CITATION NUMBER: 220018221

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) : CA00806424

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 ART3-72311(a)(1)(B)
1336.2(a)(1)(2)(3A)(3B)(4)(5)
1336.2(b)
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 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

Name Of Evaluator:
Ma Corazon Sia
HFEN

Evaluator Signature:_____

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Name:_____

Title:_____

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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

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services required in subdivision (a).
On 8/2/22, at 9:00 AM,, California Department of Public Health (CDPH) conducted an unannounced complaint investigation at the facility to ensure safe discharge of Patient 5 related to the facility's policy and procedures for discharge planning, along with the approved Transfer and Closure Plan certification termination pending closure.
Based on interviews and record review, the facility failed to:
1) Comply with the nursing service requirements by failing to 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).
2) Comply with the administration service requirements by failing to implement its written patient care policies and procedures when the facility assessed Patient 5 as "not discharge ready".
These failures had the potential to result in Patient 5 not receiving continuity of care and for patient to experience emotional trauma due to leaving a familiar environment, and had the potential to result in Patient 5 not receiving care and services to meet her specific needs and medical condition(s).
Findings:
Patient 5 was admitted with diagnoses including dementia, insomnia, , and blepharitis
Patient 5 was a palliative care patient (a specialized medical care for people living with serious illness).
The Minimum Data Set (MDS, a resident assessment tool) dated 5/14/22, indicated, Patient 5 had severe cognitive impairment and was totally dependent with activities of daily living (ADL, activities related to personal care). The mood and behavior assessment, dated 5/14/22, indicated no symptoms present.
Review of Patient 5's History and Physical (H&P), dated 3/22/21, indicated a 100 year old woman initially admitted to (Name of Facility) (LHH) in 3/2018 with diagnosis of advanced vascular dementia (brain damage caused by multiple strokes) without behavioral disturbance, and insomnia. The H&P indicated, "Physical Exam – Constitutional: frail tiny thin elderly woman, curled up in bed, has contractures, has gross ectropion (an eye condition in which your eyelid sags or turns outward), does not respond to voice or touch, occasionally makes rhythmic motions with her mouth, unable to answer questions … She remains on palliative care. No intensive treatments will be ordered, she will remain on the unit for all her care. She is not to be transferred to acute hospital."
Review of Patient 5's Resident Care Team Meeting Note dated 5/18/22 indicated:
Meeting Type: Pre-Discharge Patient Assessment
Meeting Summary: "During Pre-discharge assessment, RCT reviewed and discussed potential transfer trauma … Goal: Collaborate with patient/family/caregiver to identify patient specific goals for this hospitalization … SDM (surrogate decision maker) participated with meeting via phone. Made aware re (regarding): potential discharge/relocation due to LHH potential closure. Per [Name of SDM], if ever resident will get discharge to another facility she preferred resident to be relocated in Oakland Bay area. Transfer Trauma Interventions: The RCT assessed for any risks of Transfer Trauma on May 17, 2022. Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal. Refer the patient for Psychiatry consult if need to address Transfer Trauma." The RCT Team Meeting Note indicated, recommendation to continue current plan of care; care plan reviewed and updated. Under section MD (medical doctor) Assessment indicated, "Incapacitated, dnr (do not resuscitate), comfort care, has acp (advanced car planning). Not approp (appropriate) for d/c (discharge)."

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Under section Nursing Assessment indicated, normal affect with mood and no unusual behaviors. Under section Nutrition indicated, “No aggressive nutrition intervention w/sign (with significant) wt (weight) shifts or underwt status per comfort care approach." Under section Discharge Plan indicated, “Per IDT (interdisciplinary team) meeting with friend/SDM [Name], no known d/c potential at present as Res continues to receive 24/7 nursing care. Goal remains long term, palliative. Should LHH SNF closure occur, team recommended that Res continues to require LTC SNF LOC (level of care); and friend/SDM [Name] would prefer to have Res relocate to a SNF in Oakland/Bay Area, CA. Oakland, CA would be first choice as it would be closest to [SDM Name] who is Res’ primary social support.”
1.
Review of Patient 5’s LHH Pre-Discharge or Pre-Transfer Physician Progress Note, dated 5/18/22, indicated, discharge diagnosis of dementia without behavioral disturbance. Under the section Hospital Course by Problem indicated, “No new assessment & plan notes have been filed under this hospital service since the last note was generated.” Under Relocation Stress Syndrome: Transfer Trauma Assessment indicated, “Patient was assessed for any relocation related stress. Mood and Behavior are stable. Please see additional psychosocial care plan for details." Under Disposition indicated reason for transfer, “This facility ceases to operate.”
Review of Patient 5's Psychosocial Needs care plan dated 5/18/22, 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.
[Name of SDM] participated with meeting via phone. Made aware re (regarding): potential discharge/relocation due to LHH potential closure. Per [Name of SDM], if ever resident will get discharge to another facility she preferred resident to be relocated in Oakland Bay area.
Transfer Trauma Interventions:
1. The RCT assessed for any risks of Transfer Trauma on May 17, 2022.
2. Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal.
3. Refer the patient for Psychiatry consults and f/u if needed to address Transfer Trauma.

