# Laguna Honda Hospital & Rehabilitation Center (LHH)

## April 2023
## Quality Improvement Expert (QIE) Monitoring Report

### Health Services Advisory Group, Inc. (HSAG)

**Monitoring Report #4**
**May 10, 2023**

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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).

LHH has directed the QIE to perform four root-cause analyses (RCAs) and report the results:

- RCA Report #1 detailed the factors contributing to LHH's decertification from the Medicare Program. It addressed deficiencies identified during surveys between October 14, 2021, and April 13, 2022.
- RCA Report #2 addressed findings of the first 90-day monitoring survey conducted between November 28, 2022, and December 16, 2022.
- RCA Report #3 addressed findings of the Life Safety Code (LSC) and Emergency Preparedness (EP) surveys conducted between March 13, 2023, and March 15, 2023.
- RCA Report #4 addressed findings of the health survey conducted between March 13, 2023, and March 17, 2023.

LHH, in consultation with the QIE, developed an Action Plan to address the RCA findings. It includes improvement solutions that must be addressed to ensure long-term substantial, sustained compliance in the future with Federal participation requirements. The Action Plan must be fully implemented by May 13, 2023.

## Monthly Monitoring Reports

After CMS' approval of the LHH Action Plan, the QIE is required to provide monthly written monitoring reports. The QIE is required to submit the monitoring reports to CMS by the 10th calendar day of each month. These monitoring reports will also be sent contemporaneously to the California Department of Public Health (CDPH) and LHH. Under the settlement agreement, the QIE monitoring report must include, but is not limited to, the following information.

1. Dates and times of the visits by the external QIE
2. Summary of observations made during the visits
3. Summary of any interviews conducted and with whom
4. Summary of records reviewed
5. Any quality concerns identified
6. Any complaints related to resident health and safety received and reviewed by the QIE
7. Number and description of complaints received by LHH from any source
8. Number and description of incidents reported to CDPH
9. Assessment of LHH in meeting established goals outlined in the Action Plan
10. Obstacles on each item of LHH's Action Plan and proposed solutions to those barriers
11. Summary of any proposed or enacted transfers and discharges

The monitoring reports will be organized by the 11 items listed in the settlement agreement.

# Monitoring Report #4 Time Period

Monitoring Report #4 covers the April 1, 2023, to April 30, 2023, reporting period. This report was submitted to CMS, CDPH, and LHH on May 10, 2023.

# 1. QIE Visit Dates and Times

## Section Overview

This section provides the dates and times of on-site visits made by external QIE staff members to LHH between April 1, 2023, and April 30, 2023, as shown in Table 1. During on-site visits, QIE staff members visited LHH nursing units, attended huddles and resident meetings, reviewed Action Plan deliverables, observed emergency drills, and met with leadership one-on-one and provided coaching around skilled nursing facility (SNF) regulations. In addition to these on-site visits, QIE staff attended numerous virtual meetings to observe Action Plan progress.

The second CMS 90-day monitoring survey occurred between March 13, 2023, and March 17, 2023. LHH received the CMS 2567 EP and LSC reports on April 7, 2023. The QIE submitted RCA Report #3 on April 17, 2023. LHH received the CMS 2567 health report on April 13, 2023. The QIE submitted RCA Report #4 on April 23, 2023.

## Site Visits

**Table 1. QIE Site Visit Dates and Times**

| Site Visit Date | Site Visit Times |
|---|---|
| April 3, 2023 | 1 p.m. to 5 p.m. |
| April 4, 2023 | 8 a.m. to 4:45 p.m. |
| April 5, 2023 | 8 a.m. to 5:15 p.m. |
| April 6, 2023 | 8 a.m. to 12 noon |
| April 10, 2023 | 1 p.m. to 5 p.m. |
| April 11, 2023 | 8 a.m. to 5 p.m. |
| April 12, 2023 | 8 a.m. to 5:15 p.m. |
| April 13, 2023 | 8 a.m. to 12 noon |

# 2. Summary of Observations

## Section Overview

This section provides a summary of observations made by the QIE between April 1, 2023, and April 30, 2023, during on-site visits at LHH. During its site visits, the QIE rounded nursing units, attended huddles, and observed resident activities. The observations are organized individually by title in chronological order of when the observations were made.

## Observations

### QIE Action Plan Office Hours

***Date(s):*** April 6, 13, 18, 20, 25, and 27, 2023

***Observation:*** During April 2023, the QIE provided virtual office hours during which LHH staff members asked questions about Action Plan items, deliverables, and deadlines. These meetings were available to all LHH staff members to support deliverable completion. This month, the QIE scheduled six office hour sessions with a total of 28 LHH staff members attending. The descriptions below identify the date of the session, the number of attendees, and the topics that were discussed with the QIE.

**April 6:** Six LHH staff members attended office hours. The QIE answered questions about tracking attendance and the training agenda for the April staff education fair. The education focused on addressing Action Plan training milestones related to fire and life safety (FLS) topics and emergency preparedness procedures. The QIE provided insight on how to verify and document staff training. The QIE answered questions about increasing attendance at resident council meetings. Strategies included continuing to have residents RSVP for meetings. The QIE encouraged LHH staff members to follow up on RSVPs to remind residents about the meetings and to help residents get ready for the meetings. The QIE and LHH staff members discussed creating a template to support teach-back training during rounding. This template was created and implemented by the April deadline. The QIE answered questions regarding LHH's work plan to further customize LHH's electronic health record (EHR) to support skilled nursing care.

**April 13:** Four LHH staff members attended office hours. The QIE answered questions about the modalities (e.g., in-person huddles, one-on-one discussions, or virtual meetings) available to train direct-care staff on the Kardex system to support the daily use of resident care plans as well as EHR documentation for resident nutritional needs. The QIE answered questions on how to improve data displayed on the facility's executive dashboard to monitor the facility's progress of work orders and preventative maintenance (PM).

**April 18:** Four LHH staff members attended office hours. The QIE answered questions related to combining emergency preparedness training topics, such as electronic alert systems and emergency preparation quick reference guides, and the best way to track completion of training by staff members. The QIE answered questions related to how to effectively display graphs to improve communication of data and how to address unresolved issues on meeting minutes.

**April 20:** Nine LHH staff members attended office hours. The QIE answered questions about staff training documents on the facility's updated PM program. The QIE confirmed that recent updates to the facility's restorative program's policy and procedures met the intent of the Action

Plan milestone. The QIE answered questions on how to integrate the facility's Behavioral Response Team (BRT) protocol into current education initiatives (e.g., the April education fair and team huddles). During the office hours, the QIE worked with LHH staff to modify a deliverable to verify that intentional rounding occurred on pilot nursing units. The QIE confirmed that the monthly education developed for staff around lessons learned from past emergency preparedness drills meets the intent of more than one milestone. The QIE also clarified what data elements and visuals should be included in the Quality Assurance & Performance Improvement (QAPI)/ Quality Assessment and Assurance (QAA) meeting. Examples include identifying high-level metrics to display prominently and the use of trend lines to shows trends and patterns.

**April 25:** Four LHH staff members attended office hours. The QIE answered questions around deliverables for the biomedical engineering department's new, proactive PM process. During the office hours, the QIE also supported LHH staff members with developing educational materials with simplified language and pictures to support staff's understanding of FLS terms, such as "means of egress." The QIE worked with LHH to develop a schedule to attend future community emergency preparedness exercises and drills.

**April 27:** One LHH staff member attended. The QIE reviewed LHH's behavioral health workplan and discussed ways to address the challenges they are facing with hiring new behavioral health specialists and how they plan to fill that gap while recruitment continues.

**CDPH Regulatory Advisor Meetings**

***Date(s):*** April 7 and 21, 2023

***Observation:*** Weekly advisement meetings with CDPH continued during this reporting period. The meetings were attended by LHH executive leadership, the QIE, and the CDPH Bureau Chief of Field Operations-Bay Area Region. The objectives of these meetings were to review barriers to the recertification work and provide an opportunity to seek advisement on regulatory compliance.

**April 7:** CDPH provided LHH leadership with guidance on federal hospice regulations. LHH provided CDPH with its policies and procedures specific to their palliative care unit and inquired about best practices when contracting with local hospice agencies. CDPH said it was important to understand that palliative care does not equal hospice care. CDPH emphasized that residents in skilled nursing beds should receive skilled services.

LHH provided CDPH with a case study of a resident who requires dialysis and has a documented history of risky behaviors, including leaving the dialysis center once the transportation leaves. LHH sought guidance on how to balance residents' rights and safety. CDPH stated that surveyors are looking for good communication between LHH and the dialysis center to coordinate care. Surveyors are also looking for documentation in the medical record and individualization of care plans.

In March 2023, CDPH offered LHH a nursing home administrator (NHA) consultant team to support the recertification efforts. Ongoing conversations will occur to decide when that resource will be on site to assist LHH. The group continued to discuss potential projects, including Preadmission Screening and Resident Review (PASRR), physical restraints, LHH's out-on-pass

(OOP) policy and procedure, LHH's bed hold policy and procedure, the wound care program, and medical director support.

**April 21:** LHH and CDPH discussed the recent COVID-19 outbreak at the facility. CDPH agreed to provide an infection control expert to review LHH's mitigation plan.

LHH leadership, CDPH, and the QIE finalized the areas on which the new NHA consultant team will focus in its support of LHH. These areas include: (1) PASRR, (2) bed holds, (3) appropriate utilization of physical restraints, (4) OOP, (5) wound care management, (6) oversight of regulatory affairs, and (7) the role of the medical director. The NHA consultant team will consist of five people and will start on May 1, 2023.

The CDPH Bureau Chief of Field Operations also agreed to meet with LHH leadership on April 27, 2023, to discuss abuse regulations and investigations. The LHH executive team, nursing leadership, and quality management staff were required to attend the meeting.

**Grievance Boxes and Form Holders: LHH South Tower**

***Date(s):*** April 4, 2023

***Observation:*** The QIE rounded on all South Tower units and confirmed that grievance boxes and grievance form holders were placed on all nursing units by the elevators, as required by the Action Plan. The QIE observed three folders, labeled English, Spanish, and Chinese, in each of the form holders. The folders contained grievance forms available in the three predominant languages spoken by LHH residents. However, the QIE observed that the wording on the grievance boxes was only in English. LHH's Resident and Safety Advocate shared with the QIE that new labels, in the three languages, for the grievance boxes have been ordered and are pending delivery.

