State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE



CITATION NUMBER: 220018217

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

Type Of Visit:

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

Incident/Complaint No.(s) : CA00806430

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<br>CITATION: Patient Care | 3000.00 | 1/3/2023 8:00:00 AM |

T22 DIV5 CH3 ART3-72325(a) 1336.2(a)(1)(2)(3A)(3B)(4)(5) T22 DIV5 CH3 ART3-72311(a)(1)(B)

**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 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

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**

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.

The Statute is not met as evidenced by:

| | |
|---|---|
| Name Of Evaluator:<br>Aurora Liganor | Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE |
| | Signature:_____ |
| Evaluator<br>Signature:_____ | Name:_____ |
| | Title:_____ |

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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 11.
2. Comply with written patient care policies and procedures when:
a. Patient 11 who was identified as "Not Discharge Ready," was not reassessed prior to discharge, and
b. The Registered Nurse (RN) failed to report the patient's conditions and care needs to the receiving facility's RN on Patient 11's day of discharge.
3.Take reasonable steps to transfer Patient 11 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 11.
4.Take reasonable steps to transfer Patient 11 safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services for Patient 11.

Failure to develop an individualized care plan may result in Patient 11 not receiving appropriate care and services to meet patient's specific needs and medical condition(s) and to experience mental and/or emotional distress due to relocation to a new environment.

Findings:

On 8/2/22, at 9:00 AM, California Department of Public Health (CDPH) conducted an unannounced state monitoring visit at the facility to ensure the safe transfer and discharge of patients related to the facility's certification termination and pending closure.
Review of the "Physician Discharge Summary," dated 6/16/22, indicated Patient 11 was a 95 year-old female who was initially admitted to the facility in 2015 from a Board and Care, with a long history of mixed Alzheimer's disease with advanced vascular dementia (brain damage caused by multiple strokes), with the agreement of her Public Guardian. She was unresponsive to verbal stimulation. She progressed in her medical conditions over the past 7 years. Transferred to the facility for comfort-based care. She doesn't get out of bed, mostly unconscious, she doesn't interact or engage or have any meaningful connection.
Patient 11's nursing discharge summary note dated 6/23/22 indicated, "…Resident non verbal, unresponsive to verbal stimuli, unable to make needs known…"
During a concurrent interview and record review on 9/7/22, at 12:08 PM, with Registered Nurse 2 (RN2) , Patient 11's Minimum Data Set (MDS- an assessment tool) dated 6/23/22, indicated Patient 11's cognitive status was rarely/never understood and they had a short term memory problem. RN2 stated Patient 11's decision making was severely impaired.
Review of Patient 11's "Pre-Discharge or Pre-Transfer Physician Progress Note," dated 5/26/22, 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 not stable. Please see additional psychosocial care plan for details…High risk for trauma from transfer, fragile, elderly…"
Review of Patient 11's "Resident Care Team (RCT) Meeting Note," dated 5/25/22, indicated: "During pre-discharge patient assessment, reviewed and discussed potential transfer trauma. Team discussed potential transfer trauma: at risk for skin break down, fx

(fracture) with movement, decompensation without care from regular providers, increased pain and discomfort. Transfer trauma interventions: The RCT assessed for any risks of Transfer Trauma on May 26, 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. Resident was admitted on 1/9/15 for comfort-focused, palliative care."

Review of Patient 11's "Psychosocial Needs" care plan, dated 5/25/22, 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 need." The care plan also included Transfer Trauma Interventions: The RCT assessed for any risks of Transfer Trauma on May 26, 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 Nurse Manager 2 (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 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."

