State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 220018220

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) : CA00804188

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

T22 DIV5 CH3 ART4-72433(b)(5)
T22 DIV5 CH3 ART3-72311(a)(1)(B)
T22 DIV5 CH3 ART5-72523(a)
1336.2(a)(1)(2)(3A)(3B)(4)(5)

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.

T22 DIV5 CH3 ART 4-72433(b)(5) Social Work Service Unit - Services
(b) Social work services unit shall include but not be limited to the following:
(5) Discharge planning for each patient and implementation of the plan.

Name Of Evaluator:
Naida Rico
HFEN

Evaluator Signature:_____

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

Signature:_____

Name:_____

Title:_____

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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

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not obligate a facility to pay for future care and services.

The Statute is not met as evidenced by:

Based on interviews with facility staff and a review of the records, the facility failed to:
1. Comply with its written patient care policies and procedures when the facility physician failed to report the resident's conditions and care needs to the receiving facility's physician on Patient 17's day of discharge, failed to develop care plan to address Patient 17's high risk for transfer trauma, and failed to develop a discharge care plan. 2. Develop an individual, written patient care plan to address high risk of transfer trauma (feelings or symptoms of stress, emotional shock or disturbance, hopelessness, or confusion resulting from the resident being moved from one residential environment to another) for Patient 17.
3. Provide medically related social services to attain and/or maintain the highest practicable physical, mental, and psychosocial well-being by failing to ensure a discharge care plan was developed for Patient 17.

4.Take reasonable steps to transfer Patient 17 safely and minimize possible transfer trauma by not ensuring that a licensed clinical social worker and nursing staff properly performed complete assessments of Patient 17.
5. Take reasonable steps to transfer Patient 17 safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services when the facility physician failed to report the resident's conditions and care needs to the receiving facility's physician on day of discharge, and when social work and nursing staff failed to develop an individual written care plan to address Patient 17's high risk of transfer trauma, and a discharge care plan.
These failures resulted in Patient 17 not receiving care and services to meet his specific needs and medical condition(s), as well as continuity of care to meet his physical, mental, and psychosocial needs following transfer. Additionally, these failures had the potential to result in Patient 17, who had a history of transfer trauma when transferred to another unit at the facility, to experience mental and/or emotional distress due to relocation to a new environment.

Findings:

On 9/22/22, at 9:40 AM, the 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.
Patient 17, a 71 year old male, was admitted to the facility on 5/12/10 with diagnoses of traumatic brain injury (TBI - brain damage), diabetes mellitus (DM - a condition that causes the blood sugar levels in the body to rise higher than normal), dementia (a term used for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and recurrent major depressive disorder (a mental health disease) in partial remission. The resident assessment tool, completed by the facility on 4/22/22, indicated Patient 17 had a Brief Interview for Mental Status (BIMS - a screening tool used to assist with identifying a resident's current cognition) Score of 6, indicating severe cognitive impairment. A public legal guardian acted as a surrogate decision maker for Patient 17 because patient 17 lacked the capacity to make medical decisions. Patient

17 was discharged to another skilled nursing facility on 6/30/22.
A review of Patient 17's "Pre-Discharge or Pre-Transfer Physician Progress Note," dated 5/24/2022, indicated, "Recurrent major depressive disorder (a serious mood disorder) in partial remission (symptoms have been reduced) - STATUS: no active, resolved, was a difficult time to adjust to the new unit on [sic] 2014 in the past. He took antidepressant for a prolonged period of time but now has resolved. Continue to monitor."
Review of Patient 17's 'Nursing Note," dated 6/30/22 at 10:44 AM, indicated Patient 17 was discharged to another skilled nursing facility (SNF) on 6/30/22 at 10:15 AM.
Review of Patient 17's "Discharge Summary," dated 6/29/22 at 3:45 PM, did not indicate the physician contacted the receiving SNF for a physician to physician hand off of patient care during to transfer.

During an interview on 10/3/22 at 3:32 PM, Medical Doctor (MD1) stated, "In general we call the facility and talk to the physicians. In this case, I don't remember the physician's name. I was unable to do a direct one on one with a physician. I called and there was no response, and I didn't call back." MD 1 also stated regarding handoff to the physician at the receiving facility, "For us, it's important…we do it for a continuity of care."

