CITATION NUMBER: 220018216

Date: 12/20/2022 12:00:00 AM

Type Of Visit:

Incident/Complaint No.(s) : CA00797118

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Licensee Name: City & County of San Francisco, Dept. Public Health
Address: 375 Laguna Honda Blvd. San Francisco, CA 94116
License Number: 220000040 Type of Ownership: County

Facility Name: LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF
Address: 375 Laguna Honda Blvd San Francisco, CA 94116
Telephone : (415) 759-2300
Facility Type: Skilled Nursing Facility Capacity: 769
Facility ID: 220000512

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT	DEADLINE FOR COMPLIANCE
	CLASS: B CITATION: Patient Care	3000.00	1/3/2023 8:00:00 AM

1336.2(a)(1)(2)(3A)(3B)(4)(5) 1336.2(b) T22 DIV5 CH3 ART3-72311(a)(1)(B) T22 DIV5 CH3 ART3-72311(a)(2) T22 DIV5 CH3 ART5-72523(a)	**CLASS** B **CITATION --** Patient Care T22 DIV5 CH3 ART3-72311(a)(1)(B) Nursing Service - General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (B) Development of an individual, written patient care plan which indicates the care to be given the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited. T22 DIV5 CH3 ART3-72311(a)(2) Nursing Service - General (a) Nursing service shall include, but not be limited to, the following: (2) Implementing of each patient's care plan according to the methods indicated. Each patient's care shall be based on this plan.

Name Of Evaluator:
Aurora Liganor

Evaluator
Signature:____________________________

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature:_______________________________________

Name:____

Title:____

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

T22 DIV5 CH3 ART5-72523(a) Patient Care Policies and Procedures
(a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved.

1336.2(a)(1)(2)(3A)(3B)(4)(5) Health & Safety Code DIV2 CH2 ART8.5

(a) Before residents are transferred due to any change in the status of the license or operation of a facility, including a facility closure or voluntary or involuntary termination of a facility's Medi-Cal or Medicare certification, the facility shall take reasonable steps to transfer affected residents safely and minimize possible transfer trauma by, at a minimum, doing all of the following:

(1) Be responsible for ensuring that the resident's attending physician or the facility medical director, if the resident does not have an attending physician, completes the medical assessment of the resident's condition and susceptibility to adverse health consequences, including psychosocial effects, prior to written notice of transfer being given to the resident. The assessment shall not be considered complete unless it provides, in accordance with these assessments, recommendations for counseling, follow-up visits, and other recommended services, by designated health professionals, and for preventing or ameliorating potential adverse health consequences in the event of transfer.

(2) Be responsible for ensuring that a licensed marriage and family therapist, a licensed clinical social worker, a licensed psychologist, a licensed psychiatrist, or a licensed professional clinical counselor and the facility nursing staff complete an assessment of the social and physical functioning of the resident based on the relevant portions of the minimum data set, as described in Section 14110.15 of the Welfare and Institutions Code, before written notice of transfer is given to the resident. The assessment shall not be considered complete unless it provides recommendations for preventing or ameliorating potential adverse health consequences in the event of transfer. The assessment may be amended because of a change in the resident's health care needs. The assessment shall also include a recommendation for the type of facility that would best meet the resident's needs.

(3) (A) Be responsible for evaluating the relocation needs of the resident including proximity to the resident's representative and determine the most appropriate and available type of future care and services for the resident before written notice of transfer is given to the resident or the resident's representative. The health facility shall discuss the evaluation and medical assessment with the resident or the resident's representative and make the evaluation and assessment part of the medical records for transfer.

(B) If the resident or resident's representative chooses to make a transfer prior to completion of assessments, the facility shall inform the resident or the resident's representative, in writing, of the importance of obtaining the assessments and follow-up consultation.

(4) At least 60 days in advance of the transfer, inform the resident or the resident's representative of alternative facilities that are available and adequate to meet resident and

family needs.

(5) Arrange for appropriate future medical care and services, unless the resident or resident's representative has otherwise made these arrangements. This requirement does not obligate a facility to pay for future care and services.