**Unit-Based QAPI Psychotropic/Behavior Subcommittee Meeting: Nursing Unit Pavilions Mezzanine Skilled (PMS)**

***Date(s):*** April 4, 2023

***Observation:*** The QIE attended and observed the unit-based QAPI psychotropic/behavior subcommittee meeting held on PMS. These unit-based QAPI meetings are being implemented in all nursing units to ensure consistent monitoring of problem-prone, high-risk areas of resident care. Attendees included LHH staff members from the nursing, social services, quality management, Minimum Data Set (MDS), pharmacy, and medical staff. The unit's nurse manager led the meeting with an agenda focused on gradual dose reduction, new and existing resident behaviors, and unnecessary medications. Two residents were reviewed by the subcommittee.

**Unit-Based QAPI Infection Control and Antibiotic Stewardship: Nursing Unit North 2**

***Date(s):*** April 5, 2023

***Observation:*** The QIE attended the Unit-Based QAPI Infection Control and Antibiotic Stewardship QAPI meeting held on North 2. This was the first time this meeting was held. These unit-based QAPI meetings are being implemented in all nursing units to ensure consistent monitoring of problem-prone, high-risk areas of resident care. Participants included the nurse manager, the unit-based infection prevention champion, and several frontline staff members. It was noted that the infection prevention champion has not yet received training for his or her role as the champion. The subcommittee reviewed residents receiving antibiotics and their diagnoses,

residents with infections, residents with foley catheters, residents with fistulas for dialysis, and residents requiring tube feedings. The infection preventionist was not in attendance; therefore, data were not presented to identify trends and patterns of concern. The nurse manager adjourned the meeting and intended to follow up with the infection preventionist and the pharmacist to ensure future attendance at meetings.

**Executive Leadership Rounding: Nursing Unit North 5**

***Date(s):*** April 5, 2023

***Observation:*** The QIE accompanied the interim Chief Executive Officer (CEO) on executive leadership rounding on North 5. An Executive Leadership Rounding Form was used to provide structure to the rounding and interactions with residents and staff. During rounding, the interim CEO greeted staff and residents. The interim CEO interviewed one resident, who was new to the unit after transferring from nursing unit South 5. The resident did not express any issues or concerns. The QIE also observed that the interim CEO evaluated the environment of care, including checking the fire extinguishers' dates and making sure equipment was positioned on one side of the hallway. He also observed the unit for its homelike environment, infection prevention and control practices, and staff and resident interactions. The interim CEO reviewed the unit huddle board, noting LHH's recertification key performance indicators (KPIs) and other items. He also attended the North 5 staff huddle and was open to questions from staff.

**Nursing Action Plan Milestone Meeting**

***Date(s):*** April 5, 2023

***Observation:*** The QIE attended and observed the Nursing Milestone Meeting, which occurs weekly and supports Action Plan implementation. The agenda for the meeting included a review of all nursing milestones, April milestones that required resubmission, upcoming May milestones, LHH's daily management system (DMS), and nursing staff recognition. Attendees included the interim CEO, the interim Chief Nursing Officer (CNO), nursing directors, and clinical nurse specialists (CNSs). The group also discussed COVID-19 mitigation strategies, unit staffing levels, the use of resident coaches, consistent nursing director rounds on assigned units, and the use of the electronic learning management (ELM) system for training and education.

**Code Blue Drill: Nursing Unit South 6**

***Date(s):*** April 5, 2023

***Observation:*** The QIE observed a drill for "Code Blue," which indicates a medical emergency. The drill announcement was clear and audible and identified the location of the drill. A CNS and nurse educator directed the drill with nine staff members using an Adult CPR Manikin, which is a medical training device with defibrillation pads and automated external defibrillator (AED). Two staff members performed chest compressions. Respiratory therapy managed the oxygen and masking the Manikin. The crash cart was staffed by one nurse preparing the medications being ordered by the CNS. One nurse administered the medications. The other staff members present included the nurse manager and patient care assistants (PCAs). A physician arrived approximately five minutes after the drill was announced. An additional physician and pharmacist arrived 10 minutes later. The CNS called the end of the drill, and a Code Blue Drill "All Clear" was announced. The CNS and nurse educator debriefed staff after the drill and

reviewed several topics, including mask and oxygen placement, medications, and the oxygen tank on the cart.

**Unit-Based QAPI Wound and Nutrition Subcommittee Meeting: Nursing Unit South 4**

***Date(s):*** April 6, 2023

***Observation:*** The QIE attended and observed the South 4 Unit-Based QAPI wound and nutrition subcommittee meeting. These unit-based QAPI meetings are being implemented in all nursing units to ensure consistent monitoring of problem-prone, high-risk areas of resident care. The weekly meeting was facilitated by the nurse manager and attended by an MDS nurse, a physician, a dietitian, and the unit wound champion. The wound champion gave an update on new and existing skin integrity concerns for two residents. Follow-up on the two residents will consist of consulting the wound specialist. The dietitian reviewed the weight variance report, and the committee reviewed two residents with recommendations for increasing calories and weekly weights. Attendees were very interactive and engaged with the discussion. The MDS nurse updated the care plans as recommendations were discussed. After the meeting, the QIE interviewed staff in attendance. The wound champion commented on the value of the process to provide best care and treatment of residents in an organized and concise manner.

**LHH Resident/Safety Advocate Rounding: North and South Towers**

***Date:*** April 6, 2023

***Observation:*** The QIE and the LHH Resident/Safety Advocate rounded on the North and South Towers. Each grievance box in the North Tower was reviewed. There were no grievances in the boxes, and the form files contained grievance forms in English, Spanish, and Chinese. No resident follow-up on grievances was necessary. Each grievance box in the South Tower was reviewed. There were no grievances in the boxes, and the form files contained grievance forms in English, Spanish and Chinese. While on South 4, the Resident/Safety Advocate followed up with a resident who had filed a prior grievance, and he provided the resident with resolution. The resident accepted the resolution and signed the grievance form acknowledging resolution of his grievance.

**Bed Workshop: Moran Hall**

***Date(s):*** April 11, 2023

***Observation:*** The QIE attended LHH's second Bed Workshop, which was intended to evaluate beds that may be more appropriate for SNFs than the acute-care environment and appropriate side rails to assist residents who are independent ambulators and use side rails for getting out of bed or positioning. The bed vendor set up a long-term care bed and a specialty bed. The company representative was available to discuss the beds. Representatives from rehabilitation, Facilities, administration, environmental services, and Nursing attended the Bed Workshop. Members of the unit-based QAPI falls and physical restraint subcommittee were in attendance. There were extensive discussions around the bedrails, bed width, and mattresses requiring bolsters to fill in the gaps between the mattress and the bedrails. LHH requested assistance and resources on the use of bedrails. A document called "Siderail and Alternative Equipment Intervention Decision Tree" was shared with LHH staff members.

**Recertification Education Fair**

***Date(s):*** April 11-12, 2023

***Observation:*** The QIE attended and observed two sessions of LHH's Recertification Education Fair: Fire Emergency Response on April 11 and Huddle and Visual Management Board and QAPI on April 12. The purpose of the Recertification Education Fair was to provide in-person education and training on a large scale at LHH to address 29 milestones of the LHH RCA Action Plan requiring education and training. Following the education session, attendees were asked to complete a "2023 Recertification Education Fair Post Test," consisting of five questions to ensure knowledge retention. Overall, 1,242 of 1,262 (98.4 percent) LHH staff members attended the trainings during April 2023.

**Dietary Tray Line Meal Prep and Meal Tray Ticket Audits**

***Date(s):*** April 12, 2023

***Observation:*** The QIE observed lunch tray line meal prep and meal tray ticket audits. LHH staff members escorted the QIE around the kitchen area and provided a brief overview of the tray line processing approach. LHH's Chief Clinical Dietitian explained the meal tray ticket audit process.

The meal tray selected for meal tray ticket audit is predetermined and tagged for review. Once the selected meal tray reaches the end of the tray line, a supervisor removes the meal tray from the tray line and reviews the meal tray contents for appropriate diet against the diet orders and visual presentation. If everything is correct, the meal tray is loaded into the food cart for delivery to the nursing unit.

The QIE observed two trays that were selected for the April 12th lunch meal tray ticket audit. The first tray was retrieved from the tray line, audited without findings, and placed on the food cart for delivery to North 2. The second tray was not on the lunch tray line intended for South 4. Immediate investigation by the Food Service Manager into the missing meal tray revealed that the meal tray had been processed in an earlier batch for South 5 due to the resident's transfer to that unit earlier in the day.

**Executive Leadership Rounding: Nursing Unit North 3**

***Date(s):*** April 12, 2023

***Observation:*** The QIE accompanied the interim Administrative Director, Care Experience, on assigned executive leadership rounding on nursing unit North 3 from 10:30 a.m. to 12:30 p.m. An executive leadership rounding form was used to provide structure to the executive rounding on the unit.

Upon arriving on the unit, the interim Administrative Director signed in per protocol and began rounds by looking at the environment of care. During rounding, a bed delivered by Facilities was found in the hallway. The interim Administrative Director immediately alerted the nurse manager, who explained that the low bed was going to be exchanged and moved the bed to the resident's room.

The interim Administrative Director was observed greeting residents in the Great Room. While on the unit, the interim Administrative Director and QIE attended the unit huddle led by the acting unit manager. The QIE also interviewed two staff members who had attended the huddle regarding the huddle process. They shared that they liked the new system, and they get good

information; however, sometimes there is too much information to cover in 15 minutes and the huddle goes overtime. This puts them behind in their work. They noted that the huddle started at 10:45 a.m. and lasted to 11:15 a.m. The QIE shared this feedback with Nursing.

When the interim Administrative Director and QIE reached the Pavilion elevators on the ground floor, the QIE observed two trash bins in front of one of the elevators, which was not operational. The QIE noted that the trash bins should be replaced by signage indicating the elevator was out of service. The interim Administrative Director assumed responsibility to follow up with Facilities and Quality Management, which was done via email with the QIE copied. An email response from the facilities director indicated the issue will be addressed.

