility Services.

46. The Environment of Care (EOC) checklist will be updated to reflect the spare fire extinguisher inventory list for monthly inspection.
Completion Date:
January 6, 2023.
Responsible Person:
Administrative Director, Operations.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

47. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**

    Responsible Person:

    Administrative Director, Operations.

    Completion Date:

    January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #45, #46, & #47

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 363
NFPA 101 Corridor - Doors

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the corridor doors. This was\ evidenced by doors that did not latch and were obstructed from closing. This affected two of three buildings and could result in the spread of fire or smoke in the event of a fire.

1. A wet floor sign was observed obstructing the corridor door to Resident Room N347.
2. A wet floor sign was observed obstructing the corridor door to Resident Room N141.
3. A wet floor sign was obstructing the corridor door to Resident Room NM34.
4. The corridor door to the Telecom Room (S3046) on the Third Floor was equipped with a self-closing device. The door failed to latch when allowed to self-close. Upon interview, ES2 confirmed the finding and stated that air pressure in the room prevented the door from latching.
5. The corridor door to the Conference Room (S3066) on the Third Floor was equipped with a self-closing device. The door failed to latch when allowed to self-close. Upon interview, ES2 confirmed the finding and stated the self-closure device needed adjusting.

Plan of Correction

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

48. **The wet floor sign observed obstructing the corridor door to Resident Room N347 was removed.**
49. **The wet floor sign observed obstructing the corridor door to Resident Room N141 was removed.**
50. **The wet floor sign obstructing the corridor door to Resident Room NM34 was removed.**
51. **The corridor door to the Telecom Room (S3046) on the Third Floor was repaired to latch when allowed to self-close.**
52. **The corridor door to the Conference Room (S3066) on the Third Floor was repaired to latch when allowed to self-close.**

Completion Date:

December 14, 2022.

Responsible Person:

Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

53. **Facility Services confirmed all corridor doors are able to latch when allowed to self-close and no doors remain propped open.**

Completion Date:

December 14, 2022.

Responsible Person:

Director of Facility Services.

54. **LHH staff will receive education on the facility expectation that doors may not be propped open and the method to complete a Work Order for doors that do not latch when allowed to self-close via the DSS and Town Hall.**

Completion Date:

January 13, 2023.

Responsible Person:

Acting Director of Fire Life Safety.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

55. **Facility Services staff will conduct semi-annual inspections of all self-closing and manually closing doors as part of the EOC rounds to ensure proper closing and latching. The Chief Engineer and Maintenance Supervisor are responsible for monitoring compliance with the completion of any generated work orders.**

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations

Plan of Correction

56. The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.

Responsible Person:

Administrative Director, Operations.

Completion Date:

January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #55 & #56

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 374
NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors

Doors in smoke barriers are 1-3/4-inch-thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the smoke barrier doors. This was evidenced by doors that were obstructed from closing. This affected one of three buildings. This could result in the spread of smoke or fire, in the event of a fire.

1. On the Mezzanine Floor, the double door to Room PM011 was observed. The right leaf door remained completely wide open.
2. The 45-minute fire rated cross corridor doors near the Clinic area in the Pavilion Building was observed. The left leaf failed to fully close upon activation of the fire alarm system. There was an approximately a three-inch gap.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

57. The double door to Room PM011 was inspected and repaired.
Completion Date:
December 29, 2022.
Responsible Person:
Director of Facility Services.

58. The 45-minute fire rated cross corridor doors near the Clinic area in the Pavilion Building was inspected and repaired.
Completion Date:
December 29, 2022.
Responsible Person:
Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

59. Facility Services will check all smoke barrier doors to ensure there are no obstructions from closing.
Completion Date:
January 13, 2023.
Responsible Person:
Acting Director of Fire Life Safety.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

60. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**

    Responsible Person:

    Administrative Director, Operations.

    Completion Date:

    January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #61

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 511
NFPA 101 Utilities - Gas and Electric

Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by receptacle outlets that were damaged and missing faceplates. This could result in an increased risk of an electrical fire and or electrical shock. This affected two of three buildings.