Review of Patient 5’s “Other Orders” dated 6/8/22, indicated, “Discharge patient. Discharge date and time: 6/10/2022 Midday. Discharge disposition: Discharged/Transferred To Skilled Nursing Facility (SNF) With Medicare Certification.”
During an interview with Registered Nurse (RN1) on 8/16/22, at 1:43 PM, RN 1 stated, the Resident Care Team (RCT) assessed Patient 5 for potential transfer trauma during the pre-discharge assessment. RN 1 explained, a "general" transfer trauma care plan was developed and that all patients identified at risk for transfer trauma had the same care plan.
During an interview with NM 2 on 8/16/22, at 1:45 PM, NM 2 stated, the transfer trauma care plan was a "pre-populated" care plan for all patients. NM 2 confirmed the transfer trauma care plan was not specific to Patient 5.
During an interview with RN 1 on 8/16/22, at 1:47 PM, RN 1 explained that the

interventions for transfer trauma is to monitor patients for behavioral changes, anxiety, or irritability. During concurrent record review, RN 1 was unable to show evidence of documentation of emotional and/or behavioral monitoring in Patient 5's electronic health record (EHR).
Review of the clinical record from the receiving facility indicated, Patient 5 was admitted on 6/16/22 under palliative care and expired on 7/7/22.
Review of the facility's policy titled, "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)", dated 7/9/19, indicated, "… 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. 8. Evaluating Effectiveness of the Care Plan: a. Evaluation of the care plan requires accurate knowledge and analysis of resident's present status and is documented in the summary notes … d. The evaluation of the effectiveness of the care plan is documented in the EHR (electronic health record) under: i. The RCT summary note ii. The nursing weekly/monthly summary iii. Discipline specific progress notes in the electronic health record…"
Review of LHH Notification of Closure and Patient Transfer and Relocation Plan, submitted to the Department and Centers for Medicare and Medicaid Services (CMS) on 5/13/22, under Part 1 – Notification Requirements indicated, "Notice to Individual Patient of Proposed Transfer/Discharge (per Health & 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 a 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 any changes in condition or clinical/nursing care needs that may affect a patient's level of care. The 3-month cadence of re-assessments will continue until the patient is transferred or discharged 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..."
The failure to comply with these policies and to develop an individualized care plan for this patient had the potential to disrupt Patient 5's continuity of care and to exacerbate transfer trauma caused by placement in an unfamiliar environment.

2.
During an interview on 8/16/22, at 10:55 AM, Social Worker (SW3) stated, "Not Discharge Ready means the patient is not ready to transfer to a lower level of care. The patient will continue to need long term SNF (Skilled Nursing Facility) level of care."
Review of Patient 5's Resident Care Team Meeting Note, dated 5/18/22, indicated:

Meeting Type: Pre-Discharge Patient Assessment
Meeting Summary: "During Pre-discharge assessment, RCT reviewed and discussed potential transfer trauma … Goal: Collaborate with patient/family/caregiver to identify patient specific goals for this hospitalization … SDM participated with meeting via phone. Made aware re (regarding): potential discharge/relocation due to LHH potential closure. Per [Name of SDM], if ever resident will get discharge to another facility she preferred resident to be relocated in Oakland Bay area…"

Review of Patient 5's LHH Pre-Discharge or Pre-Transfer Physician Progress Note, dated 5/18/22, indicated, discharge diagnosis of dementia without behavioral disturbance. Under the section Hospital Course by Problem indicated, "No new assessment & plan notes have been filed under this hospital service since the last note was generated." Under Relocation Stress Syndrome: Transfer Trauma Assessment indicated, "Patient was assessed for any relocation related stress. Mood and Behavior are stable. Please see additional psychosocial care plan for details." Under Disposition indicated reason for transfer, "This facility ceases to operate."
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2. Provide quiet environment.
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[Name of SDM] participated with meeting via phone. Made aware re (regarding): potential discharge/relocation due to LHH potential closure. Per [Name of SDM], if ever resident will get discharge to another facility she preferred resident to be relocated in Oakland Bay area.
Transfer Trauma Interventions:
4. The RCT assessed for any risks of Transfer Trauma on May 17, 2022.
5. Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal.
6. Refer the patient for Psychiatry consults and f/u if needed to address Transfer Trauma.