**Director of Nursing (DON) Interview Panel**

***Date(s):*** April 25-26, 2023

***Observation:*** The QIE participated in LHH's DON interview panel, which interviewed three DON candidates. (The DON interviews followed interviews LHH conducted between April 18 and April 20 with 10 NHA candidates. The QIE did not participate in the NHA interviews due to the focus on the RCA work required for CMS monitoring survey #2.) During the DON interviews, LHH used a standardized interview approach, which used the same nine questions for each candidate. (The QIE had collaborated with the LHH team to develop interview questions for the NHA and DON interviews.) The panel discussed the interview and scored candidates to determine which candidates moved on to the next round of interviews, which will be in person at LHH in May 2023. The QIE will participate in the second round of NHA and DON interviews.

# 3. Summary of Interviews

## Section Overview

This section provides a summary of interviews the QIE conducted with LHH staff members between April 1, 2023, and April 30, 2023. These interviews are organized individually by title in chronological order of when the interviews occurred. The description provides the job titles of the interviewees and a summary of the discussion.

## Interviews

### Action Plan Executive Interview: Co-Incident Commander for Recertification

***Date:*** April 6, 2023

***Participants:*** Co-Incident Commander for Recertification

***Summary of Discussion:*** The QIE interviewed the Co-Incident Commander for Recertification regarding Action Plan progress. He stated that the decrease in deficiencies following the second CDPH/CMS 90-day monitoring survey, which was an abbreviated survey, was encouraging. He is focused on ensuring LHH can sustain the changes being made using the RCA Action Plan and the milestones. To do so, LHH must continue shifting its culture to seeing itself as a skilled nursing facility and not an acute-care hospital. He said LHH's executive leadership rounds, which were implemented as part of the Action Plan, have shown improvements in the environment of care. He added that April and May activities need to focus on completing Action Plan milestones and being proactive with improved internal monitoring processes to identify non-compliance and to immediately fix issues when they are identified. One area of concern that remains is a lack of consistent care and critical thinking at the bedside that is used when issues occur, often resulting in a delayed or appropriate response.

### LHH Participation in Community Emergency Preparedness Exercise

***Date:*** April 6, 2023

***Participants:*** Deputy Director of San Francisco Department of Public Health's (SFDPH) & LHH Interim Emergency Operations Manager

***Summary of Discussion:*** The QIE interviewed the deputy director of SFDPH's Emergency Preparedness and Response Branch/LHH interim Emergency Operations Manager, who is currently deployed to support LHH's emergency operations program. During the interview, she described LHH's March 31, 2023, participation in a community event organized by SFDPH's Public Health Emergency Preparedness and Response (PHEPR) branch.

The event simulated a mass casualty incident (MCI), including a bombing and active shooter at San Francisco Bay Area Rapid Transit (BART) stations. Approximately 60 people from healthcare facility groups, emergency medical services, SFDPH leadership, and LHH attended the event. The exercise included a presentation, review of policies, scenarios, breakout sessions with facilitated conversations, and group report outs. A key aspect of the scenarios focused on how the health system would handle an influx of trauma patients.

The LHH attendees will share learnings (e.g., the specific training scenarios and solutions shared) from the community event with the LHH Emergency Preparedness Committee, which

will review LHH's MCI policy to ensure it is up to date with current best practices. The LHH team will also educate nursing operations on the MCI policy to ensure understanding of proper protocols during an MCI. PHEPR's next community exercise is in June 2023 and will focus on widespread communication breakdowns. LHH plans to have a representative attend the next community exercise.

**LHH Resident/Safety Advocate Interview: North and South Towers**

***Date:*** April 6, 2023

***Participants:*** LHH Resident/Safety Advocate

***Summary of Discussion:*** The QIE met with LHH's newly appointed Resident/Safety Advocate. During the discussion, the Resident/Safety Advocate shared that he was excited for this new role and described what a typical day looks like. His first task of the day is to round on each of the 13 nursing units and check the locked grievance boxes for any submissions and to check the three folders located in the file holders to ensure there are grievance forms in each file. If grievance form files need to be replenished, he restocks the holders with extra forms he carries or returns with replacement forms. If grievances are in the boxes, he reviews the submissions and visits the residents to acknowledge receipt of the grievances, clarifies information so he has a good understanding of the concerns, and explains the next steps to be taken. If grievances are submitted by persons other than residents, he follows up with the contact information on the grievances when he returns to his office, using the same process. The second task is to visit any resident with an outstanding grievance and to advise him/her of the status. If he has a resolution, he speaks with the resident, reads him/her the resolution, clarifies any questions, and has the resident sign a receipt of resolution.

**Action Plan Executive Interview: Interim Chief Medical Officer (CMO)**

***Date:*** April 11, 2023

***Participants:*** Interim CMO

***Summary of Discussion:*** The QIE interviewed the newly appointed interim CMO regarding her orientation to LHH, long-term care, and the RCA Action Plan. The interim CMO, who joined LHH in March 2023, shared that her professional experience has prepared her for this role, including addressing the challenges the resident population may have while living in a skilled nursing facility. To prepare for the role, the interim CMO shared that she enrolled in the 29-hour core curriculum course from AMDA (The Society of Post-Acute and Long-Term Care Medicine). This includes taking the required core curriculum for the Certified Medical Director designation. In addition, she is a member of the California Association of Long-Term Care Medicine (CALTCM). She added that her initial goal since arriving in March 2023 is meeting with each of the LHH medical staff to understand their issues and concerns, including their current involvement with the unit-based QAPI topics.

LHH's interim CMO is also the SFDPH Chief Medical Informatics Officer. She said she wants to focus on using the EPIC EHR to promote resident-centered documentation, communication, and decision-making to describe the story of the care and treatment provided to LHH residents. She shared that she is aware of the RCA and Action Plan milestones. She stated that her predecessor remains as the executive sponsor for the RCA behavioral health milestones and provides continued support.

**Fire and Life Safety RCA Interview**

***Date:*** April 10, 2023

***Participants:*** LHH Director, Facilities Services & Fire Life Safety; LHH CMS Recertification Co-Incident Commander; Consultant NHA, FLS Consultant

***Summary of Discussion:*** The QIE interviewed a group of LHH participants to identify isolated and systemwide causes for deficiencies identified during the second CMS LSC monitoring survey. These interview findings supported the development of RCA Report #3 and Action Plan recommendations. LHH staff reported a need for additional education reinforcement to help staff better identify, address, and escalate FLS issues, such as means of egress, door latching, and expectations during emergency activations. Participants also identified a need to improve LHH's work order management process and its preventative maintenance program.

**Fire Alarm Activation and Preventative Maintenance RCA Interview**

***Date:*** April 18, 2023

***Participants:*** LHH Director, Facilities Services & Fire Life Safety; LHH CMS Recertification Co-Incident Commander

***Summary of Discussion:*** The QIE interviewed a group of LHH participants to identify isolated and systemwide causes for deficiencies identified during the second CMS health monitoring survey. These interview findings supported the development of RCA Report #4 and Action Plan recommendations. The QIE and LHH identified that staff confusion persists regarding what to do if an alarm is called in another unit in the same tower. Staff are confused regarding what to do when a Code Red is announced in one Tower (e.g., North Tower) but not in the neighboring Tower (e.g. South Tower), since these are two distinct fire zones with a fire wall separating them. There are also inconsistencies regarding how the nursing office is using the script to announce Code Red activations. A vendor needs to support LHH in evaluating the overhead paging system functionality, including identifying areas of LHH that may need additional speakers to ensure alarm activation announcements are heard by all staff and residents.

The QIE and LHH also identified the following policy and process issues through the RCA: (1) LHH does not have a formal policy and procedure to guide rental bed preventative maintenance and (2) LHH's preventative maintenance schedule does not include preventative maintenance due dates for rental beds.

**Transfer Notice RCA Interview**

***Date:*** April 18, 2023

***Participants:*** Director, LHH Department of Care Coordination; LHH Social Worker

***Summary of Discussion:*** The QIE interviewed a group of LHH participants to identify isolated and systemwide causes for deficiencies identified during the second CMS health monitoring survey. These interview findings supported the development of RCA Report #4 and Action Plan recommendations. The QIE and LHH identified that a new bed hold and transfer discharge process was implemented in September 2022. According to current LHH policy, Nursing is responsible for providing notices when residents are sent to the emergency department (ED) or acute care hospital. Medical social workers are responsible for providing notices for community discharges. LHH provided in-person training on units in November 2022. Additional training

occurred in February and March 2023. However, there was apparent confusion since there are two separate policies that address these tasks and are not completely aligned. Those being interviewed agreed that policy changes need to occur. Forms should be faxed to the medical records department for inclusion in the medical record, but this does not always occur.

**Restorative Nursing RCA Interview**

***Date:*** April 18, 2023

***Participants:*** Nurse Manager, LHH Restorative Nursing Program; MDS Coordinator; MDS Coordinator 2

***Summary of Discussion:*** The QIE interviewed a group of LHH participants to identify isolated and systemwide causes for deficiencies identified during the second CMS health monitoring survey. These interview findings supported the development of RCA Report #4 and Action Plan recommendations. The QIE and LHH identified that after the isolated incident was discovered, a huddle was held to discuss proper restorative nursing documentation with details such as repetitions and resident refusals. The team also discussed the need to be consistent with charting, accurate care plans, reminders for residents, and checks and balances for workflow.

**Resident Care Plans for Falls RCA Interview**

***Date:*** April 18, 2023

***Participants:*** Nurse Consultant, Nurse Manager, North Mezzanine

***Summary of Discussion:*** The QIE interviewed a group of participants to identify isolated and systemwide causes for deficiencies identified during the second CMS health monitoring survey. These interview findings supported the development of RCA Report #4 and Action Plan recommendations. Through the RCA interview, the QIE and LHH identified that the LHH team reviewed the care plan after an isolated incident involving a resident who was an independent ambulator. The team reviewed the Resident Care Conference (RCC) note, which included monitoring the floor for puddles. This note/intervention was not transferred into the care plan. The team subsequently updated the care plan. However, at the time of the update, no further discussion occurred regarding how the intervention could have been further individualized, such as ensuring cups have sealed lids.