Review of the facility's "Standard Work Instructions," titled "Transfer to Skilled Nursing Facilities (TSNF)," revision #1, 2, 3, and 4, all dated 6/23/22, indicated, "Purpose: To prepare and coordinate the transfers of patients to other skilled nursing facilities." Further review of the TSNF indicated, "Major Steps: 17. Day of Transfer: Physician will contact the facility for physician to physician handoff."

Review of facility's policy titled, Notification of Closure and Patient Transfer and Relocation Plan (Closure and Relocation Plan) " dated 5/13/22 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…".

The facility failed to coordinate the safe transfer of Patient 17 to the receiving facility when the aforementioned "Standard Work Instructions" and Closure and Relocation Plan were not followed during the transfer of Patient 17.

In violation of the above cited standards, the facility failed to comply with, and implement, the facility's established written patient care policies when coordinating the transfer of Patient 17 to another SNF on 6/30/22.
As a result of these failures, the facility did not adequately prepare Patient 17 for transfer, and did not mitigate the potential for transfer trauma evidenced by the physician's documentation of Patient 17's history of negative impacts after being moved to different living arrangements in 2014 on the "Pre-Discharge or Pre-Transfer Physician Progress Note," dated 5/24/2022. This result in Patient 17 not receiving adequate care.
Additionally, the facility failed to take reasonable steps to transfer affected patients safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services when it did not perform the physician to physician handoff.
A review of Patient 17's "Pre-Discharge or Pre-Transfer Physician Progress Note," dated 5/24/2022 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. But at risk of

instability, previous Hx (history) of severe depression and suicidal ideas when relocated from NM (unit at the facility) to N3 (another unit at the facility) few years ago."

A review of Patient 17's "Discharge Summary," dated 6/29/22 indicated, "Recurrent major depressive disorder in partial remission. STATUS: no active, resolved, was a difficult time to adjust to the new unit on 2014. [sic] in the past. He took antidepressant for a prolonged period of time but now has resolved. Continue to monitor." The Discharge Summary also indicated, "Issues requiring follow up: He likes music and is very happy in general. It might have a difficult time with the transition and might need treated with antidepressant."

During a concurrent interview with Registered Nurse (RN) 5 and review of Patient 17's clinical records, on 9/22/22 at 1:56 PM, the "Resident Care Team Meeting Note (RCTMN)," dated 5/24/22, indicated, "Meeting Type: Pre-Discharge Patient Assessment." The RCTMN indicated, "If pre-discharge patient assessment RCC (Resident Care Conference), review and discussion of potential transfer trauma: High risk of transfer trauma due to hx (history) decompensating when moved or relocated. Res (resident) Past longtime companion he is attached to." Further review of the RCTMN indicated, "Transfer Trauma Interventions," as follows:
? The RCT (Resident Care Team) assess risks of Transfer Trauma on 5/24/22
? 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."

RN 5 stated Patient 17's high risk of transfer trauma is, "Something probably should be care planned, probably put in the behavior, so the staff know what they should be observing, to engage the person."

During a concurrent interview with Social Worker (SW) 4 and review of Patient 17's clinical records on 9/22/22 at 2:45 PM, SW 4 reviewed the care plans of Patient 17 but was unable to provide documented evidence of a written care plan addressing risk of transfer trauma. Review of Patient 17's RCTMN indicated, "Care Plan Problems/Goals," and listed the following:
1. Mobility/activity is maintained at optimum level for patient (ADL maintenance)
2. Verbalizes/displays adequate comfort level or baseline comfort level (Pain-Adult)
3. Free from fall injury (Safety Adult – Fall)
4. Patient's chronic condition and co-morbidity symptoms are monitored and maintained or improved (Chronic condition and co-morbidities)
5. Patient will be free of physical & verbal abusive behaviors (Behavioral symptoms)
6. Glucose maintained within prescribed range (Metabolic/Fluid and Electrolytes)
7. Will not develop new pressure ulcer/injury (Pressure Ulcer/Injury or at risk)
8. Resident will participate in meaningful leisure of choice 2-3 times a week (Resident Activity Needs)
9. Mobility level is maintained or improved (ADL Maintenance)
10. Achieves stable or improved neurological status (Neurosensory – Adult)
11. Absence of seizures (Neurosensory – Adult)
12. Remains free of injury related to seizures activity (Neurosensory-Adult)
13. Achieves maximal functionality and self-care (Neurosensory-Adult)
14. Skin integrity remains intact (Skin/Tissue Integrity-Adult)

