State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 220018223

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) : CA00797115

Licensee Name: City & County of San Francisco, Dept. Public Health

Address: 375 Laguna Honda Blvd. San Francisco, CA 94116

License Number: 220000040 Type of Ownership: County

Facility Name: LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

Address: 375 Laguna Honda Blvd San Francisco, CA 94116

Telephone : (415) 759-2300

Facility Type: Skilled Nursing Facility Capacity: 769

Facility ID: 220000512

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

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

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.

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:

Name Of Evaluator:
Ma Corazon Sia
HFEN

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

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

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

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

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

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

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

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

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

The Statute is not met as evidenced by:

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1.
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 of residents related to the facility's certification termination and pending closure
.
The facility failed to appropriately assess and plan for Patient 38 prior to transfer as required by statute and the facility's policy and procedure to minimize the 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), by failing to provide an individualized plan based on the required assessments.
The facility failed to:
1. Develop an individualized patient care plan (CP) for discharge planning, and to address high risk of transfer trauma for Patient 38.
2. Implement a patient care plan to address high risk of transfer trauma for Patient 38.
3. Implement its written policies and procedures requiring development and implementation of an individualized care plan for discharge planning and to address risk of transfer trauma.
4. Take reasonable steps to transfer Patient 38 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 38.
These failures had the potential to result in Patient 38 experiencing mental, emotional, and physical distress after relocation to a new environment and Patient 38 not receiving continuity of care to meet his specific needs and medical conditions upon transfer due to his inability to verbalize emotions and nutrition intake concerns.

Findings:
Patient 38 was admitted with diagnoses including vascular dementia (brain damage caused by multiple strokes) with behavioral disturbance, hypertension (high blood pressure), and left sided weakness from polio (a virus that may cause paralysis).
The Minimum Data Set (MDS, a resident assessment tool) dated 4/1/22, indicated, Patient 38 had severe cognitive impairment and was totally dependent with activities of daily living (ADLs, activities related to personal care) requiring one staff assist.
The History and Physical (H&P) dated 5/27/22, indicated, "History Of Present Illness: [Patient 38] is a 77-year-old male transferred from [Name of acute hospital] after getting treatment for urosepsis from 05/20/2022 patient is a 77-year-old nonverbal male with past medical history of vascular dementia, polio with bilateral upper extremity flexion contraction deficit, hypertension, benign prostatic hyperplasia [prostate gland enlargement, a common condition as men get older]…neurogenic bladder [a problem in which a person lacks bladder control due to a brain, spinal, or nerve condition] with chronic indwelling Foley catheter [a flexible tube that a clinician passes through the urethra and into the bladder to drain urine]… Patient continued to refuse oral intake does goals of care were discussed with family son with position transition to comfort care [a patient care plan that is focused on symptom control, pain relief, and quality of life] at [Facility Name] and possible hospice [focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life] if unable to tolerate oral liquids can hold off on antibiotics … Physical Exam: Generally cachectic elderly [having

cachexia – physical wasting with loss of weight and muscle mass due to disease]… Assessment/Plan: …Patient comfort care and no transfer to acute if he refuses the antibiotics or feeding no feeding tubes no labs… Comfort care hospice care at [Facility Name] with no further workup of prostate infection abscess [collection of pus that develop as the result of acute bacterial prostatitis] Per family dysphagia (difficulty of swallowing) on lowest level diet and no feeding tubes … Family informed son agree to comfort care…"
Review of the Resident Care Team (RCT) Meeting Note, dated 6/2/22, indicated:
Meeting Type: Pre-Discharge Patient Assessment + Readmission + 5 days Medicare.
Patient/Family/SDM (surrogate decision maker)/Conservator participated: yes
"Meeting Summary: resident is oriented to his name. He is cognitive impaired with poor intake. He cannot eat or drink by himself. He has difficulty to express his needs or discomfort, e.g., [example] thirsty [sic] or hungry. He eats 25% to 50% of his meals and drinks fluids about 8000 [sic] to 1100 daily. He has [foley catheter] for his neurogenic bladder. He is at high risk for UTI and dehydration. On 05/21/22, he developed chills, nausea and low [oxygen saturation] and was transferred to acute. He was readmitted to [North 5 unit] on 5/27/22. He is still on [antibiotic] for his UTI and Bacteremia. He needs total assist for all his ADLs. He may be transferred to other [skilled nursing facility (SNF)] for long term care. Wife joined this {resident care conference (RCC)] and was notified of resident's current condition, and plan for transferring to boarding care. Wife verbalized her understanding and agreement of transferring to other SNF for long term care."