1. There was a cracked cover plate in Room S525 behind Bed B located on the Fifth Floor.
2. An electrical outlet at the head of bed C in Resident Room N434 was observed with a broken cover plate.
3. A broken data plate cover was observed at the head of Bed B in Resident Room N411.
4. An electrical switch next to the laundry chute in the Laundry Room on the Mezzanine level of the North Tower was observed missing a cover plate.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

61. **The cracked cover plate in Room S525 behind Bed B located on the Fifth Floor will be replaced.**
62. **The broken cover place in Resident Room N434 will be replaced.**
63. **The broken data plate cover at the head of Bed B in Resident Room N411 will be replaced.**
64. **The cover plate for the electrical switch next to the laundry chute in the Laundry Room on the Mezzanine level of the North Tower will be replaced.**

    Completion Date:

    January 6, 2023.

    Responsible Person:

    Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

65. **LHH staff will receive education to complete a Work Order for electrical faceplates that are found to be missing and/or broken via the DSS and Town Hall.**

    Completion Date:

    January 13, 2023.

    Responsible Person:

    Acting Director of Fire Life Safety.

Plan of Correction

66. **The Environment of Care (EOC) checklist will be updated to reflect electrical equipment – electrical faceplates.**
    Completion Date:
    January 6, 2023.
    Responsible Person:
    Administrative Director, Operations.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

67. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**
    Responsible Person:
    Administrative Director, Operations.
    Completion Date:
    January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #66 & #67

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.
Completion Date:
January 13, 2023.
Responsible Person:
Administrative Director, Operations.

Plan of Correction

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 521
NFPA 101 HVAC

Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the integrity of the heating, ventilation, and air-conditioning (HVAC) system. This was evidenced by the failure to provide a current fire damper report and by missing an access panel door for the fire dampers in an air duct. This affected three of three buildings and could result in the spread of smoke in the event of a fire.

1. The smoke barrier walls were observed in the elevator lobby on the first floor of the North Tower. An HVAC duct above the drop ceiling near Elevator 1 was observed missing an access door near the damper, creating an approximately four inch by eight-inch penetration in the air duct.
2. There was no current maintenance and testing record for fire dampers upon request. The previous maintenance and testing record of fire dampers provided for review was dated 9/17/18.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

68. The access door near the damper in the elevator lobby on the first floor of the North Tower was replaced.
Completion Date:
December 14, 2022.
Responsible Person:
Director of Facility Services.

69. The maintenance and testing of the fire dampers began in November 2022. The duration of the inspection is expected to take three to four months. The facility will submit a time-limited waiver due to the completion date being after the 30th day post survey.
Completion Date:
February 28, 2023.
Responsible Person:
Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

70. Facility Services will ensure all damper covers are present and intact.
Completion Date:
January 13, 2023.
Responsible Person:
Director of Facility Services.

Plan of Correction

71. **The maintenance and testing inspection of the fire dampers will be scheduled proactively to release a Work Order prior to the due date. This will allow the team sufficient time for scheduling and completion of the inspection within in required four-year window of inspection.**
    Completion Date:
    January 13, 2023.
    Responsible Person:
    Acting Director of Fire Life Safety.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

72. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**
    Responsible Person:
    Administrative Director, Operations.
    Completion Date:
    January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #72

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.
Completion Date:
January 13, 2023.
Responsible Person:
Administrative Director, Operations.

Plan of Correction

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 531
NFPA 101 Elevators

Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)

CDPH concluded that this Statute is not met as evidenced by:

The facility failed to maintain the elevators. This was evidenced by an elevator that was not in service. This could result in a delay in egress, and affected two of four floors in the Pavilion Building.

1. The monthly maintenance log for the elevators were reviewed. There was one of ten elevators that was out of order. The maintenance log dated 10/12/22 and 11/13/22 indicated the elevator in the "Pavilion near the Pharmacy 1st Floor (primary landing) to 2nd floor (secondary landing)" was out of order. When interviewed, ES1 confirmed and stated that the circuit board for the door closing mechanism was damaged. ES1 further stated that the elevator was a service elevator.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

73. The service elevator was repaired and is operable.
Completion Date:
December 17, 2022.
Responsible Person:
Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

74. Facility Services shall check all ten elevators to ensure they are operating appropriately.
Completion Date:
January 13, 2023.
Responsible Person:
Director of Facility Services.