15. LTG (long term goal) – Patient will tolerate the least restrictive diet without signs or symptoms of aspiration (ADL Maintenance)
16. Food and/or Nutrient Delivery (ND) (Altered Nutrition-Related Laboratory Values)
17. Patient maintains adequate hydration (Nutrition)
18. Patient maintains weight (Nutrition)
19. Resident will optimize number of hours slept with minimal use of medication (Sleep Pattern Disturbance)
20. Maximize patient orientation and to communicate needs (Cognitive Loss/Dementia)
21. Ability to express needs and understand communication (Communication)
22. Resident will not show a decline in psychosocial wellbeing or experience adverse effects through next review (Facility Isolation Psychosocial Wellbeing)
23. Resident will not show no signs or symptoms of COVID-19 (COVID-19 Prevention and Monitoring)
24. Incisions, Wounds, or Drain Sites Healing Without S/S (signs/symptoms) of Infection (Skin/Tissue Integrity-Adult)
25. Resident will not elope from facility (High Elopement Risk AEB)

The list did not include a care plan addressing facility-identified high risk of transfer trauma for Patient 17. SW 4 stated, “There is supposed to be a care plan attached to it (RCTMN). I think it should be nursing doing the care plan for that.” SW 4 stated the care plan should have been created after the Resident Care Team Meeting held on 5/24/22.

During a concurrent interview with RN 5, SW 4, and Quality Management Nurse QMN 4, and review of Patient 17’s “Care Plan Event Log,” on 9/22/22 at 3:16 PM, QMN 4 assisted RN 5 and SW 4 in locating a care plan that addresses the risk for transfer trauma for Patient 17 in the clinical records. QMN 4 stated, “It’s not showing. There is no other areas, it’s not documented.” RN 5 stated, “I don’t see (a care plan) that specifically addresses transfer trauma. We would normally do a discharge care plan. Up until the decertification, he was not on discharge track.”

During an interview on 10/3/22 at 4:10 PM, the acting Chief Nursing Officer (CNO) stated that creating the risk of transfer trauma care plan for the patient is a shared responsibility between the nursing and social services department. The CNO was informed that there was no care plan for risk of transfer trauma for Patient 17. The CNO stated, “If it’s not there, it’s not there. They should be updating the care plan with what he is doing and where he is going.”

Review of [the facility’s] Notification of Closure and Patient Transfer and Relocation Plan, submitted to the Department and Centers for Medicare and Medical Services (CMS) on 5/13/22, under Part 1 - Notification Requirements indicated, “Notice to Individual Patient of Proposed Transfer/Discharge (per Health and Safety Code 1336.2 (a)(3) These notices will be sent out on a patient-by-patient based on the individualized needs of each patient after the assessment is done to minimize the possibility of what is called transfer trauma, or the stress that the person may experience when changing living environments.” Under Part 2 - Patient Assessment indicated, “Because of likely placement delays, these assessments will be conducted every 3 months (quarterly) from the initial assessment date (each a re-assessment). These re-assessments will take in consideration and the changes in condition or clinical/nursing care needs that may affect the patient’s level of care. The 3-month cadence of the re-assessments will continue until the patient is

transferred for discharge from Laguna Honda… To achieve the overall goal of helping patients move to a new location, the facility will maintain a patient-focused discharge process. The facility will provide services such as social services and psychiatric support to minimize stress to patient and/or Representative…" Further review of the facility's Notification of Closure and Patient Transfer and Relocation Plan," dated 5/13/22, indicated, "The intent of this Closure Plan is to ensure the safe, orderly, and clinically appropriate transfer or discharge of each patient with a minimum amount of stress for patients, families, guardians, legal representatives (collectively, Representatives)." Further review of the Closure and Relocation Plan indicated, "Part 9 – Administrator and Facility Closure Team: Roles and Responsibilities…Facility Closure Team: Roles and Responsibilities:…Facility Closure Team – The Resident Care Team will have a role in the transfer/discharge process to assure a safe and orderly transfer for all patients. Nursing Services-Lead: Acting Chief Nursing Officer – Ensures that each patient's care plan is in place and continues throughout the closure process…"

The lack of a care plan that included measurable objectives and a timetable to address the high risk of transfer trauma for Patient 17 was not in accordance with the facility's policy and procedure (P&P) titled, "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)," dated 7/9/19. The facility P&P indicated, "Policy: 2. The RCT, in conjunction with the resident, resident family, or surrogate decision maker, shall develop a comprehensive care plan, based on the care team disciplines' assessments, that includes measurable objectives and a timetable to meet the resident's medical, nursing, and mental health needs."