**Resident Wound Care RCA Interview**

***Date:*** April 18, 2023

***Participants:*** Nursing Director; Nurse Manager 1; Nurse Manager 2

***Summary of Discussion:*** The QIE interviewed a group of LHH participants to identify isolated and systemwide causes for deficiencies identified during the second CMS health monitoring survey. These interview findings supported the development of RCA Report #4 and Action Plan recommendations. Through the RCA interview, the QIE and LHH identified that the EHR is not user friendly nor intuitive to help nurses accurately record wound care treatments. The EHR has multiple entry points for would care documentation. Some staff are not familiar with how to navigate the EHR to appropriately document daily care in the detail needed. When presented with a barrier, staff exhibit a lack of critical thinking and regulatory understanding to effectively resolve concerns.

# 4. Summary of Record Reviews

## Section Overview

This section provides a summary of any LHH records the QIE reviewed between April 1, 2023, and April 30, 2023. The QIE is including in its record review: documents, reports, audits, and all Action Plan milestone deliverables. The record reviews are organized by category and include a description of the review's purpose, the documents that were reviewed, and a summary of findings.

## Record Reviews

### Second Emergency Preparedness (EP) and Life Safety Code (LSC) CMS Monitoring Survey 2567

***Purpose of Review:*** To conduct a thorough RCA and provide tailored consultation to LHH on the Action Plan development, the QIE reviewed the EP and LSC 2567 reports and identified deficiencies. These reports encompass the findings of the second LSC and EP monitoring surveys that occurred between March 13, 2023, and March 15, 2023. The reports were provided to LHH on April 7, 2023.

***Record(s) Reviewed:*** The one-page EP and 14-page LSC 2567 reports CMS provided to LHH

***Summary of Findings:*** CMS reported that LHH's EP Program (EPP) was in substantial compliance. The LSC survey identified five K-Tag deficiencies. Of these five tags, three were a Level D scope and severity, one was Level E, and one was Level F. This information was used to develop RCA Report #3, submitted by the QIE on April 17, 2023, and the Action Plan revision, submitted by LHH on April 17, 2023.

### Second CMS Monitoring Health Survey 2567

***Purpose of Review:*** To conduct a thorough RCA and provide tailored consultation to LHH on the Action Plan development, the QIE reviewed the 2567 report and identified deficiencies. This report encompasses the findings of the second monitoring health survey that occurred between March 13, 2023, and March 17, 2023. The report was provided to LHH on April 13, 2023.

***Record(s) Reviewed:*** The 58-page 2567 report CMS provided to LHH

***Summary of Findings:*** The health monitoring survey identified seven F-Tag deficiencies, along with scope and severity. Of these deficiencies, six were Level D scope and severity, and one was Level F. This information was used to develop RCA Report #4, submitted by the QIE on April 23, 2023, and the Action Plan revision, submitted by LHH on April 23, 2023.

### LHH Action Plan Deliverables

***Purpose of Review:*** The QIE reviewed all LHH Action Plan deliverables that were due by April 30, 2023. The review ensured that the deliverables submitted met the intent of LHH's milestone and deliverable descriptions. The QIE provided feedback and coaching for deliverables that did not meet this standard.

***Record(s) Reviewed:*** 122 LHH Action Plan deliverables

***Summary of Findings:*** Examples of Action Plan deliverables include, but are not limited to, assessment reports, meeting minutes, audit results, and training materials. The QIE reviewed 122 deliverables LHH submitted for the April 2023 reporting period. Of these, 30 (24.6%) deliverables needed to be revised and required coaching by the QIE to meet the intent of the Action Plan. The following were common reasons for revisions:

1. Some deliverables lacked thoroughness. For example, some reports are not researched sufficiently and do not delve deep enough into issues.
2. Some deliverables are submitted with incomplete or inaccurate data.
3. Some deliverables are submitted with improper formatting, making them difficult to read and understand.

An example of an LHH deliverable that was approved on initial submission to the QIE is as follows: A monitoring report was developed to identify strengths and weaknesses of LHH's purposeful rounding program, which was pilot tested on two nursing units in April 2023. The report used the Situation, Background, Assessment, and Recommendation (SBAR) format to efficiently describe results and action steps. This information can help improve purposeful rounding on the two pilot units and inform implementation of purposeful rounding on the remaining 11 nursing units.

# 5. Quality Concerns

## Section Overview

The following section provides a summary of any quality concerns identified by the QIE between April 1, 2023, and April 30, 2023. The quality concerns are organized by title. The description provides a summary of the quality concern identified and any actions taken by LHH to mitigate the issue.

## Summary of Quality Concerns

### QIE Escalation: Resident Out-on-Pass Action Plan

***Summary of Concern:*** On April 6, 2023, the QIE escalated a quality concern to LHH leadership regarding residents inappropriately being allowed to go out on pass (OOP). During an Action Plan deliverable review, the QIE identified several OOP issues, including (1) some residents allowed to go OOP were identified as high elopement risks or had documented suicidal ideations; (2) there were no OOP physician orders; and (3) information was missing from care plans or care plans were not individualized for OOP. In addition, some residents did not have a note in the EHR indicating a return from OOP. During the deliverable review, the QIE was concerned that LHH staff failed to analyze the data findings, did not recognize the risk or regulatory vulnerability these findings presented, and lacked critical thinking to effectively address the findings without QIE involvement.

***LHH Mitigation Actions:*** LHH executive leadership developed an immediate action plan to ensure all residents are assessed for OOP. This includes documentation of necessary orders, assessments, and interventions within the medical record. A task force was formed on April 6, 2023, that included the CNO, the CMO, the CMO's Chief of Staff, physician staff, the DON, the Nursing Director of Operations, and the Care Experience Officer. Specifically, the plan outlined that (1) physicians will assess residents' ability to safely go OOP; (2) physicians will place orders for residents to go OOP; (3) Nursing will note the orders and intent for residents to go OOP; (4) Nursing will ensure care plans are individualized; (5) nursing assessments will be completed within an hour of the residents' return to the unit; (6) Nursing will conduct a chart review to assess compliance; and (7) a training tip sheet covering OOP standards will be developed and distributed to all nursing units.

### QIE Escalation: Fire Alarm Activation

***Summary of Concern:*** On April 12, 2023, the QIE escalated a quality concern to LHH leadership regarding staff non-responsiveness to a fire alarm activation. The QIE was attending the staff education fair in the chapel (administration building) when an alarm sounded. An LHH staff member went to the chapel to inquire about the appropriate response (evacuation or shelter in place) for the approximately 60 residents attending a Bingo activity next door in Simon Auditorium. The QIE did not hear audible announcements (i.e., an announcement for the alarm nor an "all clear") from the pager in the chapel. These announcements were also not heard in Simon. The QIE observed general confusion among LHH staff as to whether residents should be evacuated or shelter in place. The FLS consultant present at the training followed policy and advised that the residents should shelter in place, which was done. The residents were not given earmuffs to mitigate noise exposure, per the policy. These observations signified a vulnerability

in the alarm response with residents in Simon Auditorium and a lack of critical thinking among staff during emergency situations.

***LHH Mitigation Actions:*** LHH conducted an after-action review (AAR) to address staff confusion regarding the policy and the inaudible paging system in the chapel and Simon Auditorium. LHH will ensure speakers are present and audible in these locations. The AAR results will be reported in the monthly communication to all staff to promote awareness of the policy. LHH also held a huddle training with Activities Therapy and Spiritual Care staff regarding the Simon Auditorium and chapel fire activation policy and procedure, since they are most likely to be present with residents in this scenario.

**April Surge in COVID-19 Resident Cases**

***Summary of Concern:*** On April 19, 2023, the QIE escalated a quality concern to LHH leadership regarding the increase of COVID-19 cases among residents. Resident COVID-19 cases peaked at 81 cases in mid-April. Staff cases did not exceed 15 during the month. Root causes for the current increase in cases include: (1) residents who were COVID-19 positive wanting to smoke and LHH not having a designated smoke area for residents who are positive for COVID-19; (2) visitors removing masks, which is against current LHH protocol; (3) residents not wearing masks in public areas; (4) a delay in implementing an aggressive mitigation strategies at an early onset of COVID-19 outbreak and (5) staff members not consistently reinforcing to residents the importance of hand hygiene and wearing masks.

***LHH Mitigation Actions:*** During the April 2023 surge and following the QIE escalating the concern, LHH's COVID-19 Hospital Incident Command System (HICS) met daily to monitor progress and implementation of interventions. LHH required increased personal protective equipment (PPE) use among staff, including N95 and eye protection in shared resident care areas. LHH increased routine environmental cleaning and disinfection of high-touch surfaces. Hand hygiene was reinforced among staff, residents, and visitors. LHH increased the frequency of staff and resident testing, strengthened entrance screening for staff and visitors, and increased the focus on social distancing. LHH provided additional visitor options, including virtual visits. Group activities were limited. There was a focus on small group activities within the same nursing units. A second smoking area was added on the LHH campus. Infection prevention and control (IPC) auditors were deployed to provide just-in-time education across all shifts and days (including weekends) to reinforce PPE compliance, hand hygiene, and infection control unit-based observations. LHH continued contact investigation of positive cases to identify all high-risk contacts among staff or residents. LHH also deployed additional HEPA air-filtration units. As a result of the mitigation efforts, LHH reported 54 resident cases as of May 2, 2023.

**QIE Escalation: Care Plan Reviews**

***Summary of Concern:*** On April 21, 2023, the QIE escalated a quality concern to LHH leadership regarding the pace to complete resident care plan reviews, which are part of the LHH Action Plan. Data provided to the QIE indicated that care plan reviews were not progressing at a rate to meet LHH's internal May 13th goal to review and individualize resident care plans. This effort has been underway since November 2022. The QIE expressed concern that this goal may not be met by the deadline and suggested that LHH leaders meet to prioritize next steps, such as identifying priority residents whose care plans should be reviewed for accuracy and individualization.

***LHH Mitigation Actions:*** LHH executive leadership developed an immediate action plan to address project barriers to reviewing and ensuring all resident care plans are appropriately individualized. LHH prioritized residents with high-risk, problem-prone clinical issues, including (1) behavioral health and substance use disorder, (2) documented wounds, (3) physical restraint orders, (4) elopement risk, (5) a resident coaching assignment, and (6) OOP privileges. As part of the process improvement, subject matter experts (SMEs) review the care plans and send corrections and updates to the MDS Department. The MDS nurses review the issues and notify the necessary disciplines that they have something to correct. The teams have 48 hours to make the corrections. If corrections are not made in a timely manner, the issue is escalated to the interim CEO.