The RCT Meeting Note, dated 6/2/22, indicated, "Recommendations: 1. Plan to transfer to other SNF facility. 2. Continue to remind and assist to drink more fluids. 3. [Patient Care Assistant] assess and address his needs q (every) 2 hours. Care plan reviewed and updated: Yes"

The RCT Meeting Note, dated 6/2/22, indicated, "If pre-discharge patient assessment RCC, review and discussion of potential transfer trauma: Problems: Risks for Transfer Trauma. Goals: minimize fear or emotional trauma of being transferring to other facility."
Under the Social Services section of the RCT Meeting Note indicated, "On 06/02/2022, team and wife discussed [discharge (d/c)] assessment; wife agreed [resident] SNF level for [possible] d/c."
Review of Patient 38's Psychosocial Needs care plan, dated 6/3/22, indicated, "Problems: Risks for Transfer Trauma Goals: minimize fear or emotional trauma of being transferring to other facility." The "Psychosocial Needs" care plan indicated the following interventions: "1. Assess and monitor patients' ability to cope with resident's illness and hospitalization. 2. Encourage verbalization of feelings/concerns/expectations. 3. Provide quiet environment. 4. Observe patient's emotional or behavioral changes. 5. Encourage participation in diversional activities Reinforce positive adaptation of new coping behaviors. 6. "I" Invite family members to join RCC to discuss the fear, concerns or questions from resident and resident's family. 7. "I" Provide the possible available facilities for resident or resident's family to select. 8. The RCT assessed for any risks of Transfer Trauma on Jun 02 and 3, 2022. 9. Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal. 10. Psychiatry consults and f/u if needed to address Transfer Trauma."
Review of Patient 38's Discharge Summary, dated 6/16/22, indicated, Patient 38 will be discharge to [Name of SNF] on 6/17/22 with discharge diagnosis of vascular dementia with behavioral disturbance. Patient 38's mental status is at baseline. Under the comment section indicated, "Awake on verbal stimuli, tracking but not follow commands, not answer

question."
Review of the clinical record from the receiving facility indicated, Patient 38 was not eating and taking his medications since admission. Patient 38 had significant weight loss of 11.9% in 1 month and was placed on IV fluid therapy. On 7/28/22, Patient 38 was transferred to the acute hospital for critical lab values and later expired on 7/30/22.
During an interview on 9/7/22, at 3:28 PM, Nurse Manager 3 (NM 3) stated, "Patient 38 has impaired cognitive. He's verbal most of the time but does not make any sense."
During an interview on 9/7/22, at 3:37 PM, NM 3 stated, Patient 38's mood and behavior was "unstable." NM 3 explained, Patient 38 was "sometimes agitated and resistance during ADLs."
During an interview on 9/7/22, at 3:40 PM, NM 3 stated, "Patient 38 has difficulty to express himself. He's advanced dementia. He's able to verbalize but does not make sense."
During a concurrent interview and record review with NM 3 on 9/7/22, at 3:50 PM, the RCT Meeting Note and Psychosocial Needs care plan were reviewed. NM 3 was unable to find documented evidence of transfer trauma risk assessment on 6/3/22 as indicated in the RCT Meeting Note and Psychosocial Needs care plan. NM 3 stated, the transfer trauma assessment was completed during the RCT meeting on 6/2/22. In addition, there was no documented evidence of Patient 38's emotional and/or behavioral assessment and monitoring as indicated in the Psychosocial Needs care plan. NM 3 stated, the facility document by exemptions, "general documentation only if behavior is stable."
Review of 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. 4. The resident, family, significant other(s) and/or conservator shall be part of the development and implementation of his or her person-centered plan of care."
According to the facility's policy, person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. Under the procedure of the resident care plan policy indicated, "1e. The RCT shall address resident care needs and preferences through assessment of the resident and the development and implementation of the RCP … 7b. Interventions are specific, individualized and describes the team member(s) responsible for carrying it out and the frequency for conducting the interventions…"
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.

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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..."
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