75. The Watch Engineer will round once per shift per day to check all ten elevators and ensure proper functionality.
Completion Date:
January 6, 2023.
Responsible Person:
Director of Facility Services.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

76. The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.

Responsible Person:

Administrative Director, Operations.

Completion Date:

January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #75 & #76

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 711
NFPA 101 Evacuation and Relocation Plan

There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.

CDPH concluded that this Statute is not met as evidenced by:

The facility failed to ensure that all staff members were familiar with the emergency plan procedures. This was evidenced by staff members that were not familiar with the facility's Fire Safety procedures. This affected two of three buildings and could result in failure to protect residents in the event of an emergency.

1. A staff member on the Sixth Floor was interviewed on what action to take in the event of fire. The staff member stated that she would follow R.A.C.E. When staff was asked what R.A.C.E. stand for, staff was not able to state "Rescue, Alarm, Contain, Extinguish/Evacuate" (R.A.C.E.). The same staff also failed to identify where the closest manual pull station was located.
2. On the Second Floor, a kitchen staff was asked how she would respond to a grease fire on the stove. The staff stated that she would use the K extinguisher and walked over to the location. The Kitchen staff failed to identify the pull device for the kitchen hood fire-extinguishing system.
3. A nursing staff was interviewed on what actions to take in the event of a fire. The nursing staff failed to recite R.A.C.E. The staff was given a chance to use their attached badge but she failed to locate R.A.C.E. on her badge.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

77. **Food and Nutrition Services staff will receive education on the process to respond to a grease fire on the stove.**
    Completion Date:
    January 6, 2023.
    Responsible Person:
    Acting Director of Fire Life Safety.

78. **Nursing staff will receive education on LHH Fire Safety procedures and the R.A.C.E. acronym. Staff will be reminded where the information can be accessed on their "badge buddy" which is to be worn at all times.**
    Completion Date:
    January 6, 2023.
    Responsible Person:
    Acting Director of Fire Life Safety.

Plan of Correction

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

79. **Facility Services will initiate staff training on the R.A.C.E. acronym through teach back methodology while simulating fire drills through the facility.**
    Completion Date:
    January 13, 2023.
    Responsible Person:
    Acting Director of Fire Life Safety.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

80. **All staff will receive an in-service through an electronic learning module (ELM) on Disaster Preparedness, which will include LHH Fire Safety procedures.**
    Completion Date:
    January 13, 2023.
    Responsible Person:
    Nurse Director, Department of Education and Training.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #80

The Department of Education and Training will monitor the compliance with the completion of the in-service on the updated Emergency Response Plan. Any staff on leave will be required to complete this education on return and before any patient contact.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.
Completion Date:
January 13, 2023.
Responsible Person:
Nurse Director, Department of Education and Training.

Plan of Correction

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 741
NFPA 101 Smoking Regulations

Smoking regulations shall be adopted and shall include not less than the following provisions:

1. Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
2. In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language
3. Smoking by patients classified as not responsible shall be prohibited.
4. The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.
5. Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.
6. Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the designated smoking areas. This was evidenced by combustible items in the safety-type smoke poles. This could result in the increased risk of fire and affected the designated smoking area.

1. The designated smoking area near the lobby in the Pavilion building was observed. There was combustible garbage mixed with cigarette butts in the catch bucket of a safety-type smoke pole.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

81. The combustible garbage in the catch bucket in the designated smoking area was removed.
82. The cover was replaced on the safety-type smoke pole.

Completion Date:
December 14, 2022.
Responsible Person:
Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

83. A secure top will be added to the safety-type smoke pole as an additional safety precaution.

Completion Date:
January 13, 2023.
Responsible Person:
Director of Facility Services.

Plan of Correction

84. **An Environment of Care (EOC) checklist will be created for the designate smoking area for staff to conduct a daily inspection of the area.**
    Completion Date:
    January 13, 2023.
    Responsible Person:
    Administrative Director, Operations.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

85. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**
    Responsible Person:
    Administrative Director, Operations.
    Completion Date:
    January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #84 & #85

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.
Completion Date:
January 13, 2023.
Responsible Person:
Administrative Director, Operations.