# 6. Complaints Related to Resident Health and Safety Received by the QIE

## Section Overview

This section provides a summary of any complaints received and reviewed by the QIE between April 1, 2023, and April 30, 2023. The complaints would be organized in Table 2; however, the QIE did not directly receive any complaints related to resident health and safety during this reporting period.

## Complaints

**Table 2. Complaints Related to Resident Health and Safety**

| # | Date Received | Date Resolved | Complaint Title | Complaint Description | LHH Actions Taken |
|---|---|---|---|---|---|
| 1 | n/a | n/a | n/a | n/a | n/a |

# 7. Complaints Received by LHH

## Section Overview

This section provides a summary of the number and description of complaints received by LHH from any source between April 1, 2023, and April 30, 2023. The complaints are organized in Table 3 individually by number and the date the complaint was received. The table includes a brief description of the complaint, actions taken by LHH, and the date the complaint was resolved or if it is pending.

## Complaints

**Table 3. Complaints Received by LHH**

| # | LHH Date Received | LHH Date Resolved | Complaint Description | LHH Actions Taken |
|---|---|---|---|---|
| 1 | 4/2/2023 | Pending | The resident has a grievance that most day staff "registry" allow other residents to "play the race card," so that Nursing spends more time with them and therefore, his/her treatment time gets limited. He/she also has concerns that he/she has had two UTIs. | The LHH grievance official contacted the treatment team and forwarded the grievance. A social worker responded and stated that she met with him/her, heard his/her concerns, and stated she would follow up with his/her team to see how LHH can meet his/her needs. |
| 2 | 4/3/2023 | Pending | The resident resubmitted a grievance regarding torn pages from a notebook. The grievance included a list of people he/she suspects could have ripped the pages. | The LHH grievance official met with the resident, went over the notebook with him/her, and explained that the pages being numbered by staff indicate that no pages or time are missing from when he/she owned the notebook. This was a notebook he/she inherited from someone else. The information seems consistent with his/her schedule that day. He/she refused to agree. |
| 3 | 4/3/2023 | 4/3/2023 | The resident filed a grievance of overnight RN rude behavior around dispensing medication at 5 a.m. The RN was disrespectful when addressing the resident's concerns. | The LHH grievance official met with the resident, contacted the treatment team, and spoke with the nurse manager. The official went in the room with the nurse manager to confirm the resident's statement of what happened. The nurse manager notified nursing operations and filed a case with CDPH, the ombudsman, and the Sheriff. The RN (registry) will not be coming back to LHH. |
| 4 | 4/3/2023 | Pending | The resident feels his/her pain management has not been effective. "I can't think. I don't have good quality of life. I can't enjoy the | The LHH grievance official notified the treatment team and the physician about the resident's concerns. They will address the issue with the resident and have the pain clinic re-evaluate if the resident agrees. |

| # | LHH Date Received | LHH Date Resolved | Complaint Description | LHH Actions Taken |
|---|---|---|---|---|
| | | | things in my life with meaning." The resident has severe pain in his/her feet. | |
| 5 | 4/4/2023 | Pending | The resident resubmitted a grievance regarding three ombudsmen wanting to meet with him/her regarding his/her money from 1999 to present as well as regarding pages from a notebook being ripped out. | The resident continues to assert that the three ombudsmen have ripped pages from his/her notebook and have taken his/her money or know who has taken his/her money since 1999. |
| 6 | 4/4/2023 | Pending | The resident complained of his/her bathroom floor being wet in the morning and that it has happened two times before. Also, he/she wants to speak with the CEO. | The LHH grievance official called EVS and notified them of the grievance. They agreed to speak with the porter on that floor and the resident and come up with a workable solution. |
| 7 | 4/5/2023 | 4/21/2023 | The resident had received some individually wrapped ice cream cones (3) and wanted to store them in the neighborhood refrigerator. He/she was told no. | The resident met with the charge nurse and was allowed to keep the ice cream (with name and date) this one time in the small staff freezer but no longer than three days. The resident was happy and said they would be out by tomorrow. |
| 8 | 4/7/2023 | Pending | The resident wants regular staff to take care of him/her and wants the nursing office to assign staff that knows him/her well. | The LHH grievance official met with the resident, who wants to take a picture of staff with whom he/she does not want to work to share with the charge nurse. |
| 9 | 4/8/2023 | Pending | The resident resubmitted a grievance about three ombudsmen, who he/she alleges have taken his/her money and have ripped out pages from his/her notebook. | The resident continues to re-submit grievances he/she filed earlier regarding torn pages from a notebook and ombudsmen and his/her money. |
| 10 | 4/9/2023 | Pending | The resident resubmitted grievances regarding the ombudsmen and his/her notebook and regarding a large amount of money that has been taken from his/her account since 1999 and again wants to video tape the ombudsmen or staff to document exchanges. | The resident has submitted a grievance that combines several recent grievances regarding the ombudsmen, his/her money, and being able to record staff when they interact with him/her. |
| 11 | 4/9/2023 | 4/16/2023 | The resident did not receive a hot meal tray for lunch and had a delayed meal tray for breakfast. | A grievance was filed by the Grievance Officer on behalf of the family and the resident. The resident's brother emailed the general LHH email to report staff was refusing to feed the resident. The Grievance Officer met with the resident, went over the grievance and the dietitian’s response, and was able to close the grievance. |

| # | LHH Date Received | LHH Date Resolved | Complaint Description | LHH Actions Taken |
|---|---|---|---|---|
| 12 | 4/10/2023 | Pending | The resident has concerns that he/she had slipped/fell with the PCA and now needs more pain medication that he/she is not getting from his/her doctor. | The LHH grievance official met with the charge nurse, and she stated the resident had an assisted fall with the PCA when the resident attempted to get up on his/her own. But per the resident, he/she has in fact been getting pain medication, and she would follow up on the incident. The LHH grievance official met with the resident who says he/she slipped on urine and fractured his/her shoulder and needs more medication. The LHH grievance official will check back with the team. |
| 13 | 4/13/2023 | Pending | The resident is unhappy with the hair cut from the beautician. | The Grievance Officer filed a grievance at the request of the resident. The beautician alerted Administration to an issue with the resident's hair. The Grievance Officer visited with the resident, and the resident wants a haircut with the beautician. Requested for her team to make an appointment with the beautician immediately and to notify the Grievance Officer. The Grievance Officer/Resident/Patient Safety Advocate will follow up with the resident post new haircut. |
| 14 | 4/13/2023 | 4/18/2023 | The family member (sister) is concerned about lowering bedrails on both sides. The resident has fallen almost daily since the bedrails were lowered. | The resident's sister is concerned since the resident has Huntington's and has uncontrollable movements. The issue will be discussed with the treatment team. The resident has a side rail order after his/her recent fall, and a message was sent to the executives following the new guidelines of restraints. The physician recommended side rails and said he/she will change the resident's bed to an Umano bed, which is wider than what the resident is using right now. Spoke with the sister, and she said they had contacted her and the resident has not fallen since the new order. She was grateful. |
| 15 | 4/14/2023 | Pending | The family member is unhappy with the nursing assignment of the resident; says staff is not helpful and disappeared when the resident said he/she needed help; and wants regular staff to attend to the resident. | The LHH grievance official will contact the treatment team and meet with the resident to get more details. Spoke with the sister and confirmed the concern. Met with the sister and explained and will follow up. |
| 16 | 4/14/2023 | Pending | The resident has asked to have the staff leave his/her door open. He/she was moved to a new neighborhood and is not comfortable with the door being closed. The | The LHH grievance official will contact the staff and pass on the resident's concerns regarding the door being open and will check on the care team about learning the resident's care preferences. |

| # | LHH Date Received | LHH Date Resolved | Complaint Description | LHH Actions Taken |
|---|---|---|---|---|
| | | | resident also has concerns that new staff do not know his/her care preferences. | |
| 17 | 4/17/2023 | Pending | The resident had several concerns. A person he/she believed to be a psychiatrist met with him/her to set up a meeting, and the resident wanted to know about his/her money. The person from psychiatry said, "That's not a black and white thing." The resident felt that was disrespectful and has concerns about his/her money. | The LHH grievance official met with the resident, and his/her concerns were more regarding his/her discharge and money than the interaction with the alleged psychiatry staff member. He/she wonders about an inheritance from his/her mother. The LHH grievance official told the resident they would let the team know the concerns. |
| 18 | 4/17/2023 | Pending | The resident has a grievance with the New Motion company that services his/her wheelchair. A bolt has fallen off and he/she would like them to come out and repair. He/she feels the footrests are too short and causes calluses and foot pain. | The LHH grievance official met with the resident who was very angry about his/her wheelchair needing repair. A bolt fell off, causing his/her footrest to need adjustment, causing him pain. The LHH grievance official called the social worker and New Motion to try and get someone to help. Contacted the nurse manager, and they will call and schedule today or tomorrow to come out for repair. Contacted the staff to let the resident know. The LHH grievance official will follow up. |
| 19 | 4/17/2023 | Pending | The resident met with the social worker for a grievance on a recent visit to Zuckerberg San Francisco General Hospital (ZSFGH) ER regarding:<br>1. Missing leg rest<br>2. Missing clothing<br>3. The resident being poorly treated. Staff were rough, and staff physically restrained him/her. The resident was given medication against his/her will. | The LHH grievance official passed on the grievance to the Supervisor and emailed the CEO at ZSFGH on 4/17 for assistance with the grievance. Belongings were not found in the ED, and the resident will be asked if he/she would like to file a claim. The ED nurse manager investigated. |
| 20 | 4/17/2023 | Pending | The resident states that while in the ED at ZSFGH, staff took his/her money, but he/she was unclear on the amount. | The LHH grievance official submitted a request to the Eligibility and Admission Department to look into the resident's money and account to try and determine the issue he/she has with the money. |
| 21 | 4/19/2023 | Pending | The resident would like to return to his/her home unit (filed grievance on another unit). | Staff did explain to the resident that he/she will be able to return to his/her unit as soon as he/she tests negative for COVID-19. The LHH grievance official will continue to follow up with the team for support. |

