Laguna Honda Hospital & Rehabilitation Center (LHH)

Root Cause Analysis Findings and Recommendations

Health Services Advisory Group, Inc. (HSAG)

December 1, 2022

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Introduction

In October 2022, Laguna Honda Hospital and Rehabilitation Center (LHH) contracted with Health Services Advisory Group, Inc. (HSAG) to serve as the Quality Improvement Expert (QIE) in response to its Settlement and Systems Improvement Agreement with the Centers for Medicare & Medicaid Services (CMS). As the QIE, HSAG was charged to perform a root cause analysis (RCA) to determine the factors that resulted in LHH's decertification from the Medicare Program and to identify areas that must be addressed to ensure long-term substantial compliance and sustainability in future Federal participation.

For the RCA, the QIE identified and defined problems, investigated and collected supporting information specific to 21 survey citations, and analyzed and identified the root cause of each identified problem. The RCA specifically addressed deficiencies identified during surveys between October 14, 2021, and April 13, 2022, and all deficiencies that were discovered and disclosed to LHH by the California Department of Public Health (CDPH), CMS, or a contract surveyor after those surveys. The review also examined processes that need to be improved for LHH to obtain certification to the Medicare Program and substantial and sustained compliance.

Report Structure

The report is organized by the eight foundational root cause categories that represent the systems-level areas needing significant improvement for LHH to sustain long-term compliance. The eight categories are:

1. Quality Assurance & Performance Improvement (QAPI)
2. Infection Prevention and Control
3. Behavioral Health and Substance Abuse
4. Medication Management and Administration
5. Resident Rights and Freedom from Harm
6. Comprehensive Care Plans and Quality of Care
7. Competent Staff, Training, and Quality of Care
8. Emergency Preparedness Program

Each category includes discussion of the following:

- Problem statement that summarizes the overall systems-level problem
- Survey citations reviewed that are associated with each foundational root cause category
- Priority root causes and recommendations
- Analysis and findings

Upon approval from CMS, the recommendations outlined in this RCA report will inform the development of an Action Plan to respond to the RCA findings and implement the recommendations and necessary improvements. The Action Plan will include a detailed list of milestones and completion dates for each corrective action. All elements of the Action Plan will be incorporated into LHH's quality assurance program. This Action Plan will be submitted to CMS no later than January 6, 2023.

1. Quality Assurance and Performance Improvement

Problem Statement

The QAPI Program and Quality Assessment and Assurance (QAA) Committee lack a consistent approach of systematic analysis, action, and proactive program activities, such as performance improvement projects and strongly documented, good-faith effort initiatives. This results in a program that is ineffective in including direct-care staff members in addressing the full range of complex care and services provided by LHH and is unable to signal deficiencies at an early onset.

Survey Citation(s) Reviewed

Developing, implementing, and maintaining an effective, comprehensive, data- driven quality assurance performance improvement program that focuses on indicators of the outcomes of care and quality of life and that is accountable to the governing body in compliance with 42 C.F.R. § 483.75 (F865).

Ensuring that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care in compliance with 42 C.F.R. § 483.24 (F675).

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: QAPI Program not aligned to skilled nursing facility (SNF) setting

The QAPI structure is designed to align with LHH's affiliated acute care hospital within the San Francisco Network and acute care processes, resulting in a QAPI Program that is not tailored toward the SNF setting and does not effectively involve direct-care staff, medical staff, or residents. This increases the risk that performance goals are not met and the necessary care to residents related to SNF regulations is not delivered.

Recommendation: LHH will reorganize its QAPI Program to have subcommittee involvement on all 13 nursing units. It will use a unit- and department-based structure that takes a systematic, interdisciplinary, comprehensive, and data-driven approach to improving and maintaining safety and quality, while involving multi-departmental direct-care staff, medical staff, residents, and families in practical and outcomes-focused problem solving. This puts the resident at the center of the QAPI Program. **(Stronger action)**

Root Cause 2: Lack of strong QAA Committee oversight

The QAA Committee members focus on data reporting compliance rather than analysis, discussion, and follow-up actions to make changes to ensure regulatory compliance. This results in a program that does not proactively identify issues for performance improvement, safety vulnerabilities, or regulatory compliance. For example, the Pharmacy Department monitors and reports the percentage of medications not given without further analysis as to the reasons why the medications were not given.

Recommendation: LHH will follow its most current QAPI plan and restructure the QAA Committee to align with SNF regulations by ensuring:

1. The right participants are included in monthly QAPI meetings;
2. An effective and relevant data dashboard is created and utilized to convey the current status of regulatory compliance and optimal resident outcome to properly inform leadership in the governing body;
3. Committee members are trained and coached regarding data and data analysis;
4. Committee meetings have effective facilitation to drive discussion to connect data findings to immediate actions, such as chartering performance improvement projects (PIPs); and
5. Committee members are trained and coached in order to monitor and support staff and medical staff who are implementing systemic changes into practice. **(Stronger action)**

Root Cause 3: Direct-care staff and medical staff not active in QAPI activities

Direct-care staff and medical staff do not contribute to daily QAPI activities, such as RCAs and PDSA (plan-do-study-act) cycles, due to lack of training on how to raise quality concerns. This results in a culture of silence and indifference, increasing the likelihood that quality concerns are not raised and addressed, which places residents at risk for harm.

Recommendation: LHH will provide scheduled training, using adult learning techniques, such as teach-back, to reinforce QAPI principles to direct-care staff and medical staff. This training will be applied daily through the use of unit-based huddle boards, which will include data relevant to the nursing unit as well as mechanisms for staff to raise concerns. In addition, nurse managers, charge nurses, licensed nurses, and CNAs/PCAs will be trained on huddle facilitation techniques. These staff members will lead and participate in daily huddles using the huddle boards to identify concerns and actively include direct-care staff in RCAs and PDSA cycles to solve issues. To increase unit-based accountability, once training has occurred, supervisors will meet routinely with their middle managers to develop their individual QAPI dashboards, so they can monitor progress and the effectiveness of their interventions and efforts. Leadership rounds will include huddle observations to convey the importance of these meetings to all staff. During these rounds, leadership will reinforce the importance of straightforward and candid feedback from all staff. To address staff concerns regarding retaliation for speaking up, the CEO and CNO will provide their direct phone number to staff for confidential conversations. This will be conveyed through weekly communications via an all-staff email newsletter and during all town hall meetings. On a routine basis, a report of huddle boards and interventions will be reported through the QAA Committee. **(Stronger action)**

Root Cause 4: QAPI policies and procedures not current to Phase 3

LHH's QAPI policies and procedures do not fully align with Phase 3 regulations, including a lack of how specific feedback from residents, resident representatives, and staff will be included in the QAPI process and a lack of implementation of trauma-informed care requirements. This results in a systemwide inability to proactively identify areas of regulatory non-compliance and resident care issues.

Recommendation: LHH will create and implement a plan to ensure all policies are immediately updated to be in compliance with Phase 3 regulations. LHH will then create a monthly review calendar to ensure continuous reviews and updates occur based on changes to the facility assessment or additional regulatory changes. The status of each month's policy and procedure activities will be reported during the QAPI meeting. **(Intermediate action)**

Root Cause 5: Lack of QAPI competencies by middle management and staff

Middle managers and staff members across all LHH departments are not properly trained and coached on the QAPI process, roles, expectations, basic data competency, and how to implement and participate in quality improvement (QI) activities. This results in a systemwide lack of QAPI knowledge, increasing the likelihood that staff are unable to identify and communicate proactive opportunities for improvement or contribute to QAPI activities and a culture of resident-centered care and safety.

Recommendation: LHH will train middle managers and staff on QAPI roles and responsibilities, data collection, QI strategies, such as effectively using PDSA cycles, data analysis, appropriate action statements, and how to incorporate feedback from staff and residents. The training must use scenario-based training to improve knowledge retention. **(Intermediate action)**

Analysis and Findings

Policy and Process Flow

Per Policy 60-01, "It is the policy of LHH to establish and maintain an ongoing, systematic, and proactive organization-wide process to measure, assess, and improve patient care and safety based on the organization's True North and regulatory requirements." The policy further states, "The intent of the QAPI Program is to promote a culture of safety and provide a systematic, coordinated and continuous approach to optimizing clinical outcomes and patient safety."

However, the current set of QAPI policies do not align with the current Phase 3 Federal regulations. For example, the policy does not give a clear indication of how the specific feedback from residents, resident representatives, and staff will be utilized in the QAPI process. The QAPI Program does not identify how it would use the facility assessment in its day-to-day operations. The policies and procedures lack a plan to monitor the effectiveness of all of the performance improvement activities to ensure sustained compliance.

The overall QAPI Program is not directed toward the SNF setting. The current structure of QAA is directed toward the acute care setting to align with LHH's affiliated acute care hospital and processes. The deviation of the intended process occurs at several levels. First, the annual performance goals, developed in collaboration with the governing body, are not met. Second, the QAPI Program is reactive instead of proactive, often having an inability to identify and acknowledge areas of non-compliance to ensure regulations are met. Third, the members of the committee are not functioning in their roles as outlined in the regulation. For example, at a recent QAA meeting, a request was made for additional support to assist with obtaining data. The request for assistance was not acknowledged or addressed.

In addition, the Quality Management (QM) Department and LHH leadership response fails to hold management of emergency codes accountable. Various codes occur, such as Code Green for

elopement and Code Red for fire, but have various levels of response urgency. For example, observations include Code Red for fire alarm system that is not at an audible level throughout the facility or Code Green for elopement being announced multiple times over multiple days without immediate and coordinated response and a delay in escalation to leadership to ensure resident safety.

Staffing & Competencies

Direct-Care Level

The overall lack of knowledge at the direct-care level regarding the QAPI process has contributed to an ineffective program. The QM Department and reporting are kept at a high level with little involvement of the direct-care staff. There has been an established trend where committee members at the meetings provide little to no engagement in the presentation of the data, analytics review of the data, and feedback for robust follow-up actions.

Knowledge of Regulations

The overall lack of knowledge of the regulations and Phase 3 requirements has placed the QAPI Program at a disadvantage to be successful. The failure to stay current with long-term care industry standards has resulted in an ineffective QAPI Program. The QM Department did not proactively delegate the task of implementing Phase 3 into practice or involve relevant departments that would be impacted.

Competency and Qualifications

The four new hires in the QM Department do not have SNF or healthcare quality experience, a common hiring practice throughout LHH. This gap in nursing home knowledge and experience contributes to the staff not being properly qualified or competent. This is also evidenced by the following:

- The lack of data integrity in metrics provided to the QAPI Program and by metrics being reported that do not address deficiencies that were identified by previous surveys;
- The lack of proactive activities related to the regulatory updates, often resulting in the facility being out of compliance with regulations (e.g., restraints, care plans, trauma-informed care, and call light response time);
- An established trend where committee members at the meetings provide little to no engagement in the presentation of the data, analytics review of the data, and feedback for robust follow-up actions; and
- QAA Committee members not being fully trained or coached on their roles and responsibilities during the QAPI meetings involving data reporting and expectations.