Plan of Correction

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 781
NFPA 101 Portable Space Heaters

Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius).

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the portable space heaters. This was evidenced by a space heater plugged into a power strip. This affected one of three buildings and could result in causing a fire.

1. A portable space heater was observed plugged into a power strip at the reception desk in the lobby on the ground floor of the Pavilion. According to the manufacturer's instructions, it indicated "Always plug heaters directly into a wall outlet/receptacle. Never use with an extension cord or relocatable power tap (outlet/power strip)."

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

86. The power strip at the reception desk in the lobby on the ground floor of the Pavilion was removed. The portable space heater is plugged directly into the wall outlet.

Completion Date:

December 13, 2022.

Responsible Person:

Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

87. LHH staff will receive education on the facility expectation and policy regarding power strips, electrical outlets, and portable heaters via the DSS and Town Hall.

Completion Date:

January 13, 2023.

Responsible Person:

Acting Director of Fire Life Safety.

88. The Environment of Care (EOC) checklist will be updated to reflect all appliances to be plugged directly into wall outlets.

Completion Date:

January 6, 2023.

Responsible Person:

Administrative Director, Operations.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

89. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**

Responsible Person:

Administrative Director, Operations.

Completion Date:

January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #88 & #89

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 909
NFPA 101 Gas and Vacuum Piped Systems - Information and Warning Signs

Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency.

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the central supply system location. This was evidenced by the failure to have a precautionary labeling or marking identifying the gas piping system. This affected the bulk cryogenic liquid storage location and could result in the increased risk of a hazardous condition.

1. The bulk cryogenic liquid storage located in back of the Pavilion building was observed. The piping system had two green oxygen labels that were weathered, damaged, and were not legible. When interviewed, ES3 confirmed the finding and stated that the two damaged labels on the piping system were for the main tank.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

90. The two green oxygen labels on the piping system were replaced.

Completion Date:

December 19, 2022.

Responsible Person:

Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

91. The Environment of Care (EOC) checklist will be updated to reflect green oxygen labels.

Completion Date:

January 6, 2023.

Responsible Person:

Administrative Director, Operations.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

92. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**

    Responsible Person:

    Administrative Director, Operations.

    Completion Date:

    January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #92

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 918
NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing

The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.

Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20–40-day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions includes a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the emergency power supply (EPS). This was evidenced by the failure to exercise the diesel-powered generator once every 36 months for 4 continuous hours. This affected three of three buildings. This could result in the ineffective operation of the generator in the event of an emergency.

1. The facility failed to provide records for two of two diesel powered generators to be exercised once every 36 months for 4 continuous hours. The previous 4-hour load bank test was conducted on 4/10/19. When interviewed, ES1 stated that the vendor was scheduled to conduct the 4-hour load test on 12/13/22.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

93. The 4-hour load bank test was conducted on two of two diesel powered generators.

Completion Date:

December 14, 2022.

Responsible Person:

Director of Facility Services.

Plan of Correction

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

94. **The 4-hour load bank test will be scheduled proactively to release a Work Order 6-months prior to the due date. This will allow the team sufficient time for scheduling and completion of the inspection within in required three-year window of inspection.**

    Completion Date:

    January 13, 2023.

    Responsible Person:

    Acting Director of Fire Life Safety.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

95. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**

    Responsible Person:

    Administrative Director, Operations.

    Completion Date:

    January 13, 2023.

Plan of Correction

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #95

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 919
NFPA 101 Electrical Equipment – Other

List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99)

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by obstructions to electrical panels. This affected one of three buildings and could result in delayed access to the electrical panel in the event of an emergency.

1. An electrical disconnect panel labeled FCU-E1 for the exhaust fan located in the Laundry Room on the Mezzanine level of the North Tower was observed obstructed by chairs and plastic laundry bins that were stored directly in front of the panel.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

96. The chairs and plastic laundry bins that were stored directly in front of the electrical panel in the Laundry Room on the Mezzanine level of the North Tower were removed.

Completion Date:

December 14, 2022.

Responsible Person:

Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

97. The visual markers have been added to the laundry rooms for LHH staff to be aware of the area which needs to remain clear of any obstructions.

Completion Date:

December 14, 2022.

Responsible Person:

Acting Director of Environmental Services.