| # | LHH Date Received | LHH Date Resolved | Complaint Description | LHH Actions Taken |
|---|---|---|---|---|
| 22 | 4/19/2023 | Pending | An AIDS legal fund staff attorney submitted a grievance on behalf of the resident. Concerns noted in the letter: discomfort and pain due to bed, difficulty with abdominal catheter changes, requests for prompt answering of call light response, feeling isolated, did not feel he/she was included in decision making, lack of response to previous grievances through the Ombudsman's office, and concerns with care coordination. | The LHH grievance official notified the nursing unit City Attorney Office, who was engaged for a response for the ADA accommodation. The nursing unit staff met to make a plan to address the resident's concerns, which include increasing accessibility to the team and to activities in which he can participate. The City Attorney Office will work with the AIDS legal fund for the ADA request. |
| 23 | 4/19/2023 | Pending | The durable power of attorney (DPOA) for a deceased resident is asking why reimbursement was denied for cremation expenses. The DPOA asked for an explanation: if funds seemed available, why was the expense denied. The DPOA also asked for a copy of the policy of the resident's right to access the funds. | The LHH grievance official spoke with the DPOA on the phone for grievance acknowledgement. Resident Rights and Resident Trust account policies were sent via email. Requested a review of the complaint from Admissions and Eligibility. The LHH grievance official will follow up and sent an email reminder to Admissions and Eligibility. |
| 24 | 4/23/2023 | Pending | A resident's brother emailed with three concerns: lack of access to preferred colostomy supplies, concerns about lost clothing, and concerns that resident's medical history isn't taken into consideration. | The LHH grievance official emailed the brother an acknowledgment letter and gave the Grievance Officer's cell phone number for direct follow-up versus using the Board of Supervisor email. The LHH grievance official will follow up with the resident and the team. |
| 25 | 4/24/2023 | Pending | A resident has concerns about staffing on the unit and the impact it is having on his/her care | The LHH grievance official forwarded the grievance to the Chief Nursing Officer for follow up. |
| 26 | 4/25/2023 | Pending | The resident and the family are not happy with the care being received on the COVID unit and reported dentures are missing and a conflict with another resident. | The issue was reported as conflict/name calling by another resident as resident-to-resident by the nurse manager. The incident was reported to CDPH by the home unit nurse manager and the social worker. An email was sent to the nursing unit team for follow up. |

# 8. Incidents Reported to CDPH

## Section Overview

This section provides a summary of the number and description of any incidents reported to CDPH between April 1, 2023, and April 30, 2023, and provided to the QIE by the LHH Quality Department. The incidents are organized in Table 4 individually by number and the date of the incident. A description and the status of the CDPH investigation is included for each incident as well the date the incident was resolved or if it is pending.

## Incidents

**Table 4. Incidents Reported to CDPH**

| # | LHH Date Received | LHH Date Resolved | Incident Title | Incident Description | CDPH Investigation |
|---|---|---|---|---|---|
| 1 | 4/3/2023 | 4/7/2023 | Abuse: Staff to Resident | The resident reported the a.m. shift nurse was rude, impolite, and slammed his/her door shut despite the resident's telling her not to because he/she was claustrophobic. | Pending |
| 2 | 4/4/2023 | 4/10/2027 | Abuse: Other to Resident Theft | The resident is missing one pair of gold earrings. | Not started |
| 3 | 4/4/2023 | Pending | Anonymous Complaint | Description of complaint not provided | Pending |
| 4 | 4/7/2023 | 4/13/2023 | Adverse Event: Major Injury | The resident has a left proximal humerus fracture. | Not started |
| 5 | 4/11/2023 | 4/17/2023 | Abuse: Injury of Unknown Source | The resident has right upper eyelid discoloration. | Not started |
| 6 | 4/12/2023 | 4/18/2023 | Abuse: Staff to Resident | The resident complained that there was a delay with his/her incontinent/morning care in the a.m. shift and a delay with tracheal suctioning. The resident had difficulty breathing, and when the nurse was suctioning him/her, the nurse seemed sarcastic. | Not started |
| 7 | 4/12/2023 | Pending | Anonymous Complaint | Description of complaint not provided | Pending |
| 8 | 4/12/2023 | Pending | Anonymous Complaint | Description of complaint not provided | Pending |
| 9 | 4/14/2023 | 4/20/2023 | Abuse: Other to Resident | A grievance was filed. A resident's wheelchair was broken and the wheelchair company took too long to conduct the repairs. | Not started |

| # | LHH Date Received | LHH Date Resolved | Incident Title | Incident Description | CDPH Investigation |
|---|---|---|---|---|---|
| 10 | 4/14/2023 | 4/14/2023 | Potential Privacy Breach | A staff member sent an unsecured email containing PHI to LHH Leadership and another individual, who does not have any relationship with LHH. | Not started |
| 11 | 4/15/2023 | 4/20/2023 | Abuse: Resident to Resident | A resident approached staff and stated, "That lady hit that lady." The other resident denied the incident but stated he/she was hit on the back but does not know who hit him/her. | Not started |
| 12 | 4/15/2023 | 4/20/2023 | Abuse: Resident to Resident | A resident was hit in the mouth and right shoulder by another resident while they both were trying to get into the elevator. | Not started |
| 13 | 4/17/2023 | 4/21/2023 | Abuse: Injury of Unknown Source | The resident had left pinky finger discoloration. | Not started |
| 14 | 4/17/2023 | 4/21/2023 | Abuse: Other to Resident | A resident alleged that two staff members assaulted him/her, ripped off his/her splint, twisted his/her leg, and made his/her knee sore. | Not started |
| 15 | 4/17/2023 | | Anonymous Complaint | Description of complaint not provided | Pending |
| 16 | 4/22/2023 | 4/27/2023 | Abuse: Other to Resident Theft | A resident had a missing red wallet with $7 to $10. | Not started |
| 17 | 4/23/2023 | 4/27/2023 | Abuse: Resident to Resident | A resident reported physical abuse by roommate. A resident hit another resident on the right side of the head while the resident was looking through his/her drawer for money. | Not started |
| 18 | 4/24/2023 | 4/28/2023 | Staff to Resident Theft | A resident was missing $300 black-framed prescription glasses. | Not started |
| 19 | 4/24/2023 | 4/27/2023 | Adverse Event: Major Injury | A resident had an acute fracture of the right proximal humerus & SDH. | Not started |
| 20 | 4/25/2023 | Pending | Abuse: Staff to Resident | A resident was dissatisfied with care. Basic needs were not met, delayed response time, appear not checking enough, did not feel safe, missing dentures, and mocked by roommate. | Not started |
| 21 | 4/27/2023 | Pending | Abuse: Injury of Unknown Source | A resident had right side of chin discoloration. | Not started |

| # | LHH Date Received | LHH Date Resolved | Incident Title | Incident Description | CDPH Investigation |
|---|---|---|---|---|---|
| 22 | 4/27/2023 | Pending | Abuse: Resident to Resident | A resident had a verbal altercation. | Not started |

# 9. LHH Action Plan Assessment & 10. LHH Action Plan Obstacles and Solutions

## Section Overview

The following section provides an assessment of LHH in meeting established goals for the 11 foundational root causes outlined in RCA Reports #1, #2, #3, and #4 and the Action Plan between April 1 and April 30, 2023. The section also provides a brief assessment of overall progress of program sustainability for all milestones completed as of April 30, 2023.

## Action Plan Progress Assessment, Obstacles & Solutions

LHH completed 100% (122/122) of the Action Plan milestones with April 2023 deadlines. RCA Reports #3 and #4 added additional milestone deliverables to the LHH Action Plan. Currently, the Action Plan includes 500 milestones. Overall, LHH has completed 91.4% (457/500) of all planned Action Plan milestones, which must be fully implemented by May 13, 2023.

### 1. Quality Assurance & Performance Improvement (QAPI)

***Actions Completed:*** All QAPI milestone deliverables (11/11) were completed for the April 2023 reporting period. Of these, four milestone deliverables required resubmission following QIE content review, guidance, and coaching.

LHH implemented the QAPI physical restraints and falls subcommittees on all nursing units. The rounding team incorporated questions into teach-back rounding to include QAPI concepts, such as RCA and plan-do-study-act (PDSA). The teach-back rounding also reviewed with staff performance improvement projects, the five elements of QAPI, and how to raise quality concerns. Clinical staff (i.e., nurse managers, charge nurses, licensed nurses, medical staff, and CNAs/PCAs) were trained on huddle board facilitation. Key topics included data presentation, data analysis, data trends/patterns, current PDSAs, RCAs, and how to raise concerns. LHH also created a real-time process to communicate to staff any policy changes identified during monthly QAPI reviews. LHH's updated facility assessment was also approved.

***Overall Progress Assessment:*** To sustain gains made in the Action Plan to date, LHH must continue to review and update its facility assessment to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require both day-to-day and during emergencies.

Many of the activities in the Action Plan developed new work flows, process changes, policy changes, and data collection processes. To be successful, LHH must focus on examining data sources, verifying accuracy, and ensuring the integrity of the data presented at meetings. This must be coupled with an ongoing focus on data analysis and problem-solving for low-performing areas of care. There is a lack of critical thinking skills, regulatory understanding, effective communication, and timely response to data findings. This results in poor unit-based management and clinical performance and/or patient outcomes at the bedside. LHH must improve timely follow-up on data presented and sound assessment at QAPI meetings that show consistent poor performance to ensure a strong feedback loop with frontline staff.

## 2. Infection Prevention and Control (IPC)

***Actions Completed:*** All IPC milestone deliverables (9/9) were completed for the April 2023 reporting period. Of these, two milestone deliverables required resubmission following QIE content review, guidance, and coaching.

LHH integrated the IP team into the nursing quality and safety meeting and reporting structure. LHH developed a unit-based IPC champion program, which includes audits and unit-based rounding with a focus on high-risk opportunities for improvement. IPC champions also established monthly unit-based meetings. LHH IP staff communicated to all staff about recent IP policy changes. LHH IP staff also established regular communication with the SFDPH EHR team to optimize the EHR system to support SNF reporting requirements. LHH implemented an individualized education plan for each of the IP team members. The education included best practices and expectations from the Association of Professionals in Infection Control and Prevention (APIC), CMS, CDC, and CDPH. LHH also created a monthly education/training calendar for all staff members. Topics include PPE use, hand hygiene, biohazard bin organization, and reducing clutter in resident rooms.