The facility recently standardized huddle board communication on all 13 nursing units; however, after two months, staff do not understand the data on the board and how this impacts their work and limits their ability to proactively address issues.

Staffing Level

The QM Department staffing is unstable due to unfilled vacancies, recent resignations, and the decertification status. The QM Department has experienced difficulty in recruiting permanent staff because of the decertification. Registry staff and consultants are being used to augment staffing gaps. However, the registry staff often lack SNF and regulatory knowledge and QM

experience, which contributes to other departments not recognizing QM as a supportive resource to guide QAPI efforts.

Staff Performance

Staff performance (including medical staff) does not meet expectations, as evidenced by a failure to follow the patient safety policy (60-13) and lack of the required meetings and minutes for some subcommittees (e.g., pressure ulcers and nutrition), often resulting in a delay of early detection of condition changes and/or deficient nursing practices (e.g., widespread physical restraint use). Facility staff are not effectively trained on the QAPI process and upcoming changes to the regulations. As a result, middle managers are not adept at implementing effective PDSA cycles to address problems identified at the unit and department level. This results in deficient practices related to QAPI and the responsibility to ensure LHH has developed, implemented, and maintained an effective, comprehensive, data-driven program that focuses on indicators of the outcomes of care and quality of life.

Technology & Data Integrity

Data integrity issues include the following:

- LHH does not have well-defined data definitions for metrics (e.g., assessment upon return of out on pass).
- Of the data provided, the sample size does not match the size and scope of the facility, often providing a misleading conclusion of the true status (e.g., hand hygiene).
- Staff do not have appropriate training on data metrics, collection, and reporting.
- LHH has in place an electronic health record (EHR) that does not have the right functionality to capture the data. Therefore, staff are not able to enter appropriate codes, so staff cannot pull automated reports from the EHR that reflect an accurate status (e.g., physical restraints).

Communication

The size of the facility lends itself to challenges in communication. Decisions are made at the upper management level with slow or no trickle down to direct care levels. Emails are a primary mode of communication about policy and process changes, but staff have said they do not always check or have access to emails, limiting access to information and effectiveness of communications.

Leadership has a limited presence on the units, which restricts the opportunity for staff to ask questions, receive just-in-time training, and participate in the QAPI process, such as providing feedback and participating in PDSA cycles. Leadership also does not communicate, on a timely basis or with urgency, newly found problem-prone areas, current findings of gaps in care, survey findings, and corrective actions to direct-care staff to promote and ensure systemwide improvements are made to quality-of-care issues. This results in the potential for ongoing harm and non-compliance and a failure to meet resident needs.

In addition, there is a significant breakdown of communication for the QA process. Direct-care staff are unaware of the program and the intent and do not feel comfortable or know how to raise quality-of-care concerns observed at the unit level.

2. Infection Prevention and Control

Problem Statement

The Infection Prevention and Control Program (IPCP) does not follow SNF best practice recommendations and regulatory requirements regarding risk assessment, planning, implementation, and corresponding surveillance activities. The approach causes key required elements of an IPCP to be performed unsatisfactorily.

Survey Citation(s) Reviewed

Establishing and maintaining an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections in compliance with 42 C.F.R. § 483.80(a)(1)(2)(4)(e)(f) (F880).

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Lack of nursing involvement

Nursing partners are not part of the healthcare-associated infection (HAI) review process, resulting in nursing not being aware if residents have infections or receiving feedback on how to prevent future events. This increases the likelihood of continued infections causing resident harm.

Recommendation: LHH will change the reporting structure of the Infection Prevention and Control (IPC) Department to report to the Chief Nursing Officer. IPC staff will be part of the ongoing weekly nursing huddles and the monthly nursing executive committee. IPC will be added as a standard agenda item to provide relevant updates to nursing leadership to include feedback on how to prevent future events. LHH will implement unit-based (on 13 nursing units) IPC meetings that include participation from nurse managers and nursing directors to identify, communicate, and prevent HAIs. **(Stronger Action)**

Root Cause 2: Misaligned IPC facility risk assessment

LHH's IPC facility risk assessment was developed for the acute care setting, resulting in priorities that are misaligned with SNF infection control regulatory requirements and best practices, increasing the likelihood of a non-compliant IPCP.

Recommendation: LHH has secured a current SNF facility risk assessment tool. LHH will standardize a continuous review process and update its facility risk assessment, at a minimum, on a monthly basis. IPC facility risk assessment accountability will occur through monitoring via the QAPI Program. LHH will retain an IP-certified expert consultant or executive coach to support IPCP regulatory compliance. **(Stronger Action)**

Root Cause 3: Non-compliant policies and procedures

More than 80% of LHH's IPC-related policies and procedures are not updated to current evidence-based standards and have lapsed and are non-compliant with annual review cycle expectations. This results in disjointed facility-wide guidance, increasing the likelihood of staff confusion and non-compliant behavior.

Recommendation: LHH will create a monthly calendar of activities that includes reviews of policies and procedures, the surveillance program, the water management program, the antibiotic stewardship program, and education based on any updates. IPCP accountability will occur through monitoring via the QAPI Program. LHH will retain an IP-certified expert consultant or executive coach to support IPCP regulatory compliance. **(Stronger Action)**

Root Cause 4: Inadequate EHR

LHH's Epic EHR system is not fully configured for the SNF setting, leading to an increased reporting burden for IPC staff, duplicative efforts, incorrect reference information in the EHR, and inaccurate isolation information in the EHR.

Recommendation: LHH will prioritize updating its Epic build to align with SNF-specific needs and develop usable reports for the agile prevention, surveillance, communication, and management of infections. **(Stronger Action)**

Root Cause 5: Lack of adequate staff and level of competency

LHH has staffing at 350 beds to 1 infection control professional, which is lower than the best practice ratio of 100 to 1, resulting in an inability to meet the basic IPC needs of the organization. This increases the likelihood of systemwide infection prevention non-compliance, including audits, education, and surveillance activities.

Recommendation: LHH will create an appropriately staffed IPC team with SNF-appropriate certification and/or SNF working knowledge to administer an IPCP for the size and scope of LHH. LHH will update current staff requirements for IPC certification, transitioned from the current one-year-from-hire expectation to within three months of hire (via CDPH or other appropriate entity). Registry staff or expert consultants will be used to augment gaps in staffing or before additional permanent staff members can be hired. (**Intermediate Action)**

Root Cause 6: Insufficient hand hygiene and personal protective equipment (PPE) audits

Hand hygiene and PPE audits are not collected in a volume that meets the size and scope of the facility and/or may be performed ineffectively. This results in an incorrect picture of overall facility compliance, increasing the potential for non-compliant IPC practices systemwide.

Recommendation: The IP Department has recently secured eight registry staff members, who have been trained on conducting observational audits and unit-based rounding, which has increased the volume of audits to industry standards. The audit process will be standardized across all 13 nursing units to ensure systemwide adoption and consistency with hand hygiene and PPE. LHH will continue this practice on an ongoing basis and will conduct monthly audit integrity checks (e.g., secret shopper approaches), at least quarterly, to ensure accuracy of findings. Based on audit findings, audits may increase in frequency to weekly from monthly.

PPE and hand-hygiene audits will have an expanded scope to include practices during resident care, such as wound care, trach care, and medication administration. In addition, leadership rounds will include a component to observe hand hygiene and PPE compliance to ensure staff see leaders supporting these changes. Overall compliance will be monitored monthly through QAPI. (**Stronger Action)**

Root Cause 7: Lack of effective IPC education to all staff

LHH does not effectively organize IPC communication and training to staff members, resulting in confusion, compliance concerns, and discord between various departments and service lines. This increases the likelihood that IPC practices are not uniformly implemented facility-wide and are non-compliant with regulations.

Recommendation: LHH nursing and IPC staff will partner to create an education calendar, focusing on IP issues specific to SNF IPC needs and using adult learning principles, including teach-back and return demonstration, to fully equip nursing staff to prevent, identify, report, investigate, and control infections and changes in condition. (**Intermediate Action)**

Analysis and Findings

Policy and Process Flow

Guidance from Federal and State authorities has changed throughout the pandemic, but at the time of this review, the following was in place:

- Policy states that staff are supposed to perform hand hygiene before and after PPE use and all resident care activities (per Centers for Disease Control and Prevention [CDC] guidance).
- Policy states that staff should wear PPE (per CDPH, CDC, and San Francisco Department of Public Health (SFDPH) guidance regarding COVID-19 and other transmission-based illnesses). PPE should not be worn in hallways unless exposure to blood/body fluid is expected.
- Policy states all equipment should be cleaned by clinical staff between residents.

Additional findings include the following:

- The knowledge deficit related to care expectations is an ongoing concern.
- During the COVID pandemic, staff were expected to follow policy, but the facility failed to provide the requisite products and/or resources to ensure compliance.
    - Hand hygiene products were not readily available to staff. Audits were not occurring (IPC Department staff at 1/350 beds versus the recommendation of 1/100 beds), so accountability suffered.
    - PPE carts were not available at the point of care. Staff were expected to travel to obtain necessary PPE, which impacted compliance.
    - Cleaning products were not available at the point of care/use.
    - PPE carts and hand sanitization stations were significantly lacking in sufficient supply to meet the needs of the organization.
- The facility is using inappropriate disinfecting solutions/wipes for cleaning some equipment, such as glucometers, portable BP cuffs, and Workstations on Wheels

(WOWs), resulting in an ineffective disinfection process and potential for cross-contamination.
- LHH has multiple points of entry, so consistent COVID-19 screening is a challenge. Visitors and staff can bypass screening areas and enter the facility.
- Because IPC staff were consumed with the COVID-19 response, the IC policies and procedures were not reviewed on an annual basis per regulatory requirements.
- The IPC team has a standardized tool for PPE and hand hygiene compliance reviews. Unfortunately, the number of observations is inadequate for the size of the facility. This creates an incorrect picture of overall facility compliance. Recent adjustments to compliance reviews have been made to remedy this issue.
- The IPC Department performs an annual risk assessment and plan for the facility; however, the documents that LHH used were developed for a hospital, not a nursing home. The format likely contributes to priorities being selected for the facility that are inappropriate.
- The facility has a water management plan that is driven by an assessment of risk. Unfortunately, the plan is inappropriately implemented. Items are tested that do not align with best practice expectations and therefore do not identify water contamination throughout the facility, increasing the risk for staff and resident harm.

Staffing & Competencies

Staff Performance

The facility is one of the largest NHs in the country. As such, it has been at the epicenter of the COVID public health emergency. Staff, provider, leadership, and IPC staff identify complacency and burnout as contributing factors.

Competency and Qualifications

Leadership at LHH is a group of individuals that have been redeployed from the hospital-owned/operated by SFDPH. While these individuals are extremely adept in hospital-based QI and care, their knowledge of nursing home requirements/expectations/best practices is lacking.

