CITATION NUMBER: 220018218

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) : CA00806432

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 ART5-72523(a)

CLASS B **CITATION --** Patient Care

Cal. Code Regs., tit. 22, § 72523. 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.
Health & Safety. Code § 1336.2

(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 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

Name Of Evaluator:
Aurora Liganor

Evaluator Signature:_____

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Title:_____

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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.

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

Based on interview and record review, the facility failed to:
1. Comply with written patient care policies and procedures when:
a. Patient 24, who was originally assessed to be discharged to Board and Care (B&C) level of care, was not reassessed prior to transfer to a skilled nursing facility (SNF), and
b. The Registered Nurse (RN) failed to report the patient's conditions and care needs to the receiving facility's RN on Patient 24's day of discharge.
2. Take reasonable steps to transfer Patient 24 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 24.
These failures had the potential to result in Patient 24 not receiving appropriate care and

services to meet patient's specific needs and medical condition(s).
Findings:
On 8/16/22, at 9:30 AM, California Department of Public Health (CDPH) conducted an unannounced complaint investigation at the facility to ensure the safe transfer of residents related to the facility's certification termination and pending closure.
a. Review of the Physician Discharge Summary, dated 7/5/22, indicated, Patient 24 was a 93-year-old female with dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), unsteady gait and poor balance, no safety awareness and is a high risk for falls, with several falls over the last three years. Patient 24 was exposed to COVID and was COVID positive on 6/8/22 with minimal symptoms. Disposition: Board and Care.
Review of Patient 24's "LHH Medical Social Services Discharge Assessment" dated 5/24/22 indicated, Discharge status had discharge barriers of: totally dependent with ADLs (activities of daily living) and mobility; cognitively impaired and/or displays at risk behaviors such as AWOL risk, wandering; history of recurrent falls; incontinent. Patient 24 had chronic progressive disease and cognitive impairment. Evaluating relocation needs: Board and Care Home level with close supervision. Team Recommendation: Board and Care Home.
Review of Patient 24's "Resident Care Team Meeting Note" (RCTMN), dated 5/24/22, indicated, resident was medically stable but she was confused and had no safety awareness. She was a good candidate for boarding care. Daughter joined the resident care conference and was notified of resident's current condition, and possible transferring to boarding care. Daughter verbalized her understanding. The RCTMN under social services indicated, "On 5/24/22, team discussed with daughter possible discharge plan, B&C home level. Family agreed."
During an interview on 8/16/22 at 10:39 AM, Social Worker (SW2) stated that Patient 24 was dependent, needed a lot of assistance with ADLs. SW2 further said, Patient 24 was cognitively impaired (confused, doesn't know name) and had history of falls. SW2 explained that for Board and Care (B&C) level of discharge, patient can be independent for certain things. SW2 stated, "Patient 24 can eat by herself." SW2 said that Patient 24's condition is between B&C and SNF and stated, "But SNF is more protected environment. She's a little bit different."
During an interview on 8/24/22 at 1:26 PM, Transfer Coordinator (TC1) stated, "Discharge Barriers" are factors to consider for discharge. TC1 explained that the LHH Medical Social Services Discharge Patient Assessment form was a template meant for patients to be discharged to the community.
During an interview on 8/24/22 at 1:26 PM, the Director of Social Services (DSS) explained that B&C facilities can cater to higher level needs. DSS acknowledged Patient 24 was not going to lower level of care.
During an interview on 8/24/22 at 2:34 PM, TC1 stated, "They do not need to do re-assessment because they pursued discharge to SNF level."
During an interview on 9/7/22 at 3:58 PM, with Nurse Manager (NM3), NM3 said that Patient 24 was moderately impaired, able to verbalize concerns, lower extremities are weak, and had a history of stroke. NM3 stated, "Better to discharge to SNF."
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 do 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, "Discharge Status: Discharge Barriers" 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 24 prior to transfer to another SNF facility.
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 review of facility's closure plan titled, "Laguna Honda Hospital and Rehabilitation Center Notification of Closure and Patient Transfer and Relocation Plan" dated 5/13/22, indicated, "... Part 2-Patient Assessments...These re-assessments will take in consideration any changes in condition or clinical/nursing care needs that may affect a patient's level of care..."
Failure to perform a reassessment to determine the appropriate level of care prior to discharge to a Skilled Nursing Facility (SNF) for Patient 24 after an initial assessment indicated she should be discharged to a Board and Care had the potential to result in Patient 24 not receiving continuity of care, and experiencing mental, emotional, and physical distress due to transfer to a new environment that may not meet the needs for her care.
b. Patient 24 was discharged to another (SNF) on 7/5/22. Review of Patient 24's nursing discharge summary note, dated 7/5/22, indicated, "...Resident is alert and oriented to self...Verbally responsive well in Cantonese...VS (vital signs) stable...Resident discharged at 10:30...". 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 4:20 PM with NM3, NM3 said that on the day of patient discharge, nurses perform an assessment, then call the facility and give the report. NM3 further said, there are three reports made to the receiving facility, namely, MD to MD (physician), RN to RN, and SW to SW. NM3 stated, "We need to communicate. It's very important for patient's safety." NM3 acknowledged that there was no documentation of RN-to-RN hand-off, and stated, "None."
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 24 was transferred from the facility to another certified SNF facility on 7/5/22. On

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7/22/22, Patient 24 had a change in condition of poor oral intake (decreased or unable to eat and/or drink adequate amounts). Patient 24 expired on 7/24/22, after experiencing symptoms commonly associated with transfer trauma response, including reduction in fluid and nutrition intake, and an exposure to COVID-19.
In violation of the above cited standards and the facility's written patient care policies and procedures, a Registered Nurse (RN) failed to report the patient's conditions and care needs to the receiving facility's RN on Patient 24's day of discharge to another skilled nursing facility on 7/5/22.
In violation of the above cited standards, the facility failed to comply with its established written patient care policies and procedures, Patient Transfer and Relocation Plan, Title 22 regulations, and Health and Safety Code section 1336.2, including but not limited to failing to reassess Patient 24, failing to report the patient's conditions and care needs to the receiving facility's RN on the day of discharge, 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 24 not receiving continuity of care and for the patient to experience physical, mental, and emotional trauma following relocation to a different skilled nursing facility.

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