***Overall Progress Assessment:*** To sustain gains made in the Action Plan to date, LHH must have a heightened level of response to implement COVID-19 mitigations during early indications of an outbreak. As reported in the Quality Concerns section of this report, this was an area in need of improvement. This appears to be the result of the ongoing pattern of a lack of critical thinking skills, the inability to recognize poor clinical outcomes at an early onset, and ineffective communication skills. It is imperative that LHH maintains ongoing diligence in monitoring hand hygiene and PPE. LHH also needs to consistently reinforce IPC training and education that includes the charge nurses and nurse managers. This education needs to be active, engaging, and in person to support its effectiveness. LHH must also continue unit-based QAPI infection control subcommittee meetings, which should be supported by IPC champions.

## 3. Behavioral Health and Substance Abuse

***Actions Completed:*** All Behavioral Health and Substance Abuse milestone deliverables (6/6) were completed for the April 2023 reporting period. Of these, one milestone deliverable required resubmission following QIE content review, guidance, and coaching.

LHH provided training to staff about de-escalation, overdose prevention, and motivational interviewing. The training used adult learning principles, such as case studies, knowledge verification, and in-person and electronic modalities. Trainings were prioritized by unit, based on resident needs and volume. LHH also added agenda items to monthly security meetings to discuss security staff training and LHH policy updates. LHH developed a monitoring process for release-of-information (ROI) consents, and aggregate ROI data were reported through QAPI.

***Overall Progress Assessment:*** To sustain gains made in the Action Plan to date, newly hired behavioral health staff members will need to be quickly integrated into the care team. Their knowledge and expertise on managing behavioral health issues will ensure person-centered care and provide just-in-time learning opportunities for staff. An example of this is providing support to staff with managing escalating resident behaviors and updating care plans with individualized interventions. As more behavioral staff members are hired, LHH must also ensure their participation in the care planning process, resident care conferences, and unit-based QAPI psychotropic medication and behavior monitoring subcommittee meetings.

## 4. Medication Management and Administration

***Actions Completed:*** All Medication Management and Administration milestone deliverables (11/11) were completed for the April 2023 reporting period. Of these, two milestone deliverables required resubmission following QIE content review, guidance, and coaching.

Each nursing unit established an interdisciplinary team (IDT) to include at a minimum, physicians, nurse managers, social services, and a pharmacist and meeting times for the monthly psychotropic/behavior meeting. LHH IDT members reviewed residents for appropriateness of medication self-administration. For residents who self-administer routine scheduled medications, nurses observed residents taking the medications and documented, according to LHH policy. Nurse leaders started random monthly checks to ensure bedside medications are securely stored. Audit findings were shared with nurse managers, and data were shared through QAPI. Pharmacy and Nursing implemented the medication pass critical element pathway (CEP) as a shared responsibility. Licensed nurses passing medications were observed across three shifts. Pharmacy and Nursing gathered and reported safe medication storage, labeling, disposal data and medication pass observations to Nursing Quality Improvement Committee and QAPI/QAA.

***Overall Progress Assessment:*** To sustain gains made in the Action Plan to date, the pharmacy and nursing departments must continue strong collaboration using a data-driven approach to problem solving. Examples of this include examining specific gaps noted during medication pass observations (e.g., expired medications) and follow-ups required for drug regimen reviews. LHH must ensure unit-based QAPI psychotropic medication and behavior monitoring subcommittee meetings continue to support effective IDT collaboration and contribute meaningful, individualized interventions to the care plan.

## 5. Resident Rights and Freedom from Harm

***Actions Completed:*** All Resident Rights and Freedom from Harm milestone deliverables (29/29) were completed for the April 2023 reporting period. Of these, five milestone deliverables required resubmission following QIE content review, guidance, and coaching.

LHH provided education to Executive leadership on resident care standards related to abuse and neglect, resident rights, and care concerns. LHH continued to monitor and report abuse using meaningful criteria that identifies trends and patterns. This was reported to QAPI/QAA. LHH also created a standardized investigative plan and hosted training sessions for staff on abuse policies and procedures.

The falls and restraints subcommittee for each of the 13 nursing units reported the ongoing status of restraints and efforts to reduce restraints to the nursing quality committee. The subcommittee evaluated the individual needs of each resident specific to restraints and identified interventions for reduction and barriers requiring mitigation plans. Care plans will be updated, and changes will be immediately communicated to the resident care team (RCT) and the resident/resident representative. Following the nursing quality committee, the DONs will report nursing restraints to QAPI/QAA Committee. Feedback received by the QAPI/QAA Committee will be incorporated as part of the restraint subcommittee's PDSA process.

The LHH Patient Safety Advocate or designee checked each new drop box daily during rounds and collected forms. When a form is collected, the grievance will be triaged by the Patient Safety Advocate or designee for response. The grievance will be logged into the grievance log and

assigned to the appropriate departments for timely follow-up. The Grievance Officer (or designee) will review the grievance log for appropriate response and timeliness. The grievance data will be analyzed for trends and patterns and reported to the resident council monthly. The monthly analysis of grievance data will be reported to the QAPI/QAA Committee for critical analysis and follow-up action.

LHH pilot tested its purposeful rounding program on one unit in North tower and one unit in South tower. LHH developed a report that evaluates the effectiveness of pilot programs and plans for spread in units as indicated. Using these results, LHH started implementing a rounding program on the remaining units.

An executive rounding standard work process was created that includes an assessment of the staff's understanding of residents' rights, EPP, and freedom from harm standards. Upon completion of the rounds, executive leadership will document findings in a designated spreadsheet. Executive leadership will review staff feedback regarding new expectations for staff accountability and the aggregate findings for trends and patterns. The review and appropriate follow-up action plans will be reported monthly through the QAPI/QAA Committee.

To maintain program integrity and resident functionality, LHH continued ongoing evaluation quarterly following the MDS schedule to ensure residents' restorative needs are met. Updated program elements and policies and procedures were submitted to the QAPI/QAA committee.

***Overall Progress Assessment:*** To sustain gains made in the Action Plan, LHH must start to measure specific outcomes in addition to process measures. For example, LHH leadership rounds have been recently implemented, and it is still early in the process to identify trends and patterns from rounds. LHH must ensure rounding continues and must also use the data to inform the PDSA process and address problematic issues with the intent for correction.

LHH indicated it has reduced 85 percent of potential restraint devices that were present at the onset of the Action Plan. With the remaining 15 percent, LHH must continue to use the PDSA process to ensure the appropriateness of devices. This includes attempting less restrictive alternatives. LHH must also ensure elements of proper documentation (e.g., assessment, consent, physician order, care plan, and outcomes) are in place when devices are used. The QIE remains concerned that staff do not understand the intent of the regulations as it relates to using less restrictive alternatives prior to using restraint devices and that documentation requirements are not clearly understood by the resident care team.

LHH has improved its resident grievance process, including making grievance forms more accessible to residents. LHH must continue to look at the grievance log on a daily basis, decrease the lag time between grievance and resolution, and examine the data to ensure timely follow-up and resolution occurs with residents.

Many of the new programs that will improve resident-centered care (e.g., no pass zone, purposeful rounding, and consistent assignment) have completed their pilot programs. The analysis of these programs has shown a need for continued training to enforce the continued use of best practices daily and proper documentation of activities.

Executive management has developed a stop-the-line mindset when processes are not working, such as care plan individualization, physical restraint use, Code Red drills, and other emergency activations. They immediately conduct rapid cycle improvement in these high-risk areas. To

maintain these gains, improvement middle managers, such nurse managers, need additional training and support on effectively managing QAPI at the unit level

There has been significant improvement in attendance at resident council meetings and at unit-level resident community meetings. LHH must make a continued effort to support residents to maintain attendance gains.

To support recent changes made to the restorative nursing program, ongoing data analysis will be critical to PDSA processes to ensure that the program meets residents' restorative needs.

There was regulatory confusion in the bed hold transfer notification process specific to who provides certain notifications (e.g., nurse vs. social worker). This appears to be the result of the ongoing pattern of a lack of critical thinking skills, the inability to recognize poor data outcomes at an early onset, understanding the intent of the regulations, and ineffective communication skills. Program changes made in April 2023 and early May 2023 should have an impact on regulatory compliance. LHH must continue to monitor data by unit to properly implement PDSA cycles for any identified gaps and issues.

LHH's Activity Program must continue to solicit feedback from residents regarding preferred activities. The facility had a recent COVID-19 outbreak, which limited group activities. LHH must ensure activities are safely reestablished once the outbreak subsides.

### 6. Comprehensive Care Plans and Quality of Care

***Actions Completed:*** All Comprehensive Care Plans and Quality of Care milestone deliverables (16/16) were completed for the April 2023 reporting period. Of these, eight milestone deliverables required resubmission following QIE content review, guidance, and coaching.

Supervisory leadership from IDTs attended at least one RCC monthly on each unit to ensure accountability of active team participation. Results of MDS coordination validation were monitored by MDS leadership, who provided coaching and support. An SME also provided weekly coaching to the nurse leaders, including the MDS Department, to ensure active participation in developing and implementing individualized care plans.

LHH pilot tested its consistent staffing program on one North Tower unit and one South Tower unit and identified implementation barriers to help inform an ongoing PDSA process. LHH also created a report that evaluated the effectiveness of the pilot program to support implementation across LHH and plan for spread in units.

LHH implemented in-person training for direct-care staff on the Kardex and daily report sheet through a hands-on, in-person training. The MDS team reviewed each Kardex with the RCC to ensure accuracy and individualization. The results were presented to the QAPI/QAA Committee for evaluation of trends and patterns and opportunities for improvement.

LHH implemented its education plan and curriculum for direct-care staff who have various levels of knowledge on (1) how to use care plans; (2) how to include care plan interventions in their practice; (3) how to access care plans through the EHR; and 4) how to update care plans. It included in-person, scenario-based learning. Departments included Nursing, Activities Therapy, social services, medical staff, Food and Nutrition Services, and others.