The facility does not have a nursing home administrator on staff, which also contributes to the lack of knowledge specific to nursing home regulations and operations.

One infection preventionist (IP) has a doctorate in leadership and is a registered nurse. He holds a certification in infection control and has 17 years of experience. The second IP is a registered nurse. She had minimal IPC training when she was hired for the role. The IP with experience is responsible for training the new IP. The lead IP delegates responsibilities to the secondary IP but did not develop a robust training schedule. This impacted the new IP's ability to operate efficiently/independently within the IPC role and impacted her ability to provide direct teaching and guidance to staff when queried.

A common practice for LHH is to hire individuals without nursing home background who do not know SNF regulations. This often results in the spread of inaccurate information specific to nursing home care.

LHH's plan for dealing with staffing contingencies is to use registry staff. Currently, the facility has utilized eight registry staff for the sole purpose of conducting IPC floor rounds daily to

provide a dashboard for basic IPC practices, such as hand hygiene and PPE compliance to prevent the spread of infection.

Required IPC activities during COVID-19 were paused for extended periods (HAI surveillance only occurred in 6 of 12 months). During peak COVID-19 times, the IPC team did not perform audits, surveillance, education, training, competencies, etc.

The facility does not use strong adult learning principles in training and educating on IPC practices and standards, especially with validating comprehension of the information provided. Staff remain confused, as demonstrated by not being able to answer questions related to the COVID-19 Yellow Zone and other IPC practices, which results in inconsistent application from unit to unit.

The facility does not have a progressive disciplinary action for non-compliant behaviors. As such, staff have learned that even if they choose not to follow policies, there is a low likelihood of them losing their position or being reprimanded.

Staffing Level

Studies indicate best practice staffing is one infection control professional to 100 beds. LHH has staffing at one infection control professional to 350 beds.

The number of full-time employees (FTEs) assigned to the IPCP was insufficient to meet the basic needs of the organization. The IPCP should have no less than six, and LHH currently has two. This was not adequately identified in the 2021 or 2022 Annual Facility Assessment.

Technology & Data Integrity

The facility has an EHR with an IPC surveillance software program with the ability to ease reporting burden and surveillance activities. Unfortunately, the EHR is not leveraged to ease IPC burden, which leads to duplicative efforts, incorrect reference information within the EHR, and inaccurate isolation information.

Communication

LHH uses various methods of communication, which include town hall meetings, memos, education through learning management software, just-in-time education, department meetings, and in-services. Unfortunately, coordination between the different departments (such as nursing, IPC, QM and environmental services [EVS]) groups and methods is inconsistent. This causes confusion, non-compliance, and discord between the different departments and service lines.

Nursing staff communication at shift change is inconsistent and not a standardized process, often excluding certified nursing assistants (CNAs), patient care assistants (PCAs), registry staff, dietary, and EVS staff. This often results in isolation needs not being clearly communicated to the whole care team.

Nursing and IPC teams do not work together to ensure that education and training are facility-wide (multiple shifts) and targets identified areas of opportunity as well as mandatory annual education.

IPC leadership is siloed, often not communicating unsafe IPC issues, such as emerging infections or new COVID outbreaks to nursing, EVS, and dietary leadership. This results in potential hazardous exposures.

3. Behavioral Health and Substance Abuse

Problem Statement

LHH has historically admitted residents with complex needs regarding behavioral health (BH) and substance use disorder (SUD). LHH staff are not well trained nor do they have the expertise to properly treat and manage these complex needs. In addition, ongoing systemwide EHR documentation issues limit the potential effectiveness of individualized care plans. The confidentiality rules involved with CFR42 Part 2 impact the information flow between the two EHRs. These LHH practices limit the ability for LHH residents to receive the services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

Survey Citation(s) Reviewed

Ensuring that each resident receives the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, including but not limited to providing prevention and treatment for mental and substance use disorders in compliance with 42 C.F.R. § 483.40 (F740).

Ensuring that, based on a comprehensive assessment, residents who use psychotropic drugs receive gradual dose reductions, and behavior interventions, unless clinically contraindicated, in an effort to discontinue these drugs in compliance with 42 C.F.R. § 483.45(e)(2) (F756).

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Lack of behavioral health and SUD experience

LHH does not have the nursing staff, social workers, psychiatric technicians, or activities staff with BH and/or SUD experience to support the specialized needs of residents with SUD and BH needs and concomitant challenging medical issues. This results in residents with SUD and BH needs receiving limited individualized interventions to meet their needs.

Recommendation: LHH will review and update its facility assessment and admission protocol to accurately reflect LHH's ability to provide adequate care to residents who are admitted for SNF care. LHH will hire FTEs with BH and SUD specialized skillsets. LHH will partner with an external vendor on the following: 1) conduct focus groups with staff to determine specific training and educational needs regarding SUD and BH; 2) provide comprehensive SUD/BH training for staff members, as indicated; 3) apply adult learning techniques, such as teach-back, videos, and 24/7 in-person educational rounds; and 4) evaluate the need to augment current staffing. LHH will also retain a consultant to investigate alternative models for a focused SUD care and BH unit. **(Stronger action)**

Root Cause 2: Care plans not consistently updated with SUD needs

LHH uses the Avatar EHR for residents with SUD and the Epic EHR for all resident care plans. LHH does not consistently follow its policy and procedure for obtaining consents from residents

to disclose SUD information from Avatar to Epic, due to medical staff concerns regarding violating SUD confidentiality laws (CFR42 Part 2). The result is an inability to document and update care plans in the Epic EHR with pertinent SUD information, increasing the likelihood that resident care teams (RCTs) are not fully aware of a resident's individualized SUD needs and interventions. In addition, the care plans do not effectively document individualized therapeutic interventions (e.g., SUD support groups, safety plans prior to out on pass, assessment completed after out on pass) to address underlying behaviors or increased services necessary to address the resident's specific needs. This has resulted in an overreliance on using clinical searches as an intervention that can infringe on resident rights and/or the clinical needs of the resident exceed the scope and licensure of the SNF setting.

Recommendation: LHH will align behavioral health/SUD, resident rights, and care planning policies and procedures to align with CMS Phase 3 regulations to ensure residents' rights are protected. This includes ensuring consents are appropriately obtained to ensure documentation barriers between EHRs are adequately addressed. These revisions will also address proper resident assessment and the care planning process to ensure individualized therapeutic interventions and services are provided to residents with behavioral health and substance use disorder needs. The policies will also include how to determine whether LHH can safely and adequately provide residents the care they need. If LHH determines the specific needs of any resident cannot be safely met in the SNF setting while remaining compliant with CMS regulations, then a resident care conference (RCC) will occur to determine the most appropriate setting for the resident with subsequent transfer, as indicated. In addition, LHH will obtain legal support to address concerns regarding SUD confidentiality laws. Indicators will be developed, so the process can be monitored through the QAPI Program. Staff will be trained on interventions specific to behavioral health issues and substance use disorder. This training will include a review of care planning steps, including assessment, care planning, intervention evaluation, reevaluation, and revision so that the care plan has a continuous feedback loop to address the specific needs of residents. **(Stronger action)**

Root Cause 3: Understaffed Behavioral Emergency Response Team

LHH's Behavioral Emergency Response Team (BERT) is not fully staffed for the size, scope, and complexity of the facility, and the roles and responsibilities are not fully defined. This results in an inability to support nursing units in a timely therapeutic response (e.g., de-escalation) as well as to develop relationships with residents to provide input for individualized BH care plans. This increases the likelihood that residents with BH needs do not receive the professional standards of care needed to prevent the potential of harm to self and others.

Recommendation: LHH will hire additional, qualified staff for the BERT program to train and support direct-care staff and medical staff regarding therapeutic communication and responses to issues with residents with BH needs. The team will also provide input for individualized BH care plans. These nurses will be located near resident care areas and will actively monitor intervention effectiveness, including evaluation of out-on-pass privileges. **(Intermediate action)**

Root Cause 4: Security staff not trained on LHH policies and procedures

The safety and security staff (e.g., Sheriff's Department and private security partner) are not trained on LHH illicit substance policies, resulting in a lack of compliance or decreased knowledge of SNF regulations. This increases the likelihood of illicit substances entering the facility.

Recommendation: LHH will collaborate with safety and security leadership to ensure security staff are trained on LHH policies and procedures regarding illicit substances, visitor searches, and overall safety and pertinent SNF regulations. In addition, LHH will develop a standard process to ensure policy changes are communicated to security teams in a timely manner and executed appropriately. **(Stronger action)**

Analysis and Findings

Policy and Process Flow

The SFDPH system is a designated safety net for the San Francisco community. Therefore, LHH responds to this by admitting individuals with complex SUD/BH conditions, weakening its compliance with admission criteria. This has produced a complex population of residents with specialized needs for which staff are not trained to support in the SNF environment. These resident needs are not accurately reflected in the facility's assessment.

Consent to share information needs to be encouraged and obtained from the resident. Once consent is given, SUD information given verbally to the RCT should be documented in the psychiatry notes in Epic. Care planning items can be developed using this information. LHH medical staff need to obtain release of information (ROI) from residents and communicate to the RCT regarding the status of referrals made. ROI is obtained inconsistently from the residents to share SUD/BH information from the Avatar to the Epic system. Medical and clinical staff lack clarity about the regulations related to obtaining and sharing SUD/BH information. Psychiatrists are reticent to include resident information considered to be protected under CFR42 Part 2, regardless of consent given, due to the fear of the information being shared outside the RCT, which would be considered a violation of re-disclosure. Executive leadership was not aware of this issue until repeated critical element pathway (CEP) reviews required escalation due to no resolution for regulation conflict. This issue impairs the staff's ability to write an effective care plan due to the limited information available to them.

There is a lack of safety of the environment related to highly suspected or witnessed illicit substances on a resident's person. Illicit substances/paraphernalia are not confiscated if the resident declines a body search per SNF regulations.

Staffing & Competencies

Staff Performance

Minimum Data Set (MDS) coordinators do not account for historical information already documented in the Epic system regarding SUD services. Accurate information is not sent to CMS, and information in the care plan is not updated nor accurate.

Competency and Qualifications

Staff were unaware of the Substance Treatment and Recovery Services (STARS) protocol during the COVID pandemic.

Related to training/orientation:

- The two BERT nurses hired have been orienting and concentrating primarily on care plan interventions in documentation. Training, coaching, and support of staff in therapeutic de-escalation has not occurred.
- Staff who have no SUD or BH background require extended orientation and/or training related to these topics, such as de-escalation techniques and recognition or indicators of illicit-drug use.
- Safety and security staff are not trained on LHH illicit substance and overall safety policies or pertinent SNF regulations.
- Direct-care staff are not specifically trained and educated nor given the infrastructure to therapeutically respond to the complex needs of residents with BH and SUD issues in a SNF environment.

While medical staff protect the 42CFR Part 2 confidentiality rights of residents receiving SUD services, they do not consistently resolve the conflict with SNF regulations for individualized care plans addressing SUD-specific needs.