1336.2(b) Health & Safety Code DIV2 CH2 ART8.5

(b) The facility shall provide an appropriate team of professional staff to perform the services required in subdivision (a).

The Statute is not met as evidenced by:

Based on interview and record review, the facility failed to:
1. Develop an individual, written patient care plan to address high risk for transfer trauma (term used to describe the stress that a person with dementia may experience when changing living environments) for Patient 3.
2. Comply with written patient care policies and procedures when Patient 3 who was identified as "Not Discharge Ready," was not reassessed prior to discharge.
3.Take reasonable steps to transfer Patient 3 safely and minimize possible transfer trauma by not ensuring that the patient's attending physician or the facility medical director, a licensed clinical social worker, and nursing staff properly performed complete assessments of Patient 3.
4.Take reasonable steps to transfer Patient 3 safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services for Patient 3.

Failure to develop and implement an individualized care plan and to properly assess for discharge had the potential to result in Patient 3 not receiving appropriate care and services to meet patient's specific needs and medical condition and to experience mental and/or emotional distress due to relocation to a new environment.
Findings:
A. On 8/11/22, at 10:20 AM, California Department of Public Health (CDPH) conducted an unannounced state monitoring visit at the facility to ensure the safe transfer of residents related to the facility's certification termination and pending closure.
Review of the Physician Discharge Summary dated 6/10/22 indicated, Patient 3 was admitted with diagnoses including hemorrhagic stroke (condition in which a ruptured blood vessel causes bleeding inside the brain) and atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to blood clots in the heart). Patient has a gastrostomy in place (a tube inserted through the belly that brings nutrition directly to the stomach).
During a concurrent interview and record review of Patient 3's Minimum Data Set (MDS-an assessment tool) dated 6/10/22, on 9/7/22 at 3:22 PM with RN 2, the MDS indicated, Patient 3's cognitive status was rarely/never understood and had short term memory problem. RN 2 stated Patient 3's decision making was severely impaired, was incapacitated. Patient 3's daughter was the surrogate decision maker.
A review of Patient 3's "Pre-Discharge or Pre-Transfer Physician Progress Note" dated 5/18/22, indicated: "Relocation Stress Syndrome (a nursing diagnosis characterized by symptoms such as anxiety, confusion hopelessness, and loneliness): Transfer Trauma

Assessment -Patient was assessed for any relocation related stress. Mood and behavior are stable. Please see additional psychosocial care plan for details. Concern for trauma: Family lives nearby and visits daily. Their father/husband is an important part of their daily life. It would be traumatic to the family and the patient (who often declines if family is able to come in for a few days and becomes withdrawn) if he was moved further from their home. The family members all work and live nearby. We expect transfer to another facility would decrease visits and decrease the health of the patient."

Review of Patient 3's "Resident Care Team (RCT) Meeting Note" dated 5/25/22, it indicated: "During pre-discharge patient assessment, RCT reviewed and discussed potential transfer trauma. There would be concern if resident is transferred away from where family lives. Family would prefer San Francisco, CA area if relocation is needed; otherwise it would create distress and hardship for family to provide love and support to resident. Transfer trauma interventions: The RCT assessed for any risks of Transfer Trauma on May 18, 2022. Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal. Refer the patient for Psychiatry consult if needed to address Transfer Trauma."

Review of Patient 3's "LHH Medical Social Services Discharge Assessment" dated 5/17/22 indicated, "Not Discharge Ready" related to chronic progressive disease, cognitive impairment, and palliative care. Risk Factors: Per chart: Resident is of advanced age and currently 84 year old with complex comorbidity (disease or medical condition that is simultaneously present with another in a patient), including history of stroke, atrial fibrillation, gastrostomy in place. Mostly non-verbal.