***Overall Progress Assessment:*** To sustain gains made in the Action Plan to date, LHH must continue to train and engage direct-care staff on resident care plans. Progress is slow toward

consistent individualization of care plans. LHH must increase a sense of urgency in care plan individualization by using improved internal metrics, QAPI dashboards, PDSA cycles, and accountability standards to improve progress. Nursing leadership must also diligently monitor the implementation of consistent nursing assignment and purposeful rounding to ensure these two important interventions are implemented and sustained.

### 7. Competent Staff, Training, and Quality of Care

***Actions Completed:*** All Competent Staff, Training, and Quality of Care milestone deliverables (9/9) were completed for the April 2023 reporting period. Of these, one milestone deliverable required resubmission following QIE content review, guidance, and coaching.

LHH completed and posted a job description to hire a licensed NHA. In April, LHH also completed its first round of NHA and DON interviews. LHH implemented its executive rounding program and started to report results through QAPI. Executive leaders met with SNF industry expert coaches to review rounding findings and identify high-vulnerability areas, follow-up items, and staff education that needs to be addressed through rounding.

LHH completed its scope of service reconfiguration proposal of the LHH Department of Education & Training (DET) department to include analysts and clerical staff to support the newly defined functions of the department. LHH identified educational topics and pilot tested in-person education on nursing units using a selected adult education approach (e.g., teach back with return demonstration). LHH also created a monthly educational/training calendar with identified topics based on regulations, problem-prone areas, or other areas of need identified by leadership.

***Overall Progress Assessment:*** To sustain gains made in the Action Plan to date, LHH must continue to respond to staff training needs using in-person, interactive modalities to ensure knowledge retention rather than an overreliance on computer-based methods. During this reporting period, LHH achieved a 98% staff compliance with training.

LHH must continue to actively engage and participate in SNF associations through meeting attendance and education. LHH must improve the use of adult education techniques, such as teach-back, to reduce its overreliance on read-and-sign training and improve staff retention of education and training. LHH must also maintain consistent executive leadership rounding to support Action Plan sustainability. LHH must use a data-driven approach to guide rounding and proactively address issues while they are still small. LHH has completed phase one of NHA and DON interviews and must select and hire the permanent NHA and DON prior to recertification to support sustainability. LHH must also develop a methodical orientation program for these newly hired executives.

### 8. Emergency Preparedness Program (EPP)

***Actions Completed:*** All Emergency Preparedness Program milestone deliverables (18/18) were completed for the April 2023 reporting period. Of these, two milestone deliverables required resubmission following QIE content review, guidance, and coaching.

LHH actively assigned, monitored, and ensured staff enrollment into Everbridge as mandated by the SFDPH “Disaster Service Worker and Everbridge” enrollment policy. During active, routine drills, LHH validated emergency communications (e.g., Everbridge).

LHH added EPP activations/drills as standing agenda items to the QAPI/QAA Committee and provided AARs for the month of review. LHH distributed a communication summary from the previous month's activation/drills that notified staff about tasks performed well, tasks that need improvement, and relevant education (e.g., SBAR and teach-back documents for team huddles) for identified areas of improvement.

LHH actively participated in the PHEPR community-based activations and exercises. LHH also distributed and trained staff on the contents of the quick reference guides and the locations where they can find the guides.

LHH hosted unit-based fire drills to ensure comprehension of training and roles. LHH added an annual review, including EPP information, of the resident handbook to the Care Experience department's work plan. A member of the FLS Committee started to conduct mock drill sessions weekly in the nurse staffing office specific to announcing Code Red activations using the standard work process and script.

***Overall Progress Assessment:*** To sustain gains made in the Action Plan to date, LHH must ensure executive leadership continues to be actively engaged in emergency preparedness to sustain the infrastructure created through the Action Plan. An example is having one executive assigned to each nursing unit to provide observations and coaching during alarm activations, so that immediate learning occurs if errors are made. LHH must also adhere to its EPP work plans, trainings, use of alternative communication methods, and drill schedules to ensure staff are continuously prepared for an emergency and avoid any regression. Fire drills should also be regularly performed facility-wide in addition to unit-based drills. LHH must communicate accountability standards to staff members to ensure full participation in emergency activations. LHH must also ensure that staff are aware of EPP quick reference guides and their contents that have been placed throughout the facility to support quick responses during alarm activations.

### 9. Fire and Life Safety (FLS)

***Actions Completed:*** All FLS milestone deliverables (8/8) were completed for the April 2023 reporting period. Of these, four milestone deliverables required resubmission following QIE content review, guidance, and coaching.

The LHH FLS team, expert consultants, and trained department managers conducted frontline staff training, which included FLS concepts, such as means of egress, proper door latching, R.A.C.E. (Rescue/Remove, Alarm, Confine/Contain, and Extinguish), P.A.S.S. (Pull, Aim, Squeeze, Sweep), power strips, equipment in hallways, and door stoppers. LHH also distributed a communication summary from the previous month's activation/drills that notifies staff regarding tasks performed well, tasks that need improvement, and relevant education (e.g., SBAR and teach-back documents for team huddles) for identified areas of improvement.

The Interim Director of Operations reported patterns and trends in work orders at QAPI/QAA Committee meetings, including work orders for elevator and damper repair. The chief engineer and an SME trained Facilities staff and vendors on compliance procedures, including positive door latches, to maintain equipment integrity through the PM Program.

LHH established reoccurring work orders to create a PM schedule with appropriate assignments. LHH will inspect 25 percent of all facility fire/smoke dampers each year to ensure 100 percent regulatory compliance every four years. This schedule will also include regular inspections of

positive door latches to ensure continued proper functioning. LHH monitored progress of work orders and PM via (1) an executive dashboard that is reviewed weekly and (2) a monthly report to the QAPI/QAA Committee with patterns and trends.

***Overall Progress Assessment:*** To sustain gains made in the Action Plan to date, LHH must continue to follow the work plans, policies, and procedures created for the Action Plan. This will require consistent leadership oversight and accountability. LHH added a biomedical engineering department to manage many FLS issues. LHH must continue to integrate these staff to manage medical devices and collaborate with the Facilities Department. LHH must also maintain new PM policies and procedures to ensure medical equipment, such as specialty resident beds, is proactively maintained.

### 10. Resident Quality of Care

***Actions Completed:*** All Resident Quality of Care milestone deliverables (3/3) were completed for the April 2023 reporting period. Of these, one milestone deliverable required resubmission following QIE content review, guidance, and coaching.

LHH performed ongoing evaluations of wound care interventions and made adjustments based on findings made by unit wound care champions. Resident care plans were updated as changes were identified by the IDT or RCT to ensure ongoing, individualized person-centered care. LHH shared the audit tube feeding order report with the QAPI Committee for tracking/trending and acted upon identified gaps.

***Overall Progress Assessment:*** To sustain gains made in the Action Plan to date, LHH must continue to examine data dashboards specific to wounds, pain management, weight variances, and tube feeding. LHH must respond with urgency and focus on resident-centered interventions when gaps are identified. Updates must be integrated into resident care plans as part of the response. An ongoing feedback loop that includes all caregivers (e.g., CNAs) needs to become a daily practice. Compliance with pain assessment and reassessment continues to be an ongoing issue due to the lack of proper documentation and assessment skills. The resulting poor data performance signifies a lack of critical thinking skills at the bedside and staff engagement at the unit-based management level.

Wound management continues to be a high-priority issue. Management must continuously use the PDSA process for the wound care program, which started major improvement efforts in February 2023. This includes ensuring accuracy in data reporting and timely treatments. LHH must continue to monitor and act on resident quality of care issues through its QAPI Program. The wound care program infrastructure must be maintained using the unit-based QAPI wound and nutrition subcommittee meetings. LHH must also continue to audit resident charts for pre and post pain medication assessments. QAPI Committee members must scrutinize data to ensure the integrity and accuracy of data being presented at QAPI/QAA meetings.

### 11. Food and Nutrition Services (FNS)

***Actions Completed:*** All FNS milestone deliverables (2/2) were completed for the April 2023 reporting period. Of these, no milestone deliverables required resubmission.

LHH continued to work with its third-party vendor to make diabetic-related diet modifications in the menu management system. LHH also prioritized a workplan for EHR optimization and

implemented a training program to include in-service training on the importance of oral nutritional intake documentation and how to correctly document in the EHR.

***Overall Progress Assessment:*** To sustain gains made in the Action Plan to date, LHH must continue to implement its plan to update the menu-management system and provide updates on an ongoing basis to eliminate future extended backlogs. LHH must continue its unit-based QAPI wound and nutrition subcommittee meetings to maintain strong IDT collaboration, including dietitians. Examples of this include consistency in Nursing getting weekly weights and dietitians responding urgently to weight changes. LHH should continue to provide ongoing education to staff members on important topics, such as resident meal percentages, to improve staff knowledge and EHR documentation.

# 11. Summary of Transfers and Discharges

## Section Overview

This section provides a summary of any proposed or enacted transfers and discharges from LHH between March 1, 2023, and March 31, 2023. This information is provided to the QIE by LHH. Table 5 lists the type of transfer, the volume, and LHH notes describing the event. Table 6 lists the type of discharge, the volume, and LHH notes describing the event. The QIE was informed that CMS agreed to continue the pause of involuntary discharges and transfers of LHH residents until at least May 19, 2023. As a result, information for these tables may be infrequent. CMS approved LHH's updated Closure Plan on April 18, 2023.

## Transfers and Discharges

**Table 5. LHH Proposed or Enacted Transfers**

| Transfer Type | Volume | LHH Notes |
|---|---|---|
| Proposed Facility-Initiated Transfers | 0 | n/a |
| Proposed Resident-Initiated Transfers | 0 | n/a |
| Enacted Facility-Initiated Transfers | 0 | n/a |
| Enacted Resident-Initiated Transfers | 0 | n/a |

**Table 6. LHH Proposed or Enacted Discharges**

| Discharge Type | Volume | LHH Notes |
|---|---|---|
| Proposed Facility-Initiated Discharges | 0 | n/a |
| Proposed Resident-Initiated Discharges | 0 | n/a |
| Enacted Facility-Initiated Discharges | 0 | n/a |
| Enacted Resident-Initiated Discharges | 1 | One resident discharged to the community on April 12, 2023. |