Staffing Level

A BERT was formed to provide therapeutic de-escalation for residents with escalating behaviors. Two RNs were hired in this role, which is inadequate for the size, scope, and complexity of LHH and the population of residents.

Communication

Due to current legal concerns related to redisclosure for 42CFR Part 2, information is often not shared, even when consent has been provided. When consent is given, there is an inconsistent practice by psychiatrists documenting this in Epic. This impacts the ability to write an accurate care plan to address residents' needs.

4. Medication Management and Administration

Problem Statement

LHH medication management and administration policies are inconsistently applied, resulting in resident medication safety issues and non-compliance with Federal regulations. The policies that are most affected by this are the drug regimen review, medication storage, and self-administered medications.

Survey Citation(s) Reviewed

Ensuring that residents only self-administer medications if the interdisciplinary team determines the practice is clinically appropriate in compliance with 42 C.F.R. § 483.10(c)(7) (F554).

Labeling drugs and biologicals used in the facility in accordance with currently accepted professional principles, including appropriate accessory and cautionary instructions, and the expiration date when applicable in compliance with 42 C.F.R. § 483.45(g)(h)(1)(2) (F761).

Providing routine and emergency drugs and biologicals to residents, or obtaining them under an agreement, and ensuring that pharmaceutical services are provided to each resident that meets their individual needs in compliance with 42 C.F.R. § 483.45 (F755).

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Medication self-administration policies not routinely followed

LHH policies for self-administration of medications are not consistently followed, including self-administration assessment, secure medication storage, and appropriate documentation (e.g., physician's order, pharmacy reconciliation, drug regimen review). This results in some unsafe medication management practices, including unsecured herbal supplements at the bedside without physician orders.

Recommendation: LHH nursing, physician, and pharmacy departments will update and implement the self-administration of medication policy in accordance with the regulation. This will include a process to validate completion of 1) resident self-administration assessments using objective criteria; 2) regular re-assessments to determine continued competency; 3) observation of resident performing self-administration; 4) secure storage of self-administered medications, and 5) correlating required documentation including the Medication Administration Record (MAR). Monitoring metrics will be developed and reported to the QAPI Program. **(Stronger action)**

Root Cause 2: Non-compliance with safe medication management practices

LHH licensed nursing staff are not compliant with medication management policies and procedures, such as managing the safe storage of medications, disposing of medications appropriately, checking expiration dates on medications, and securing medication carts. This results in non-compliance with safe storage and disposal of drugs and biologicals.

Recommendation: LHH pharmacy and nursing leadership will collaborate to develop a program that regularly validates effective medication management that includes safe storage, accurate labeling, appropriate medication disposal, and checking expiration dates. This system will include increased medication pass observations from pharmacy of the licensed nurses that include just-in-time education with accountability actions when non-compliance is identified. Medication cart timers will be set to auto-lock at 1 minute to ensure medications are always secured.

LHH will provide education, at least quarterly, to licensed nurses to include safe storage, labeling, disposal of medication and biologicals, and medication cart management. This training will be scenario-based and include return demonstration to validate comprehension. The results will be monitored through the QAPI Program. **(Intermediate action)**

Root Cause 3: Lack of interdisciplinary team collaboration

LHH medical staff, pharmacy, and nursing staff lack a team-based approach and interpret the regulations in an independent fashion. There is an inconsistent implementation of the pharmacy-related regulations, such as drug regimen reviews and dose reductions. This results in non-compliance in conducting the required monthly medication review and/or dose reduction.

Recommendation: LHH will develop unit-based monthly psychotropic/behavior meetings to review and follow up on the regulatory requirements for pharmacy recommendations. The interdisciplinary team (IDT) will include physicians, nursing leadership, and a pharmacist to review monthly gradual dose reductions, drug regimen reviews, and unnecessary medications. This process will be monitored through the QAA Committee with a detailed report that indicates any areas of non-compliance**. (Stronger action)**

Root Cause 4: Lack of herbal supplement safety verification processes

Most herbal supplements taken by patients are not ordered, administered, or documented in the same way as medications, making it difficult for staff to know what is being taken and how frequently. A limited number of supplements are included on the LHH formulary and available to order via the EHR. Additionally, residents often obtain their supplements through mail order. This results in challenges for the pharmacy staff with verifying the content and quality of herbal supplements provided. This contributes to challenges in evaluating the safety of the supplement, identification of potential drug-herb interactions, and the appropriateness for each resident.

Recommendation: Pharmacy will review the formulary to allow additional herbal supplements that have the United States Pharmacopeia (USP) Verified Mark. LHH will review and revise the policy and procedure for resident acquisition of herbal supplements that are non-USP verified and determine what is allowed within their rights while balancing resident safety. For those residents who want non-USP herbal supplements, the RCT, including physicians, will consult with the resident in person to convey the risks versus the benefits of using non-USP supplements. A care plan will be developed for each resident, based on the results of the consultation. LHH will document USP and non-USP herbals in the EHR, including a physician order allowing the herbal to be administered. **(Intermediate action)**

Analysis and Findings

Policy and Process Flow

The policy and procedure for medication self-administration do not identify objective criteria to determine if the resident is safe and competent to self-administer. The policy and procedure do not indicate how frequently the resident assessment should occur.

Most herbal supplements taken by residents are not ordered, administered or documented in the same way as medications, making it difficult for all staff to know what is being taken and how frequently. Additionally, concerns about the inability to verify the content and quality of herbal supplements taken by residents contributes to challenges in evaluating the safety, evaluation of potential drug-herb interactions, and appropriateness for each resident. A limited number of supplements are on the LHH formulary and available to order via the EHR.

The intent of the regulation is to provide the resident who wants to self-administer medications with the guidelines that must be met in order to do this within a safe environment.

The facility does not develop policies that crosswalk directly to regulations, as evidenced by having vague self-administration assessment criteria when the regulations are very specific. The assessment for resident capability to self-administer medication is limited to one question and does not have robust, objective evaluation by the RCT.

LHH has a poor process specific to the sequencing of policy and procedure changes and communication of those changes to all staff. This results in staff initiating a practice per the communication without it being finalized as a policy and procedure, putting the residents at risk for harm and a lack of standardized practice throughout the facility. There is also a delay in the policy approval process, often taking three to four months due to the many committee approvals required. The facility rarely uses an expedited policy approval process.

Staffing & Competencies

Competency and Qualifications

Effective medication management is part of the basic training of licensed nurses, such as managing safe storage of medications, disposing of medications appropriately, observing residents who desire to self-administer, checking expiration dates on medications. However, some staff deviate in this core practice, which impacts their competencies. LHH does not follow up on educational requests for staff who have been observed showing deviations in their practice.

Medical staff often interpret the SNF regulations in an independent fashion, resulting in a lack of a team-based approach. Variations in practice and inconsistencies occur from physician to physician.

Staff Performance

During the April 2022 survey, a citation occurred for a resident who had 17 different herbal supplements at the bedside. On 10/26/22, all items were still at bedside. Keys to the bedside drawer, where the supplements are to be kept, were left on the bedside table, leaving the supplements unsecured. The herbal supplement list was not updated or reconciled on a regular basis, while the care plan stated that this should be completed every shift with herbal supplement

administration. The completion of the RCT self-administration assessment is not consistent with the regulation.

LHH has a labeling and storage policy that monitors for expired medications, which also includes unit inspections. However, staff fail to check for expired medications per the policy.

A consistent theme at LHH is that information, such as policies, practices, and guidelines, are vague and confusing, often leading to self-interpretation of the regulations. This results in poor management and oversight for a safe environment.

Charge nurse rounds should check for unsecured items at the bedside. Charge nurse rounds are not occurring as intended. Environment of care (EOC) rounds are occurring and show frequent observations where medication carts are left unlocked and/or unattended and accessible to the residents. Drugs are not being disposed of properly in disposal containers on meds carts and medications are co-mingled (e.g., eyedrops, eardrops, and inhalers were stored in the same medication cassette).

Participation by physicians is inconsistent in drug regimen reviews and dose reduction recommendations from pharmacy.

Staffing Level

The LHH Pharmacy Department had turnover in the supervisor position in March 2022 and had a staff member on extended leave. Both were very involved in the flu vaccine management program. The department has recently onboarded three new technicians in 2022.

5. Resident Rights and Freedom from Harm

Problem Statement

LHH daily operations have several characteristics that limit a holistic focus on residents' well-being. These include limited resident-centered care practices, an ineffective resident council, poorly implemented interventions after abuse allegations, use of physical restraints, minimal staff and resident awareness of the grievance process, lack of follow-through by leadership on grievances, lack of consistent leadership, and management oversight to ensure residents rights are consistently met.

Survey Citation(s) Reviewed

Ensuring that residents are provided the right to a dignified existence, self- determination, and communication with and access to persons and services inside and outside the facility in compliance with 42 C.F.R. § 483.10(a)(1)(2)(b)(1)(2) (F550).

Ensuring that each resident is free from abuse, neglect, misappropriation of resident property, and exploitation in compliance with 42 C.F.R. § 483.12(a)(1) (F600).

Ensuring that all LHH residents receive appropriate and sufficient supervision and that LHH implements appropriate interventions to keep LHH residents safe from accident hazards, including illegal drug use, illegal drug possession, and other contraband possession in compliance with 42 C.F.R. § 483.25(d)(1)(2) (F689).

Ensuring that residents admitted to LHH with limited ranges of motion receive appropriate treatment and services to increase their range of motion or prevent further decrease in their range of motion in compliance with 42 C.F.R. § 483.25(c)(1)-(3) (F688).

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Lack of consistent leadership rounding

LHH leadership does not consistently conduct rounds in the facility, resulting in an inability to identify and resolve resident concerns in real time. This increases the risk that resident concerns and grievances will not be identified and addressed.

Recommendation: LHH will implement standards for consistent, data-driven leadership grievance reviews and rounds on all nursing units to hold staff and leadership accountable to resident care standards related to abuse and neglect, resident rights, and other care concerns. These data will be monitored and reported to the QAPI Program. **(Stronger action)**

Root Cause 2: Lack of proactive intervention to prevent abuse

LHH does not have a strong proactive process to identify early abuse triggers between residents, resulting in a lack of interventions implemented and documented in resident care plans to prevent altercations. This increases the likelihood that residents may experience harm.

Recommendation: LHH will examine the current abuse and neglect investigation process and develop a standardized plan that enhances the abuse investigation process and intervention development (e.g., ensuring unbiased allegation investigators and IDT review of care plan interventions). In addition, LHH will create a "prevent abuse and neglect" campaign using various modalities, such as routine training, coaching, awareness posters, and case studies, targeting all staff to create a culture of resident safety. **(Intermediate action)**

Root Cause 3: Unnecessary physical restraint use

LHH physical restraint practices by nursing, rehabilitation therapy, and medical staff are not compliant with regulations and often do not include documented consent, documented alternative approaches, or a justifiable medical diagnosis, resulting in widespread physical restraint use (e.g., seatbelts, bed and chair alarms, bedrails). This increases the likelihood of regulatory non-compliance, decreased resident dignity and quality of life, and the potential for resident harm.