Further review of the P&P indicated, "Purpose: To promote the resident's highest possible physical, mental and psychosocial well-being." The P&P also indicated, "Procedure: e. The RCT shall address resident care needs and preferences through assessment of the resident and the development and implementation of the RCP."

The facility failed to address Patient 17's care needs when a care plan with measurable objectives and a timetable to meet the resident's medical, nursing, and mental health needs was not developed to address his risk of instability due to previous history of severe depression and suicidal ideas when he was transferred from one unit to another at the facility in 2014.

In violation of the above cited standards, the facility failed to comply with the nursing service requirements for planning of patient care by not developing an individual, written care plan after the facility identified Patient 17 as having a high risk of transfer trauma. The facility further failed to implement its policies and procedures that require the development of a comprehensive care plan when it did not include a plan to address the patient's risk for transfer trauma. Additionally, the facility failed to take reasonable steps to transfer affected patients safely and minimize possible transfer trauma when its social work and nursing staff did not make complete assessments to address Patient 17s high risk of transfer trauma.
According to the facility resident assessment tool, completed on 4/22/22, Patient 17 had severe cognitive impairment and needed extensive assistance with bed mobility, dressing, toileting, and personal hygiene.
A review of Patient 17's "Pre-Discharge or Pre-Transfer Physician Progress Note (PPPPN)," dated 5/24/2022 indicated, "… Given his DM, poorly controlled, the need of

insulin (medication used to regulate blood sugar levels) and he is unable to inject himself given his TBI/Dementia, he is at SNF level." Further review of the PPPPN indicated, "Reason for transferred to SNF level of care TBD (location) - This facility ceases to operate…"

A review of Patient 17's "Resident Care Team Meeting Note (RCTMN)," on 9/22/22 at 1:56 PM, dated 5/24/22, indicated, "Meeting Type: Pre-Discharge Patient Assessment." The RCTMN indicated Patient 17's SDM participated in the meeting. The RCTMN indicated that the Resident Care Team (RCT) determined Patient 17 required him to be SNF level care.

Resident Social History – 5/10/22 – Covering MSW (Medical Social Worker) discussed with IDT (Interdisciplinary Team) regarding Resident's (patient) potential for d/c (discharge). Summary: Requires SNF needs. No discharge potential."

During a concurrent interview with Social Worker (SW) 4 and review of Patient 17's clinical records on 9/22/22 at 2:45 PM, SW 4 reviewed the care plans of Patient 17 but was unable to provide a documented evidence of a discharge care plan for Patient 17. Review of Patient 17's RCTMN indicated, "Care Plan Problems/Goals" (list referenced above).

The list did not include a discharge care plan, a requirement of the Social Service Patient Assessment. SW 4 stated, "Not sure about the discharge care plan. In his (Patient 17's) case we think the reason we don't have one, up to the recertification, we do not consider (Patient 17) to be as a candidate for discharge.

During a concurrent interview with RN 5 on 9/22/22 at 3:49 PM, RN 5 stated that Patient 17 was transferred, not discharged. RN 5 stated, "It's a lateral move. If it's a same facility (referring to another SNF), there would be no discharge plan. It's more a transfer with same level of care as opposed to something to lower level of care. (Patient 17) was transferred and not discharged. Transfer would be transferring someone to different level of care or same level of care. Discharged would be going to home health (medical care provided in a patient's home), RCFE (Residential Care Facilities for the Elderly), something that was not the same level. If the patient is getting discharged, they would need a care plan."