A review of Patient 3's "Psychosocial Care Plan," dated 5/19/22, indicated, "Problem: Psychosocial Needs…Goal: Demonstrate ability to cope with hospitalization/illness." The care plan indicated the following interventions: "1. Encourage verbalization of feelings/concerns/expectations. 2. Provide quiet environment. 3. Assist patient to identify own strengths and abilities. 4. Encourage patient to set small goals for self. 5. Encourage participation in diversional activities. 6. Reinforce positive adaptation of new coping behaviors. 7. Include patient/family/caregiver in decisions related to psychosocial needs." The care plan also included Transfer Trauma Interventions: The RCT assessed for any risks of Transfer Trauma on May 18, 2022. Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal. Refer the patient for Psychiatry consult if needed to address Transfer Trauma.

During an interview with NM2 on 8/16/22 at 1:45 PM, NM2 said that the transfer trauma care plan was a "pre-populated care plan for all patients."

During an interview with Nurse Manger (NM2) on 8/24/22 at 4:04 PM, NM2 stated that interventions to "mitigate transfer trauma" is addressed in the psychosocial care plan and discharge barrier care plan. NM2 added, "We don't have a template specific to transfer trauma."

During a concurrent interview and record review of Patient 3's "Psychosocial Care Plan" on 9/7/22 at 3:46 PM with RN2, RN2 said Patient 3 was not verbally responsive. RN2 acknowledged that the care plan was not individualized and stated, "Not an individualized care plan, not for him." RN2 further said that the care plan should have been updated/revised.

Review of the facility's policy titled, "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)" revised 7/9/19 indicated, "Policy…2. The RCT in conjunction with the resident, resident's family, or surrogate decision-maker, shall develop a comprehensive care plan, based on the care team disciplines' assessments, that includes measurable objectives and a time table to meet the resident's medical,

nursing, and mental health needs. 3. The Resident Care Plan (RCP) shall be person-centered, evaluated during weekly or monthly summaries, when indicated for short term problems, every quarter, and revised as needed to serve as an essential resource for improved resident outcomes…Procedure:…7. Developing Interventions…b. Interventions are specific, individualized and describes the team member(s) responsible for carrying it out and the frequency for conducting the interventions. c. Interventions reflect standards of current professional practice…"
Patient 3 was discharged from the facility on 6/10/22. At the receiving facility, on 6/17/22, Patient 3 had a change in condition for skin tear with skin discoloration on the side of his left wrist. On 6/24/22, Patient 3 had a change in skin condition for moisture-associated skin damage (MASD-general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine) to inner right and left buttocks. On the same day, Patient 3's G-tube clogged, was sent and admitted to the hospital. Review of physician's certification for hospice indicated, on 7/6/22, Patient 3 was admitted to hospice, noted to be lethargic, opens his eyes only when his name is called. Currently pale, frail and cachectic. Patient 3 was transferred to an acute care facility (hospital) on 7/15/22 and expired at the hospital on 7/16/22.
In violation of the above cited standards, the facility failed to perform complete assessments of the patient and did not develop and implement an individual, written care plan after the facility identified Patient 3 as having a high risk of transfer trauma.

B. Review of Patient 3's "LHH Medical Social Services Discharge Assessment" dated 5/17/22 indicated, "Not Discharge Ready" related to chronic progressive disease, cognitive impairment, and palliative care. Social and Physical Functioning Risk Factors: Per chart: Resident is of advanced age and currently 84 year old with complex comorbidity (disease or medical condition that is simultaneously present with another in a patient), including history of stroke, atrial fibrillation, gastrostomy in place. Mostly non-verbal.
During an interview on 8/24/22 at 1:26 PM, Transfer Coordinator (TC1) stated that "discharge" refers to a discharge in the community for patients needing lower level of care while "transfer" refers to a lateral transfer in another skilled nursing facility (SNF) for patients needing SNF level of care. TC1 explained that the LHH Medical Social Services Discharge Patient Assessment form was a template meant for patients to be discharged to the community. TC1 stated, "This is a new process for us. The discharge template for social worker was updated to clarify meaning of "Not Discharge Ready."
During an interview on 8/24/22 at 1:26 PM, the Director of Social Services (DSS) stated, "Not Discharge Ready is related to not going to community discharge. It summarized what prevents resident from going to the community."
During a review of facility's "Discharge Planning" policy revised 10/13/20, indicated, "Laguna Honda Hospital and Rehabilitation Center (LHH) has a responsibility to provide timely access to skilled nursing services to San Franciscans who are in need of such services. In order to fulfill this responsibility, LHH continually facilitates timely and safe resident discharges to the appropriate level of care. Policy:…2. LHH provides inter-disciplinary discharge planning services that meet the resident's health and safety needs with appropriate and available resources in the community, taking into account the resident's preferences…Definition: Transfer and Discharge: Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident

expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected…"
The facility's discharge Planning policy did not indicate, "Not Discharge Ready" meant discharge to the community or lower level of care. The definition of transfer and discharge indicated in the Discharge Planning policy was not clear to the facility staff completing the pre-discharge patient assessment. This lack of staff training led to the failure in properly assessing Patient 3 prior to transfer to another SNF facility.
During an interview on 9/7/22 at 12:55 PM with Registered Nurse (RN2), RN2 said that "not discharge ready" meant patient was not dischargeable. RN2 further said, if patient is not ready for discharge, it needed reassessment.
During a review of facility's "Discharge Planning" policy revised 10/13/20, indicated, "…Procedure: 1. Discharge assessment and planning is initiated on admission and re-assessed, at a minimum, quarterly, or sooner…"
During a concurrent interview and record review on 9/7/22 at 3:23 PM with RN2, RN2 acknowledged that Patient 3's "LHH Medical Social Services Discharge Assessment" dated 5/17/22 indicated, "Not Discharge Ready" related to chronic progressive disease, cognitive impairment, and palliative care. RN2 said, Patient 3 was not ready for discharge, meaning that the discharge process was decided by the daughter. RN2 further said that usually the facility will do the referral to the SNF but it was his daughter who was the one looking for a facility for him. During further review of the Social Services Discharge Assessment, it indicated: Evaluating Relocation Needs: Per daughter, family would prefer San Francisco, CA Area if relocation is needed; otherwise it would create distress and hardship for family to provide love and support to resident. The document did not indicate that the discharge process was decided by the daughter.
Review of Patient 3's "LHH Pre-Discharge or Pre-Transfer Physician Progress Note" dated 5/18/22 indicated, "…Discharge Arrangements in Progress: Discharge Services: TBD…". The clinical record did not indicate if Patient 3 was ready for discharge.
Patient 3 had an infected PEG site (Percutaneous Endoscopic Gastrostomy – is used to provide enteral access in patients who are unable to swallow. The most common complication of PEG placement is infection at the site) during his course of stay at the facility. Patient 3 was transferred from the facility to another certified SNF on 6/10/22. At the receiving facility, Patient 3 was sent to the emergency room (ER) on 6/24/22, 7/9/22, and 7/13/22 for G-tube (gastrostomy - tube inserted through the belly that brings nutrition directly to the stomach) blockage. Review of physician's certification for hospice indicated, on 7/6/22, Patient 3 was admitted to hospice, noted to be lethargic, opens his eyes only when his name is called, pale, frail and cachectic (a "wasting" disorder that causes extreme weight loss and muscle wasting, and can include loss of body fat). On 7/15/22, Patient 3 was transferred to the ER for low oxygen level. Patient 3 expired in the hospital on 7/16/22.
In violation of the above cited standards, the facility failed to comply with the facility's established written patient care policies regarding discharge planning, to ensure safe coordination of transfer of Patient 3 to another SNF facility on 6/10/22.
In violation of the above cited standards, the facility failed to comply with its established written patient care policies and procedures, Title 22 regulations, and Health and Safety Code section 1336.2, including but not limited to failing to develop and implement an individualized care plan to address Patient 3's high risk for transfer trauma, and take reasonable steps to minimize possible transfer trauma by performing complete assessments and arranging for appropriate future medical care and services. These

failures had the potential to result in Patient 3 not receiving continuity of care and for the patient to experience physical, mental, and emotional trauma following relocation to a different skilled nursing facility.

Name Of Evaluator:
Aurora Liganor

Evaluator
Signature:____________________________

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature:______________________________________

Name:____

Title:____

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