Recommendation: LHH will complete a PIP and train staff, including medical staff, to eliminate all unnecessary physical restraints and to ensure practices are in compliance with Federal regulations. Data will be monitored and submitted to QAPI. **(Stronger action)**

Root Cause 4: Low staff and resident awareness of grievance process

The grievance process is not well known nor are the forms easily accessible to residents, resulting in residents, resident representatives, and staff not knowing how to formally escalate concerns. This increases the risk that resident grievances are not being adequately addressed.

Recommendation: LHH will ensure that grievance forms and drop boxes are easily accessible to residents on all nursing units to ensure concerns are escalated and addressed. LHH will ensure grievance form drop boxes are regularly checked by assigning the correct departmental owner and creating a schedule. LHH will discuss the grievance process at the resident council meetings. Leadership rounding will also address grievances. Grievance data submitted to the QAPI Program will be redefined to allow for critical analysis and follow-up action. **(Stronger action)**

Root Cause 5: Lack of SNF resident-centered, best practice interventions

LHH staff have not fully embraced resident-centered, evidence-based concepts, such as consistent nursing assignment, hourly rounding, or no-pass zones, resulting in a lack of awareness of resident needs, a clean and safe homelike environment, and prolonged response to call lights. This increases the likelihood of a decrease in quality of life and a dignified existence for residents. Additionally, LHH is not compliant with Phase 3 requirements in their policies and procedures (e.g., clinical searches, trauma-informed care).

Recommendation: LHH will develop and operationalize a plan for consistent staffing assignments for full-time and registry nursing staff. LHH will implement an hourly rounding program in each nursing unit. LHH will also implement an educational plan and communication campaign to promote the no-pass zone intervention to all staff members. LHH will develop a crosswalk for policies to ensure consistent alignment with CMS Phase 3 requirements with an emphasis on resident rights. **(Intermediate action)**

Root Cause 6: Lack of strong accountability standards

Organizational accountability does not include progressive disciplinary action for consistent, documented, non-compliant staff behaviors affecting resident rights and dignity. Examples of these are not using privacy bags for Foley catheters, not knocking on doors and requesting permission to enter resident rooms, and staff standing while assisting residents with meals. This results in continued staff non-compliance, increasing the likelihood of delayed behavior and practice change leading to actual or potential resident harm.

Recommendation: LHH leadership will set an expectation for managers and directors to enforce progressive disciplinary action for those staff who are consistently non-compliant. **(Stronger action)**

Root Cause 7: Ineffective resident council meetings

LHH resident council meetings were not held during the COVID-19 pandemic and alternatives to in-person group meetings were ineffective. This resulted in meetings with limited resident attendance when the resident council started meeting in person in July 2022. There was no discussion or facility follow-up on resident rights, the grievance process, or other resident concerns, increasing the likelihood that residents had limited ability to or could not exercise their rights as a resident of the facility.

Recommendation: LHH will develop a resident council meeting schedule, which includes facility-wide and unit-level monthly meetings to be facilitated by the activities therapy department. Meetings will include an agenda, minutes, review of grievance trends and concerns, resident rights, and other resident concerns. The results of these meetings will be reported to the QAPI meeting. **(Intermediate action)**

Root Cause 8: Lack of formalized restorative nursing program

LHH does not have a formalized restorative nursing program with defined ownership. The current process is not designed to maintain the functional ability of residents, resulting in inconsistent assessments for mobility and care planning and poor implementation of specific interventions. This increases the likelihood that residents could be at increased risk for harm due to declines in range of motion, mobility, and quality of life.

Recommendation: LHH will develop a restorative nursing program in collaboration with nursing and therapy leadership. LHH will utilize industry standards when developing the program to ensure best practices are established. Leadership will review the appropriateness and effectiveness of the program, including the implementation of interventions at least quarterly in conjunction with the MDS schedule. This will be reported to the QAA Committee for compliance. **(Stronger action)**

Analysis and Findings

Policy and Process Flow

The grievance process is not being followed to allow resolution of concerns, resulting in residents having to call police to investigate concerns. Residents are not consistently informed

about how to file a grievance, and grievances are not logged properly. Follow-through with grievances is also not timely.

Regarding abuse and neglect, residents are not separated when resident-to-resident altercations occur, timely interventions are not implemented after an abuse allegation, staff fail to identify and prevent abuse, and care plans are not updated with appropriate individualized interventions.

In addition, the widespread misuse of physical restraints, lack of physician knowledge on regulations, and a lack of timely call light response also contribute to a lack of resident-centered care, safety, and quality of life.

LHH does not have a formalized restorative nursing program that was designed to improve or maintain the functional ability of residents. This appears to be the result of ineffective communication between therapy and nursing and restorative nursing program coordination.

LHH staff are not held accountable to follow policies and procedures to prevent certain resident rights issues, such as call light response times and treating residents with dignity and respect (e.g., standing over residents during feeding assistance, lack of use of privacy bag for Foley catheters, failure to implement fall prevention intervention with coach, and not knocking before entering a resident rooms). Staff failure to follow through on concerns gives the perception of "not caring" or lack of interest.

There is a failure to follow regulations by medical staff regarding physical restraints and, when appropriate, to document the steps needed to properly justify their use.

Resident grievance forms and drop boxes are only at three locations throughout a very large facility. They are not predominately placed in resident care areas (e.g., one location is in the administration building that is not accessible to residents). This limits the residents' ability to quickly access and confidentially submit forms to address any concerns.

The COVID-19 pandemic limited the ability for LHH to hold in-person resident council meetings. LHH did not effectively investigate or implement alternative approaches to hold resident council meetings based on the latest infection control and prevention guidance. As a result, there were limited efforts to restart resident council meetings. These meetings started again in July 2022; however, there is a limited effort to increase resident participation at the meetings (e.g., often only four to five attendees out of more than 600 residents on-site attend).

During the height of the pandemic, the wellness gym was closed. As guidance from CDC has been modified, the gym still has not been opened, and no alternatives were identified. This concern has been voiced at the resident council meetings.

LHH has a poorly defined reporting structure for the restorative nursing program, resulting in no ownership or responsibility to develop and maintain the program.

LHH does not consistently and regularly screen for declines in range of motion, balance, and activities of daily living. LHH does not have appropriate follow-up actions for those identified in need of restorative nursing services.

Staffing & Competencies

Knowledge of Regulations

LHH nursing, therapy, and medical staff lack adequate training and knowledge of the physical restraint regulation to appropriately determine what is considered a restraint as well as to identify the least restrictive methods.

Competency and Qualifications

LHH does not have regular, ongoing abuse and neglect education for LHH staff to support a culture of safety for residents. This can lead to a lack of urgency regarding abuse and neglect interventions.

Nursing staff are not appropriately trained on how to conduct a thorough and comprehensive abuse and neglect investigation (e.g., not interviewing enough residents or staff). The last formal training occurred in 2016. In addition, nurses are often assigned to investigate abuse/neglect on the units they work, increasing bias in the investigation process.

Residents and staff are not adequately educated on the grievance process, limiting the ability for residents to file concerns in a timely manner.

When allegations of abuse occur, staff are not separating residents to prevent future altercations and abuse. Assigning coaches to provide one-on-one observation of residents is a common intervention implemented after an abuse allegation; however, coaches are re-directed to provide direct resident care with staff shortages. This leaves the residents unaccompanied and susceptible to further altercations. The RCT, which manages the coach, does not reevaluate interventions to determine their effectiveness or need for updates to ensure continued resident safety. Regarding abuse investigations, key members of the RCT are not updated on allegations and findings. In turn, they cannot update care plans with appropriate, individualized interventions. In addition, abuse allegations are not communicated to the full leadership for follow-up.

Staffing Level

Staff are not consistently assigned to the same nursing units, resulting in a limited ability to develop rapport with residents and a baseline knowledge of care challenges. This insight gained through consistent assignment could help staff proactively identify problem-prone areas, such as triggers for resident-to-resident altercations and escalation in behaviors.

A staff member who has worked with the same individual has a baseline of his or her behaviors and is able to quickly identify any deviations. In addition, coaches assigned to falls intervention are used, as "staffing permits," in the care plan but are often reassigned during staffing shortages. This practice leads to the resident not always having appropriate interventions to maintain resident safety.

Staff Performance

There is lack of leadership engagement at the unit level to build relationships with residents and staff to proactively identify resident concerns/grievances and hold staff accountable to professional standards of care, such as knocking on doors before entry or the use of unnecessary physical restraints.

The interdisciplinary teams, including medical staff, which often have an acute care mindset, do not effectively collaborate on resident care needs influencing the widespread use of physical restraints.

LHH staff are not effectively facilitating resident council meetings (e.g., no standard agenda, no solicitation from residents on what to add to agendas to discuss, no review of previous meeting minutes to ensure follow-up on resident concerns, no discussion of resident rights, and no discussion of the grievance process).

Technology & Data Integrity

LHH's call light system is 10 years old and its software has not been updated. This makes it difficult to extract data on call light times, making it difficult to analyze for QAPI purposes.

Grievance data are reported to the QAA Committee; however, the data are just numbers without specific detail. Therefore, the grievance data are not critically analyzed to determine issues and provide targeted solutions to address trends in grievances.

LHH data indicate a low physical restraint use; however, observational audits used to validate the data, incorporating industry standards of restraints, show large physical restraint use.

Communication

Since the resident council restarted in July 2022, members have commented that there is inconsistent communication to appropriate departments to follow up on resident concerns.

Staff acting as an intervention coach do not always communicate to colleagues to cover when they are "on break." This creates a gap in resident support that could result in adverse occurrences (e.g., falls interventions or call light response time).

6. Comprehensive Care Plans and Quality of Care

Problem Statement

Resident care plans are not individualized and are not being used effectively as an accessible tool for the IDT to plan and document care and accomplish individualized care goals, healthier outcomes, and overall quality of life for residents. This results in LHH not delivering care that meets professional standards of quality. This leads to poor resident outcomes in areas such as accident hazards, respiratory care, pain management, dietary needs, and range of motion.

Survey Citation(s) Reviewed

Developing comprehensive care plans and completing comprehensive assessments of all residents in compliance with 42 C.F.R. § 483.21(b)(2)(I)-(iii) (F657) and ensuring that all care plans meet professional standards of quality in compliance with 42 C.F.R. § 483.21(b)(3)(I) (F658).

Ensuring that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care in compliance with 42 C.F.R. § 483.24 (F675).

Ensuring that all LHH residents receive appropriate and sufficient supervision and that LHH implements appropriate interventions to keep LHH residents safe from accident hazards, including illegal drug use, illegal drug possession, and other contraband possession in compliance with 42 C.F.R. § 483.25(d)(1)(2) (F689).