During a concurrent interview with SW 4 and RN 5 on 9/22/22 at 3:55 PM, SW 4 stated, "The thing for (Patient 17)…they (receiving facility) coordinated the time, they said we want the patient, within a matter of days he was gone on the transfer. We did not have discharge (referring to care plan), happened very fast, did not have much control of the situation…" RN 5 stated, "In the events that they (facility) would expect the patient to return to the facility, we do not look at it as a discharge, so we were doing it as a transfer…"
During a concurrent interview with Transfer Coordinator (TC) 1 and review of the facility's policy and procedure (P&P) titled, "Discharge Planning," dated 10/13/20, on 9/22/22 at 4:25 PM, the P&P indicated, "Philosophy: (Facility) 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, (facility) continually facilitates timely and safe resident discharges to the appropriate level of care. Policy: 1. (facility) start to assist every

client/resident (hereafter "resident") keep their optimal health, functioning, and well-being and achieved discharge to the virus level of care possible. When discharge from skilled nursing unit or reliability unit is not achievable, the Resident Care Team shall continue to support maximum social integration." Further review of the P&P indicated, "Definition: Transfer and Discharge: Includes movement of the 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 the 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…" TC 1 stated, "He (Patient 17) was actually discharged…"

The resident assessment tool completed by the facility on 6/30/22 for Patient 17 indicated, "Discharge assessment-return not anticipated…Discharge Date - 6/30/22 … Discharge Status - another nursing home or swing bed."

During an interview on 10/3/22 at 4:10 PM, the Chief Nursing Officer (CNO) stated, "It's a shared responsibility (referring to the staff). Care Plans get initiated upon admission. Nursing has a portion, so does PT (physical therapy) and SW (social work). As for discharge planning, … it's not a regular discharge policy, it's our decertification plan. It is a shared responsibility, so I can understand how everyone is pointing a different way." The CNO also stated, "Honestly when we discharge someone nursing should be ensuring that with Social Work. It has to be both collaboratively…"
A review of the facility policy titled, "7.7 Social Services Department: Discharge Planning and Implementation" with revised date of 8/26/14 and last reviewed on 8/15/22 indicated, "Policy: The Social Services Department is responsible for coordinating discharge planning. Discharge Planning is a process that includes collaboration of the Resident Care Team, families and resident's legal decision makers…Procedure: 1. All residents on admission will be assessed by Social Services for discharge potential…If there is a discharge potential, 1) a care plan will be completed under the Care Plan tab in the EHR (Electronic Health Record) …"

A review of the facility's policy and procedure (P&P) titled, "Discharge Planning," dated 10/13/20, indicated, "Philosophy: (The facility) 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, (the facility) continually facilitates timely and safe resident discharges to the appropriate level of care. Policy: 1. (The facility) strives to assist every client/resident (hereafter "resident") keep their optimal health, functioning, and well-being and achieved discharge to the virus level of care possible. When discharge from skilled nursing unit or reliability unit is not achievable, the Resident Care Team [RCT] shall continue to support maximum social integration." Further review of the P&P indicated, "Definition: Transfer and Discharge: Includes movement of the 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 the 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…Procedure: 4. RCT Roles and Responsibilities. a. RCT Responsibilities. The physician, social worker, nurse, activity therapist, dietitian, rehabilitation specialist, occupation therapist, physical therapist, or speech therapist with others as needed: i. Perform the discharge assessment process as described and negotiate the discharge plan…d. Nurse – i. Collaborates with the resident and family to provide assessment and interventions to maintain or improve self-care functioning. ii. Provides resident and family education to support self-care and independence, based on the care plan. Identifies and advocates for referrals to rehabilitative services to improve self-care and independence.

A review of the facility policy titled, "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)" dated 7/9/19, indicated, "...4. Comprehensive Care Plan a. LHH shall develop and implement a comprehensive person-centered care plan within seven days of completion of the comprehensive assessment. b. The comprehensive care plan shall include measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment
specifically in CAA..."

As a result, the failure to develop a discharge care plan for Patient 17 had the potential to result in Patient 17 not receiving continuity of care to meet his physical, mental, and psychosocial needs.

Patient 17 was discharged from the facility on 6/30/22. At the receiving facility, Patient 17 had a weight loss of 9.4 pounds from 7/13/22 to 8/22/22 (5.9% weight loss in one month). Patient 17 expired on 8/24/22.
In violation of the above cited standards, the facility failed to comply with its policies and procedures, Relocation and Closure Plan, Title 22 regulations, and Health Safety Code section 1336.2, including but not limited to failing to provide a physician to physician handoff on the day of discharge, develop a care plan to address Patient 17's hjgh risk of transfer trauma, develop a comprehensive discharge care plan, 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 17 not receiving continuity of care and for the patient to experience mental and emotional trauma due following relocation to a different skilled nursing facility.

Name Of Evaluator:
Naida Rico
HFEN

Evaluator
Signature:_____

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

Signature:_____

Name:_____

Title:_____

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