98. LHH staff will receive education on appropriate locations for storing items and the importance of not obstructing electrical panels via the DSS and Town Hall.

Completion Date:

January 13, 2023.

Responsible Person:

Acting Director of Fire Life Safety.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

99. **The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.**

    Responsible Person:

    Administrative Director, Operations.

    Completion Date:

    January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #99

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.

Plan of Correction

K 920
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 (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.

CDPH concluded that this **REQUIREMENT** is not met based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by daisy chained power strips. This affected three of three buildings and could result in causing a fire.

1. A black power strip was observed plugged into a black power strip in File Room N3064. Both power strips were powering computer, phone and charging equipment.
2. A black power strip was observed plugged into a black power strip in the File Room NM3064. Both power strips were powering computer, phone and charging equipment.
3. The electrical wiring in Room S522 on the fifth floor was observed. There was a phone charger plugged into an extension cord that was plugged into a power strip by Bed A.
4. The electrical wiring in Room PM65 in the Mezzanine was observed. There was a white extension plugged to a wall outlet behind Bed A.
5. A black power strip was observed plugged into a white power strip at Nurse's Desk 04 (designated by the last two digits of the phone number for that desk) in the Nurse's Office on the first floor of the Pavilion. The black Power strip was powering a television, an electric stapler and phone chargers.
6. A white power strip was observed plugged into a black power strip at Nurse's Desk 05 (designated by the last two digits of the phone number for that desk) in the Nurse's Office on the first floor of the Pavilion. The black Power strip was powering phone chargers.

Plan of Correction

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Corrective Action:

100. The black power strip was plugged into a black power strip in File Room N3064 will be removed.

101. The black power strip observed plugged into a black power strip in the File Room NM3064 will be removed.

102. The phone charger plugged into an extension cord that was plugged into a power strip in Room S522 by Bed A will be removed.

103. The white extension plugged to a wall outlet in Room PM65 behind Bed A will be removed.

104. The black power strip observed plugged into a white power strip in the Nurse's Office on the first floor of the Pavilion will be removed.

105. The white power strip observed plugged into a black power strip at in the Nurse's Office on the first floor of the Pavilion will be removed.

Completion Date:

January 6, 2023.

Responsible Person:

Director of Facility Services.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Corrective Action:

106. LHH staff will receive education on the facility expectation and policy regarding power strips, electrical outlets, and daisy chains via the DSS and Town Hall.

Completion Date:

January 13, 2023.

Responsible Person:

Acting Director of Fire Life Safety.

107. The Environment of Care (EOC) checklist will be updated to reflect removal of all daisy chains throughout the facility.

Completion Date:

January 6, 2023.

Responsible Person:

Administrative Director, Operations.

Plan of Correction

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?

Corrective Action:

108. The LHH Environment of Care (EOC) Committee shall conduct scheduled monthly EOC rounds throughout LHH to identify potential risks and test EOC-related staff knowledge and skills. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the environment of care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care.

Responsible Person:

Administrative Director, Operations.

Completion Date:

January 13, 2023.

QAPI: 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. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Monitoring and reporting described below will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee. Overall compliance with all elements of the plan of correction shall be reported to Nursing Quality Improvement Committee (NQIC), Performance Improvement and Patient Safety Committee (PIPS), and the Medical Executive Committee (MEC), these committees shall report overall compliance to the Joint Conference Committee (JCC), the Governing Body as part of the Hospital QAPI Program.

Monitoring for item #107 & #108

Compliance shall be reported monthly to the EOC Committee, quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to the JCC until three consecutive months of 95% compliance or greater has been achieved.

Although the facility aims for 100% compliance, this will continue until the facility threshold of substantial compliance (95%) is achieved for three consecutive months. Data will be aggregated and reported by the designated staff person to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Completion Date:

January 13, 2023.

Responsible Person:

Administrative Director, Operations.

Monitoring for all corrective actions

To ensure the sustained and overall safety and security of the hospital any or all monitoring may be continued past the specified dates/timeframes based upon compliance rates. Monitoring and reporting will continue until all elements meet the goals of compliance. Ongoing issues regarding compliance will be addressed annually as part of the QAPI plan at the PIPS committee.