Ensuring that residents who need respiratory care are provided such care consistent with professional standards of practice, a comprehensive person- centered care plan, and the residents' goals and preferences in compliance with 42 C.F.R. § 483.25(a) (F695).

Ensuring that pain management is provided to residents who require those services consistent with the professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences in compliance in compliance with 42 C.F.R. § 483.25(k) (F697).

Ensuring each resident is provided nourishing, palatable, and well-balanced diet that meets the individual's daily nutritional and special dietary needs, taking into consideration the preferences of each resident in compliance with 42 C.F.R. § 483.60 (F800).

Ensuring that residents admitted to LHH with limited ranges of motion receive appropriate treatment and services to increase their range of motion or prevent further decrease in their range of motion in compliance with 42 C.F.R. § 483.25(c)(1)-(3) (F688).

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Ineffective care planning by interdisciplinary team

The IDT, including the medical staff, does not demonstrate an understanding of its role and the appropriate knowledge or training to develop and modify effective SNF resident care plans. This results in care plans that are not revised to reflect the current or changing status and interventions needed, increasing the likelihood that the whole care team is limited in working collaboratively toward optimal resident outcomes.

Recommendation: LHH will reorganize interdisciplinary care plan teams by evaluating roles and responsibilities and redefining expectations for each role to ensure their active participation in developing and implementing individualized care and creating an accountability structure. LHH will also restructure the current care plan program to include mandatory, in-person education and a coaching program, using a care plan subject matter expert to guide interdisciplinary teams to achieve resident-centered care**.** This training will include a review of care planning steps, including assessment, care planning, intervention evaluation, reevaluation, and revision so that the care plan has a continuous feedback loop to address the specific needs of residents (e.g., individualized interventions and services for residents with behavioral health and SUD needs) **(Stronger action)**

Root Cause 2: Lack of MDS Department oversight and accountability

The LHH MDS Department lacks leadership oversight and accountability, resulting in care planning being delegated to charge nurses and direct-care staff who have limited training in MDS coding processes and care planning. This increases the likelihood that resident assessments are miscoded and care plans are not accurate.

Recommendation: LHH will reorganize the MDS Department from a centralized office to a unit-based presence, including office locations on each unit, in order to become part of the unit culture and active member of the unit-based care team. LHH will actively monitor, through the QAPI Program, the accuracy of care plan individualization using standardized assessment tools, such as the critical element pathways. The competency of leadership will be reviewed with an executive dashboard that monitors the integrity and individualization of each care plan. **(Stronger action)**

Root Cause 3: LHH not using consistent nursing assignment

Currently, the majority of the nursing staff at LHH are not assigned to a specific unit. Furthermore, consistent nursing assignment is not a widespread practice at LHH, resulting in staff not working with the same residents daily. This increases the likelihood that staff do not have baseline knowledge of behaviors or do not adequately know care plans to be able to quickly identify any deviations among residents.

Recommendation: LHH will establish core staff on each nursing unit who are assigned exclusively to that unit. LHH will also adopt elements of an evidence-based consistent assignment program, such as Advancing Excellence, on each unit with a goal to have the care

team (RNs, LPNs, CNAs, PCAs, EVS, and dietary) consistently care for the same residents through most of their shift to improve staff/resident relationships. **(Stronger action)**

Root Cause 4: Limited care planning participation by nurse leaders

Nurse leaders (e.g., directors and managers) have inconsistent and ineffective participation in the care plan process. This results in activities, such as 1) not identifying discrepancies between physician orders and the nursing care being delivered; 2) having interventions not customized to the residents' needs; and 3) outdated information about the residents' current conditions and preferences. This increases the likelihood that quality of care (e.g. range of motion, pain management, respiratory care, and accidents/incidents) for residents does not meet professional standards of care.

Recommendation: LHH will clearly define nurse leaders' roles and responsibilities that include their active participation in developing and implementing individualized care plans. LHH will also require nurse leaders to attend a mandatory, in-person education and coaching program, using a subject matter expert (SME), to guide interdisciplinary teams to achieve resident-centered care. Observations of their contributions to the care plan process will be made by the SME to provide feedback to the nurse leaders. **(Stronger action)**

Root Cause 5: EHR not optimized for SNF setting

The EPIC EHR purchased is not customized for the SNF setting. This results in increased burden to staff to update and modify care plans, which increases the likelihood that residents have care plans with generic, acute-care–based interventions rather than comprehensive, resident-centered care plans.

Recommendation: LHH will develop and implement a Kardex system in partnership with Epic to ensure direct-care staff have access to current resident care plan information. Training will occur for all staff on how to use the Kardex for daily resident care and how to update, as needed. In addition, LHH will develop a business plan with timelines and milestones to customize the current Epic EHR to the SNF setting and LHH's unique population needs. **(Stronger action)**

Root Cause 6: Limited access by direct-care staff to care plan information

CNAs, PCAs, and other non-licensed caregivers do not routinely review or have limited access and training to the care plan in the EHR and do not have a Kardex system as a resource. This results in a lack of up-to-date knowledge of individualized resident needs.

Recommendation: LHH will train all care staff to understand care plan basics and how to access care plans in the EHR. LHH will implement a Kardex system to guide daily resident care and interactions. This will become part of new employee orientation and scheduled mandatory training. LHH will also create scenario-based training with return demonstration to ensure staff comprehension and validation of expectations to utilize the care plan/Kardex in their daily work and to update the care plan, as needed, to reflect changes in residents' needs and preferences. **(Intermediate action)**

Root Cause 7: Lack of specialized skills to individualize care plans

LHH staff do not have the specialized knowledge and skills needed to care for the unique needs of BH and SUD residents, resulting in care plans that do not specifically address individualized interventions to meet their psychosocial and physical needs. This gap increases the likelihood that residents are not safe from accidents and hazards (e.g., possession of contraband and illegal substances).

Recommendation: LHH will expand its BERT program and embed it in the care plan process in order to develop individualized interventions in care plans that are compliant with Phase 3 for residents with BH and SUD needs. The BERT program will also include care plan evaluation for those with BH and SUD to assure that LHH is following the proper care plan process, which includes assessment, care planning, intervention evaluation, reevaluation, and revision. Data from the observations will be analyzed for trends and patterns to identify gaps and areas of improvement to be acted upon by QAPI. **(Intermediate action)**

Analysis and Findings

Policy and Process Flow

After admission, the Omnibus Budget Reconciliation Act (OBRA) assessment process begins. The initial care plan is developed within 48 hours of admission. The care plan is to be updated regularly as changes occur by members of the IDT to include the MDS coordinator, the charge nurse, the direct care nurse, social services, dining services, and the activity department through resident care conferences (RCCs). The MDS coordinator ensures the process is completed in accordance with policy and regulations. The care plan serves as the primary communications tool for the residents' needs and preferences to guide the caregiver to ensure quality care.

The facility does not update the care plan to reflect current treatment and services for the resident to receive accurate and appropriate care. This was observed when attending RCCs that often do not include residents or family members and ancillary departments, such as activities, food and nutrition services, therapy, pharmacy, and the attending physician. This results in a care plan that is not individualized or reflective of changes in condition or resident preferences.

Additional findings related to the care plan include:

- Pre- and post-pain assessments are not completed in care plans per CMS guidance to anticipate pain, such during certain procedures, care, or treatment.
- LHH does not provide treatment that matches the orders nor are the care plans properly used to manage resident care (e.g., range of motion and respiratory therapy).
- There are no quality review checks of the care plans in comparison to physician orders (e.g., discrepancy in delivery method and flow of oxygen).
- There is no standardized process, such as a Kardex, to communicate shift-to-shift regarding care plan updates and changes in condition (e.g., range of motion needs, the detection of potential illicit drug use following resident out on pass, and accurate pain assessments following medication administration).

Four critical human factor elements contribute to the deficient care planning process, including: 1) lack of MDS Department oversight, organization, and developed systems to meet the size and

scope of LHH, resulting in minimal reviews and quality checks of care plans to ensure accuracy after each assessment; 2) lack of critical thinking and necessary resident and staff interaction of the MDS care plan process, even though all MDS staff hold Resident Assessment Coordinator (RAC) certifications; 3) failure to update policies/procedures (e.g., trauma-informed care, reimbursement [Resource Utilization Group (RUGs) to Patient Driven Payment Model (PDPM)], and Phase 3); and 4) not following industry standards for the care plan process, resulting in the care planning being delegated to charge nurses and direct-care staff who have limited training in MDS coding process and care planning.

The process to invite and include residents in the care plan process meets the minimal requirements for notification and not the intention for participation. The facilitation of the RCC meetings is inconsistent with some allowing virtual attendance versus in-person attendance (which was required), often hampering effective communication and participation by all team members.

In addition, the majority of the MDS Department is physically located in offices in a section of the campus that is a considerable distance from the nursing units, which results in limited opportunities for direct contact with residents and unit staff to ensure MDS and care plan information is accurate and up to date.

The MDS team does not have processes and redundancies to complete job tasks when staff are out on leave, such as audits, facilitating RCC meetings, and care plan updates. For example, only one staff member had access to the Quality Improvement and Evaluation System (QIES) to submit MDS data to CMS. This creates the potential that MDS was not transmitted in a timely manner if that staff members was not present at the facility.

QAPI

The QAA Committee is not using proactive assessment tools (e.g., critical element pathways). Additionally, the QAPI Program does not define metrics that appropriately measure risk (e.g., care plan individualization and resident/representative participation). This can lead to a false sense of regulatory compliance while independent audits demonstrate widespread data inaccuracies.

Staffing & Competencies

Competency and Qualifications

Staff has not been properly trained to develop care plans appropriate for those with substance use disorders and/or behavioral health issues. Therefore, they rely on generic template care plans versus individualized care.

All MDS Department staff are RAC certified and are qualified to complete the tasks of coding of the MDS, coordinating and completing the care plan, and ensuring interventions are accurate. Nursing leadership (e.g., nurse managers and charge nurses) are not always effective in their skills to ensure direct caregivers implement the interventions that were identified in the care plan. For example, there are no competencies for nursing staff related to pain assessments. Staff are not trained to identify symptoms of illicit drug use or de-escalation skills for residents with aggressive behaviors. Assessments also show that staff could not speak to where to find information on meal substitutions, which should be in the care plan. The charge nurses and

direct-care staff, who have MDS coding work delegated to them, are not specifically trained in the MDS/care plan process. Other members of the IDT do not fully understand their role in the care plan process, limiting a holistic perspective of the residents' needs and preferences.

Staff Performance

The lack of nursing home administrator (NHA)/director of nursing (DON) oversight or strong department leadership for the MDS group creates a culture of blame and minimal accountability structures, limiting systemwide understanding of outcomes. Nursing leadership does not conduct regular rounds, so they do not know the residents' baseline condition. This impacts their ability to effectively participate in the development and update care plans to meet the individualized needs of the residents. Proactive unit-based audits are not analyzed and addressed by nurse leaders (e.g., pre- and post-pain assessment, abnormal vital signs, personal food preferences, and toxicology reports).