Review of 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: 1. The Resident Care Team a. The RCT is an essential component of the care planning process. The RCT shall include members from those disciplines essential to the planning and delivery of care for the resident. RCT members include: i. Nurse Mangers (or designee) – Facilitator of RCC ii. Licensed Nurse iii. Nursing Assistant iv. Attending Physician v. Medical Social Worker vi. MDS Coordinator vii. Activity Therapist viii. Registered Dietitian…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 11 was discharged from the facility on 6/23/22. At the receiving facility, review of physician's certification for hospice indicated, on 6/24/22, Patient 11 was admitted to hospice with evidence of progressive malnutrition with significant weight loss. Patient was cachectic and pale. She was lethargic and hardly arousable. Patient 11 expired on 7/9/22.

In violation of the above cited standards, the facility failed to comply with Title 22 regulations and written policy and procedure by not developing an individualized, written care plan to address transfer trauma after the facility identified Patient 11 as having a high risk of transfer trauma. Failure to develop an individualized care plan may have resulted in Patient 11 not receiving appropriate care and services to meet the patient's specific needs and medical condition(s) and to experience mental and/or emotional distress and/or

rapid decline of medical status without customized mitigation measures to reduce the effects of relocation to a new environment.
Review of Patient 11's "LHH Medical Social Services Discharge Assessment" dated 5/26/22, indicated, "Not Discharge Ready" related to chronic progressive disease, cognitive impairment, palliative care and other unspecified reason.
During an interview on 8/24/22 at 1:26 PM, Transfer Coordinator 1 (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 11 prior to transfer to another SNF facility.
During an interview on 9/7/22 at 12:55 PM with Registered Nurse 2 (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. RN2 acknowledged that Patient 11 was not reassessed and stated, "That's the latest one I see (dated 5/26/22). There's none after that."
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…"
The facility failed to implement written patient policies and procedures when it did not reassess Patient 11 for discharge prior to transfer to a different skilled nursing facility. u
Patient 11 was discharged to another skilled nursing facility (SNF) on 6/23/22. Review of Patient 11's nursing discharge summary note dated 6/23/22 indicated, "…Conservator aware of residents discharge transfer. All belonging sent with resident, transferring via ambulance…". The clinical record did not indicate nursing service contacted the receiving

SNF for a RN to RN hand -off.
During an interview on 9/7/22 at 12:41 PM with RN2, RN2 said that on the day of patient discharge, the nurse calls the receiving facility to give report (hand-off). RN2 acknowledged there was no documentation that a hand-off was done on the day Patient 11 was discharged. RN2 stated, “Can’t find the documentation. We usually try to get the nurse’s name. I don’t see it on this one. They usually need to document it when they give report to the other charge nurse.” RN2 said a hand-off is important so the receiving facility can continue the care that patients need.
Review of facility’s policy titled, “Facility Closure Plan” dated 5/3/22 indicated, “…18. Offer to review each patient’s care routines, needs and preferences with the staff who will be caring for the patient in the receiving facility…”.
Review of facility document titled, “Standard Work Instructions Title: Transfer to Skilled Nursing Facilities” dated 6/23/22 revision #:4, indicated, “…Major Steps…17. Day of Transfer: Nursing will contact the facility for RN to RN hand-off…”.
Review of an undated facility document titled, “Transfer to Skilled Nursing Facility Checklist” indicated, “…Day of Transfer…RN to RN Hand-off…”.
Patient 11 was discharged from the facility on 6/23/22. At the receiving facility, review of physician’s certification for hospice indicated, on 6/24/22, Patient 11 was admitted to hospice with evidence of progressive malnutrition with significant weight loss. Patient was cachectic and pale. She was lethargic and hardly arousable. Patient 11 expired on 7/9/22.
The facility failed to implement written patient policies and procedures when nursing staff failed to report the patient’s conditions and care needs to the receiving facility’s nursing staff on the day of transfer.
In violation of the above cited standards, the facility failed to comply with its established written patient care policies and procedures, Relocation and Closure Plan, Title 22 regulations, and Health and Safety Code section 1336.2, including but not limited to failing to develop an individualized care plan to address Patient 11’s high risk for transfer trauma, reassess for discharge readiness, provide a nurse to nurse handoff on the day of transfer, 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 11 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

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