Review of Patient 5's Discharge Summary, dated 6/13/22, indicated, discharge diagnosis of dementia without behavioral disturbance. Under section Hospital Course indicated, Patient 5 was profoundly demented, unresponsive, bedbound, contracted, closed, does not make eye contact, does not speak, but still eats if fed, and sleeps nearly 24 hours a day. Under section Physical Exam at Discharge indicated, "Gen (general): nearly comatose with profound neurologic deficit (refers to abnormal function of a body area)… Profound advanced dementia, non-verbal, eyes closed." Under section Advanced Directives indicated, "She is to receive care on S3 only unless her comfort needs cannot be met on the ward. She remains on palliative care. No intensive treatments will be ordered, she will remain on the unit for all her care."
Review of Patient 5's social worker's notes, dated 6/15/22, indicated, "6.15.22: Per LHH Patient Flow/UM (utilization management), MSW (medical social worker) informed friend/SDM [Name] is now anticipated to transfer/discharge to [Name of SNF] tomorrow, Thurs. (Thursday) 6/16/22, pending ambulance transportation confirmation tomorrow morning. S3 aware. Friend/SDM [Name] remains agreeable for Res to transfer/discharge

to [Name of SNF]…"
Review of Patient 5's After Visit Summary, dated 6/16/22, indicated, Patient 5 was discharged to another Skilled Nursing Facility (SNF) via ambulance. During an interview on 8/16/22, at 1:38 PM, RN 1 stated, there was no other discharge assessment aside from the assessment completed on 5/18/22 that indicated that resident was not ready for discharge
During an interview with Nurse Manager (NM2) on 8/16/22, at 1:40 PM, NM 2 stated, Patient 5 was at the end of life in the S3 unit (the designated unit for patients on palliative care).
During an interview on 8/24/22, at 1:28 PM, the Director of Social Services (DSS) stated, "Not Discharge Ready is related to not going to community discharge. It summarizes what prevents resident from going to the community."
During an interview on 8/24/22, at 1:31 PM, TC 1 stated, "The facility is operating under Facility Closure Plan and discharge assessment is done quarterly." When asked if reassessment is required if there is a change of condition, TC 1 stated, "I don't have the copy of the plan in front of me and I am not familiar with the verbiage (indicated in the plan)." TC 1 further explained, the LHH Medical Social Services Discharge Patient Assessment form was a template meant for patients to be discharged to the community. TC 1 further 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 10/3/22, at 3:04 PM, TC 1 stated the facility is using the admission criteria for SNF in choosing patients to be discharged. TC 1 explained that the facility chooses who to discharge based on patient assessment by the physician, nursing, social worker, and MDS.
During an interview on 10/3/22, at 3:13 PM, TC 1 stated, the expectation was to use the most recent MDS assessment when completing the pre-discharge patient assessment and discharge care planning document.
During an interview on 10/3/22, at 3:53 PM, TC 1 was asked the difference of comfort care, palliative care, and hospice care. TC 1 explained, "Comfort care is the end of life care that is no tube feeding, getting pain medications and oxygen for comfort measures, shorter amount of time. Palliative Care is a certain level of providing a little bit more care of the patient, can be DNR/DNI (do not resuscitate/do not intubate), and lifespan of more than six months. Hospice care is six months or less lifespan."
During an interview on 10/3/22, at 3:55 PM, TC 1 stated, patients referred for discharge is based on operations and on available beds. "It's whoever's patient assessment completed in that week."
Review of facility policy titled, Discharge Planning, dated 10/13/20, indicated, "Laguna Honda Hospital and Rehabilitation Center (LHH) has a responsibility to provide times 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 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

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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 5 prior to transfer to another SNF facility.
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 by the facility 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… 2. After assessment process is completed, MSW (medical social worker) will coordinate an interdisciplinary determination of a discharge care plan to assist the resident in transition to the community and in identifying discharge considerations and interventions that impact the discharge plan…"
The facility's Social Services Department: Discharge Planning and Implementation policy did not include planning and implementation of discharge to another skilled nursing facility or to the same level of care. The facility's transfer coordinator verified that the Medical Social Services Discharge Patient Assessment form was a template meant for patients to be discharged to the community and not for another skilled nursing facility or to the same level of care.
The lack of complete facility policies and care plans related to discharge and transfer created a lack of clarity and confusion for assessment and transfer staff that could result in Patient 5 not receiving a proper assessment of required care after transfer to a new facility. 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 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 5's high risk for transfer trauma. These failures had the potential to result in Patient 5 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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