The lack of an NHA or DON with regulatory acumen coupled with a facility that is reactive and not proactive leads to an inability to identify and communicate adverse events and unsafe, hazardous conditions. Furthermore, the facility may fail to implement measures to reduce risk or ensure care plans are updated.

Specific to care plan development, staff performance does not meet the expectations of the care planning policy or procedures already in place by the facility. Chart reviews and CEP assessments demonstrate that care plans are not individualized, updated or revised to reflect the current or changing status and needs of the residents. The MDS staff and other key members of the IDT are not consistently attending the RCC meetings, resulting in generic care plans.

Specific to intervention implementation, when staff do not carry out care plan interventions, there are no checks and balances or disciplinary consequences to these actions, resulting in non-compliance.

Staffing Level

Staffing levels are sufficient in the MDS Department. The Nursing Department, however, has a staffing shortage and does not use a consistent staffing schedule, which decreases staff knowledge of resident baseline information and the ability to recognize changes in conditions as they occur. This is particularly true of residents with behavioral health, pain management, range of motion, and respiratory therapy concerns.

Technology & Data Integrity

The EHR is not enhanced for long-term care plans, resulting in caregivers having to use a "workaround process" to modify problems with interventions. Thus, care plans are not in a readable format that staff can use at a practical level and lack interventions with specificity and accuracy. The layout also shows current and resolved interventions (e.g., up to 20 interventions for one issue). This makes care plans difficult to read, understand, and apply to the residents' daily current needs and tasks. Direct-care staff do not have access to a daily snapshot, such as a Kardex, to quickly understand the residents' needs and preferences.

Communication

While the care plan is the primary communication tool between IDT members and the RCC, it is rarely used at LHH as a resource with direct caregivers. This is critically important with the use of registry staff or temporarily assigned individuals. Assessments show that the care plan is rarely accessed for resident information and relies heavily on word-of-mouth, change-of-shift reports. This leads to a task-oriented care dynamic (i.e., IV, wound treatments) versus whole-person care (i.e., psychosocial, potential for accidents, trauma-informed care, Preadmission Screening and Resident Review [PASRR]).

While there is a process in place for registry staff to receive orientation prior to the start of shift, registry staff are often not included in daily huddles during shift change where key information about residents are shared.

7. Competent Staff, Training, and Quality of Care

Problem Statement

Leadership, management, facility staff, and medical staff do not have knowledge of SNF regulations and do not know how to operationalize the regulations in a very large SNF, how to validate findings/data and performance issues, how to manage staff, and how to educate staff to ensure sustainable, substantial compliance. In addition, current communication and staff training methods do not fully support ongoing needs for effective knowledge management and skills development, especially in relation to SNF and healthcare facility regulations, to ensure staff are fully competent to provide quality care.

Survey Citation(s) Reviewed

The adequacy and competency of LHH staffing and the provision of quality of care and quality of life for LHH's residents in compliance with 42 C.F.R. § 483.35(a)(3)(4)(c) (F726).

Training of all LHH staff regarding the identification of contraband and the systems in place to ensure resident safety with regards to contraband in compliance with 42 C.F.R. § 483.35(a)(3)(4)(c) (F726).

Ensuring that each resident receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices in compliance with 42 C.F.R. § 483.25 (F684).

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Lack of leadership with SNF experience, regulatory knowledge

LHH does not have a dedicated NHA, a DON, an IP leader, or a SNF medical director with relevant SNF experience, resulting in a lack of SNF regulatory knowledge and limited staff competencies. This increases the likelihood of inappropriate care, lack of processes and policy development, and inadequate daily operations to meet the needs of the SNF resident population.

Recommendation: LHH will require executive leadership, pertinent medical staff, and management staff members to possess/acquire the appropriate SNF-related licensure, certification, and/or credentialing. A nursing home administrator will be required even though LHH is licensed as a hospital Distinct Part (D/P) SNF; therefore, an NHA is not required by the regulations. **(Stronger action)**

Root Cause 2: Lack of care rounds to reinforce training and knowledge

LHH leadership and middle management do not consistently perform routine care rounds at the facility, resulting in staff perceiving leadership as uninvolved at the frontline. Regulations, policies, and training are not reinforced at the unit level; staff do not feel comfortable raising quality concerns; and leadership is unaware of staff performance issues.

Recommendation: LHH will implement an executive leadership and middle-management rounding program that reports through the QAPI Program. An executive dashboard will be utilized to monitor compliance on rounding, and subsequent findings will be addressed in a timely manner to ensure staff are performing according to professional standards of care. Residents' input and feedback will be reviewed regularly. LHH will also develop a plan to use industry expert coaches to consult and support executive leadership and management on improvement in high-vulnerability areas. **(Stronger action)**

Root Cause 3: Lack of accountability for mandatory educational requirements

There are no consequences for employees and medical staff not completing mandatory education, resulting in some staff providing care without the tools and knowledge necessary for optimal resident outcomes.

Recommendation: LHH will monitor, through the QAPI Program, mandatory staff education compliance with an executive dashboard. LHH will also implement policies that include accountability and progressive disciplinary actions for non-compliance regarding mandatory education and training. **(Stronger action)**

Root Cause 4: Lack of focused scope of work in Department of Education and Training (DET)

The DET's scope of work (SOW) requires many human resource functions, such as validation of licensure, annual vaccine compliance (e.g., flu), and tracking CPR compliance. The DET resources are diverted to HR responsibilities, limiting its ability to develop a robust educational program.

Recommendation: The HR functions should not be part of the DET's SOW. The DET will focus on training instead of HR functions. This will allow the DET to have a robust program that meets the educational needs of staff and improves regulatory compliance.

LHH will complete an assessment of DET tasks and responsibilities, review industry standards and best practices, and realign work to the appropriate departments to increase DET bandwidth to meet the educational needs of staff. **(Stronger action)**

Root Cause 5: Adult learning approaches absent in training

Staff training relies heavily on "read and sign." The electronic learning management (ELM) system is in English only without additional adult learning techniques for a multi-lingual staff that encounter many barriers to computer accessibility. This results in limited access to and comprehension of educational materials and an inability to ask questions and validate staff comprehension.

Recommendation: LHH will conduct focus groups with direct-care, medical, and ancillary services staff to determine preferred learning methods to improve knowledge management and skills development. LHH will modify its current education program to apply adult learning techniques, such as teach-back, videos, and 24/7 in-person educational rounds, to complement standard staff messaging and verify return demonstration on new policies and/or regulatory-based education. The ELM will have additional languages available to meet the needs of staff.

LHH will develop and implement a strategy to overcome barriers to computer accessibility. **(Intermediate action)**

Root Cause 6: LHH leadership not members of SNF associations

LHH executives and pertinent medical staff are not members of traditional SNF associations (e.g., California Association for Healthcare Facilities [CAHF], American Health Care Association (AHCA), National Association of Directors of Nursing Administration of Long-Term Care [NADONA], the Association for Professionals in Infection Control [APIC]), which limits their ability to stay current with industry best practices (e.g., CASPER reports and CEP). This results in regulations and best practices not being implemented and LHH not operating in alignment with SNF industry standards of care.

Recommendation: LHH will complete an environmental scan of trade associations and industry resources and require leadership and pertinent medical staff to become members, actively participate, and share knowledge with LHH staff. **(Intermediate action)**

Analysis and Findings

Policy and Process Flow

Per the Staff Education Program Policy, last revised 9/13/16, all employees must attend hospital-wide orientation at the time of hire, or if unable to attend, make alternative arrangements to receive training. This training includes computer-based, hospital-wide orientation training related to culture, strategic goals, safety, and regulatory requirements. Annually, employees are provided with year-round mandatory in-services that meet Federal, State, and city requirements. LHH lacks a standardized unit-based orientation program for new hires.

Data from QAA Committee indicate low compliance with staff's completing annual competencies. Additionally, there is no disciplinary or accountability process in place for staff who do not complete the education by the due date.

Monitoring of compliance through the QAPI Program does not meet expectations set by leadership. When non-compliant events occur (such as staff not completing training) and/or regulatory non-compliance (high use of inappropriate physical restraints), leadership fails to look at the systemwide process and focuses instead on isolated incidents.

LHH relies heavily on "read and sign" and an ELM system for education rather than in-person and/or adult learning teaching methods (i.e., utilizing a champion PCA for unit training and updates, nurse leadership mentoring to observe processes and provide insight, return demonstration after education, teach-back, case studies and scenario-based training with an opportunity for Q&A, or office hours for questions). When LHH staff use "read and sign," it is in a rushed mode often requiring a same-day on-demand signature without the ability to ask questions for comprehension. The education packet often exceeds 10 pages and is not in staff's primary language, limiting true comprehension of the educational materials. Barriers to completing education are staffing, time to complete education, English as a second language, and computer access. Staff are not held accountable by management to complete mandatory education requirements by the due date.

Staffing & Competencies

Competency and Qualifications

Many newly hired staff do not have SNF experience or regulatory knowledge.

An education completion compliance report is distributed to managers and department directors monthly. There is no defined follow-up process to hold staff accountable or disciplinary process until compliance is obtained. Leadership has not set clear expectations for professional standards of care for the unit managers nor trained them to enact disciplinary processes, including for gross and flagrant situations.

No clear expectations have been set for staff as they relate to timely completion of mandatory/annual/on-the-spot education and regular follow-up by managers. Failure to comply with required training to measure competency could result in resident harm and quality of care issues, e.g., escalating changes in condition, not following the care plan, not utilizing communication boards, not suctioning respiratory secretions, and not providing timely meal assistance.

Some security support team members indicate that they do not receive training specific to LHH policies and procedures and do not have a clear and consistent understanding of their role in screening visitors. When contraband and illegal items are noted in care areas, nursing staff are unsure how to proceed.

LHH executives are not part of traditional SNF associations (e.g., CAHF, AHCA, NADONA, APIC), limiting their knowledge and awareness of effectiveness SNF training as it relates to the regulations and quality-of-care outcomes for residents.

Staffing Level

Staff vacancies continue to go unfilled in the DET. In addition, the scope of DET includes activities typically found in a Human Resources Department (e.g., license/certification verification, CPR). This directs them away from ongoing development and administration of training, including competencies.

The facility utilizes core staff, registry staff, float staff, PRN staff, and overtime to ensure proper staffing levels. During times with high rates of staff absences, staff who are scheduled for education sessions are redirected to direct-care assignments. This results in ongoing education non-compliance, impacting staff competency. In those situations, leadership does not follow up to ensure required education is completed and comprehended

Staff Performance

Staff lack knowledge of policies and procedures to escalate changes in condition, delays in treatment, and resident safety and quality of care issues to leadership for assistance. Staff do not follow policies and procedures and code of conduct requirements. Examples include wearing ear buds on shift, inappropriate feeding assistance, not utilizing appropriate communication boards per resident requests, and not suctioning residents, as needed.

Technology & Data Integrity

There is a computer lab on the campus, but it is not in close proximity to the nursing care areas. Access to the computer lab requires supervisor presence and a pre-scheduled time, and the lab is not available on all shifts/7-days a week for staff access. In addition, some staff report they do not have access to the training because they do not have an LHH email, which is required for log in. The ELM format is only in English, which is a barrier for some staff (e.g., basic life support training that typically takes 2 hours took in excess of 8 hours for some CNAs with language barriers).

Communication

LHH lacks a coordinated communication process from the department/unit-based management level to the direct-care staff when policy changes are made, interventions need to be implemented, or process changes have occurred. This results in poor outcomes for surveys and plans of correction (POCs). The limited in-person communication process does not encompass the 24-hour-a-day, 7-days-a-week staffing at LHH.

The facility does not have standardized processes to convey resident information, such as standardized report sheets for nurses, standardized PCA care sheets (e.g., Kardex), and change-of-shift reports.

Communication between the security support team and LHH staff regarding contraband screening is inefficient, resulting in delays in certain security interventions being implemented.

Assigned ELMs and mandated education are usually communicated through SFDPH email and a calendar available on the LHH intranet. This does not take into account language barriers or lack of computer/internet access.

8. Emergency Preparedness Program (EPP)

Problem Statement

LHH's EPP does not have elements in place, such as readily available emergency information, resulting in an ineffective program that lacks standardization across the facility. LHH also has gaps in regular training and exercises, contributing to an EPP that is out of compliance with Federal emergency preparedness requirements. This lack of awareness and knowledge of the EPP requirements leads to an overall lack of urgency among staff regarding emergency preparedness.

Survey Citation(s) Reviewed

Complying with all applicable Federal, State, and local emergency preparedness requirements, and establishing and maintaining an emergency preparedness program in compliance with 42 C.F.R. § 483.73.

Ensuring that the facility is designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public and in compliance with 42 C.F.R. § 483.90.

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Lack of alternative communication methods during emergencies

Communication methods (e.g., communication radios, mass text messaging) have not been implemented, resulting in continued reliance on an ineffective overhead paging system. This increases the likelihood that staff do not hear emergency announcements and do not respond quickly during an emergency.

Recommendation: LHH will develop processes and communications that focus on urgent, resident-centered responses during an emergency. LHH will update its paging system to ensure it can be easily heard throughout the facility. LHH will also implement and routinely actively test and implement multiple alternative communication methods to ensure communications reach all staff during an emergency. **(Stronger action)**

Root Cause 2: Lack of leadership involvement in the EPP

Leadership has not made emergency preparedness a priority for the facility, which leads to a lack of a sense of urgency or indifference by staff. Staff continue their routine tasks when an alarm or overhead page is activated, which increases the risk of resident and employee harm during an emergency. Leadership has also not engaged external partners in LHH's EPP.

Recommendation: LHH will create a calendar of leadership rounds to actively interact with staff members to communicate and reinforce expectations for emergency preparedness. In addition, leadership must be an active participant in EPP drills in resident care areas to set the systemwide standard for emergency response and ensure staff are appropriately responding.

Leadership will also actively participate in LHH's local emergency preparedness coalition. Leadership participation will be documented during EPP after-action reports (AARs) and monitored at QAPI. **(Stronger action)**

Root Cause 3: Hazard vulnerability exercises not routinely conducted

Hazardous vulnerability exercises are not regularly conducted, resulting in staff not being prepared to respond to emergencies, including those unique to LHH. This increases the likelihood that staff will not take appropriate actions to prevent harm to residents and themselves.

Recommendation: LHH leadership will complete a comprehensive hazardous vulnerabilities assessment (HVA). Incorporating the findings of the HVA, LHH will schedule and perform tailored drills and exercises to maintain staff readiness. LHH will complete an AAR after each drill. Results of the AAR and opportunities for improvement will be promptly communicated to staff and managers. Results will also be reported and monitored at QAPI. **(Intermediate action)**

Root Cause 4: EPP resources not readily accessible to staff

The EPP has no secondary documentation process and other vital pieces of information (such as unit-specific, color-coded binders; appropriate signage; maps for emergency shut offs; processes to obtain emergency equipment and services; generator information) are not readily accessible on all units within the facility, resulting in a lack of important information available to staff during an emergency. This increases the likelihood that staff do not respond appropriately.

Recommendation: LHH will create and regularly update unit-based emergency guidance manuals accessible in multiple areas per unit with appropriate language translations to meet staff needs and train staff on the contents of the manuals. LHH will electronically back up all emergency preparedness materials. The emergency preparedness badge buddies and signage will be reviewed and updated annually, and as needed, to ensure they are current and readable during an emergency. Charge nurses will be responsible on each shift to make sure staff, including registry staff, are wearing their badge buddies. **(Intermediate action)**

Root Cause 5: Staff not adequately trained for emergencies

Annual and at-time-of-hire emergency preparedness training is completed online and is available only in English, resulting in limited comprehension among staff at LHH who speak different languages and who have many learning styles. This increases the likelihood that staff are not able to articulate the meaning of emergency codes on name badges, utilize a fire extinguisher, or execute emergency preparedness procedures.

Recommendation: LHH will develop and implement a more comprehensive and robust EPP training and education program. This training program will be rooted in adult learning principles, such as scenario-based training or teach-back, and incorporate multiple learning modes, e.g., electronic and in-person. Training materials will be translated into the primary languages spoken by LHH staff and will include table-top exercises with scenarios based on the HVA results, badge-buddy definitions, and security-team collaboration (i.e., the sheriff and security team). **(Intermediate action)**

Root Cause 6: Resident and Visitors Unaware of Emergency Plan

Residents and resident representatives are unaware of their responsibilities as outlined in the emergency plan, which is not provided to them at the time of admission, nor are they included in EPP exercises, resulting in residents and visitors not being prepared during an emergency. This increases the likelihood of harm.

Recommendation: Emergency preparedness information will be updated in the resident handbook and reviewed as needed and at least annually. These updates will be communicated to the resident council and all residents to ensure the resident population is aware of its role during an emergency. Residents will also be included in drills and exercises. Resident participation will be documented in EPP AARs and monitored at QAPI. **(Intermediate action)**

Analysis and Findings

Policy and Process Flow

Per LHH's Emergency Preparedness Plan, staff will be able to demonstrate and respond appropriately to an emergency based on education and routine exercises. Residents and their representatives should be educated at the time of admission. Activation of the Hospital Incident Command System (HICS) structure will be initiated through the duration of an emergent event.

Findings show that LHH does not have a clear process for disseminating essential information needed at the department level to manage emergencies. This includes maps for emergency shut offs, the process to obtain emergency equipment, generator information, and EPP binders. EPP binders that outline processes for potential emergencies are not readily available on all units and common spaces within the facility.

The Emergency Preparedness Plan was compiled into a binder and housed in the Chief Operating Officer's (COO's) office. This binder was unable to be located since May 2022 and needed to be recreated by the new Safety Officer. Documents were not previously saved electronically, and items had to be re-created.

LHH has an ineffective process for conducting drills and does not ensure participation from all appropriate departments, e.g., the Administration building.

Exercises of the emergency plan for Hazardous Vulnerabilities (fire, earthquake, elopement, active shooter, power outage) are not conducted and staff are unaware of how to respond appropriately.

During actual emergency activations (power outages, fire alarms and water management issues), LHH staff lack urgency when responding. Examples include:

- During a power outage, secured area doors (memory care unit, stair wells) were not supervised. Staff were asked to articulate their resident census, resident whereabouts, EHR status, and emergency protocols and did not react or have the knowledge to articulate.
- A fire alarm sounded throughout the entire facility and timely evacuation of the administration building did not occur as this building does not conduct drills. Staff were observed exiting almost 30 minutes after the activation of the alarm.

- When a resident left the campus repeatedly, the staff inconsistently called a Code Green (Elopement). When the Code Green was called, the team did not execute the emergency plan, demonstrating a lack of knowledge. Interventions were not put into place to keep the resident safe from continuous elopements.

Residents and visitors are unaware of the Emergency Preparedness Plan, as it is not shared with them at the time of admission nor are they included in the exercises. Per LHH's staff training program on "Disaster Preparedness," residents receive information on an individual emergency plan. However, in practice, LHH is not following its own policy.

The Hospital Incident Command Structure (HICS) is only initiated at the leadership level. Frontline staff and middle managers do not know how to operate in the structure and training is not routine.

LHH's plan includes collaboration with internal multidisciplinary team members and the external community; however, in practice, LHH lacks internal and external collaboration for emergency preparedness. This has created deficiencies within its program, including a lack of full facility awareness (staff, residents, visitors) of the emergency preparedness program and a lapse in monitoring, compliance, education, and drills.

The facility must complete and review its HVA on an annual basis or as needed and collaborate with community entities. This practice has not consistently involved an IDT approach or included the community to integrate for emergency support.

Staff have emergency codes on their name badges but cannot articulate the meaning. Some of the badges are old and information has rubbed off. LHH does not have a clear policy/procedure to update badges.

Staffing & Competencies

Competency and Qualifications

Frontline staff do not have knowledge surrounding the Emergency Preparedness Plan and therefore are unable to articulate or appropriately demonstrate what to do when an emergency arises.

The staff are educated at time of hire and annually on emergency preparedness; however, education is completed via an online program, is in English, and does not include adult learning principles. Staff are only provided with fire emergency training during routine drills.

In most nursing home settings, the Facilities (Maintenance) Department owns emergency preparedness and fire and life safety. At LHH, the Facilities Department only owns fire and life safety and believes it has no ownership of the EPP. This approach has created barriers and confusion between the Safety Officer and the Facilities Department. Furthermore, the Safety Officer role was vacant for two years prior to May 2022, resulting in no oversight of the EPP. To remedy this, SFDPH deployed a Safety Officer, who does not have SNF experience.

Staff Performance

A lack of leadership ownership and productivity surrounds the EPP. Due to the lack of accountability, policies and procedures, community-wide partnerships, and drills have not been executed appropriately. In addition, leaders do not have an active presence at the unit level to communicate any issues or corrective actions to direct-care staff members.

A siloed approach exists, and teams do not work together to ensure residents are safe. Non-nursing departments do not initiate assisting the unit most affected by the emergency; thus, the responsibility remains exclusively with the Nursing Department.

When an alarm, signal, or overheard page is activated to announce an emergency code, staff react with no sense of urgency. They continue to perform routine tasks without responding to the emergency.

Technology & Data Integrity

The paging system has multiple deficiencies, including low alarm volume and speakers that do not carry voices clearly (e.g., inaudible words or static). These deficiencies impact the ability to communicate an emergency effectively. Other methods of communication (e.g., radios, mass text messaging) are not utilized.

Communication

Leadership has not engaged its affiliated acute care hospital and external community partners, including the city's Public Health Emergency Preparedness and Response team (PHEPHR)

As a SNF, LHH does not participate in any healthcare associations that provide training and resources for emergency preparedness.