State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 220018224

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) : CA00795848

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)
T22 DIV5 CH3 ART5-72523(a)

CLASS B **CITATION --** Patient Care

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.

Name Of Evaluator:
Ma Corazon Sia
HFEN

Evaluator Signature:_____

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

Signature:_____

Name:_____

Title:_____

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(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).

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.

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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.

The Statute is not met as evidenced by:

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 39 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 39.
2. Implement a patient care plan to address high risk of transfer trauma for Patient 39.
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 39 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 39.
5. Take reasonable steps to transfer Patient 39 safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services for Patient 39.
6. Comply with the administration service requirements by failing to implement its written patient care policies and procedures when the facility assessed Patient 39 "not discharge ready".
These failures had the potential to result in Patient 39 experiencing mental, emotional, and physical distress after relocation to a new environment and Patient 39 not receiving continuity of care to meet his specific needs and medical conditions upon transfer.
Findings:
Patient 39 was admitted to facility on 7/8/21 with diagnoses including dementia, Parkinsonism (refers to brain conditions that cause slowed movements, stiffness and tremors), and degenerative joint disease (wear and tear of the protective tissue at the ends of bones that occurs gradually and worsens over time).
Review of Patient 39's History and Physical (H&P) dated 7/8/21, indicated, "[Patient 39] is a 79-year-old right-handed male with past medical history of vascular risk factors, hearing loss, cardiac arrhythmia [irregular heartbeat], herpes zoster [a reactivation of the chickenpox virus in the body, causing a painful rash] who has mixed dementia with progressive memory decline since 2014. Was in [Name of acute hospital] on 12/12/2020 for hypoactive encephalophathy [term for any diffuse disease of the brain that alters brain function or structure], with advanced dementia and Parkinson's like features [tremor, slow movement, stiffness, and loss of balance]. Recent hospitalization due to dehydration, not eating and hypernatremia [high concentration of sodium in the blood], secondarily … Level

of alertness and activity varies from day to day and treated for fainting/low sodium …"
Review of Patient 39's Minimum Data Set (MDS, a resident assessment tool) dated 4/15/22 indicated, impaired memory and cognitive skills for daily decision making. The mood and behavior assessment, dated 4/15/22, indicated, no signs of poor appetite present. The functional status assessment, dated 4/15/22, indicated, total dependence with one-person assist on his activities of daily living (ADLs) that includes eating.
Review of Patient 39's Resident Care Team Meeting Note dated 6/6/22, indicated the following:
Meeting Type: Pre-Discharge Patient Assessment
Meeting Summary: "…During Pre-discharge assessment, RCT reviewed and discussed potential transfer trauma. Informed SDM (surrogate decision maker)/Resident [Name] that [the facility] will be searching/submitting applications to appropriate Level of Care placement. Team recommends: Long term care SNF. Team discussed potential transfer trauma: Medical and psychosocial decline, family distress re (regarding): resident being around unfamiliar staff and environment, family all lives in San Francisco/Bay Area. In case of transfer, Family prefers San Francisco – [the facility] is number one choice. Recommendations: [Continue] current plan of care. Resident Consents to post Resident Discharge Location: N/A – family does not consent to discharging resident in less than 60 days … Activity preferences discussed: No change from the last assessment on 01/14/2022. Resident spends all his time in his room laying in bed and sometimes the tv is on… Discharge Plan: [Patient 39] requires SNF level of care secondary to functional limitations and cognitive deficits … Resident had a quarterly three assessment with [assessment reference date - ARD] on 4/15/22. ADLs remain at his baseline, total dependence with extensive to total for bed mobility. He is incontinent of bowel and bladder function. No other changes noted."

Review of Patient 39's "Pre-Discharge or Pre-Transfer Physician Progress Note", dated 6/8/22, indicated, "Discharge Diagnosis: Dementia without behavioral disturbance … Current Functional Status: Total care. 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 ..."
Review of Patient 39's Psychosocial Needs care plan, dated 6/6/22, 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.

Review of Patient 39's [Facility] Medical Social Services Discharge Patient Assessment, dated 6/8/22, indicated, "Discharge Barriers: Totally dependent with ADLs (activities of daily living) and mobility, Cognitively impaired and/or displays at risk behaviors, Incontinent ... Not Discharge Ready: Chronic Progressive Disease, Cognitive Impairment, Palliative Care ... Social and Physical Functioning: Risk Factors: [Patient 39] requires total assistance with a majority of his ADLs. When [out of bed, oob], he is dependent upon a wheelchair. Due to cognitive deficits, [Patient 39] seldom verbally communicates and is

often sleeping. Per [Name], daughter, Patient 39 does not recognize family members. She reported that he appears comfortable. Both his mood and behavior are stable. RCT met with the SDM and discussed [the facility's] Closure and Patient Transfer Relocation Plan. RCT informed SDM is very concerned about the impact of the resident losing his home and familiar staff on the resident's health and well-being. SDM emphasized that [Patient 39] is familiar with both the staff and environment … [Patient 39] requires SNF level of care. SDM desires for [Patient 39] to receive palliative care in a SNF in [San Francisco, SF]. His family resides in SF …"
Review of Patient 39's Discharge Summary dated 7/7/22 indicated, "…On June 3, 2022, discussion with her [sic] daughter reveals familial stress and potential trauma from relocation of the patient … Hospital Course by Problem: Dementia, severe, advanced, mixed type with parkinsonism, Alzheimer's and vascular dementia since 2014. Slowly progressive disease over last eight years with notable decline over last 60 days … Type of Discharge: Transfer to another facility. The patient will be discharged to skilled nursing facility. Discharge Condition: Fair…"
Review of the nursing discharge summary note dated 7/8/22, indicated, Patient 39 was discharged to another skilled nursing facility on 7/8/22.
Review of the clinical record from the receiving facility indicated, Patient 39 was admitted on 7/8/22 with the primary focus on comfort management and expired on 7/25/22, at 1:30 PM. The clinical record indicated, Patient 39 had a change in condition on 7/24/22, was noted coughing on thin liquids. On 7/25/22, at 11:00 AM, the occupational therapist completed a swallowing evaluation for Patient 39 and recommended to change diet to NPO (nothing per orem or nothing by mouth) and initiate intravenous fluids (IVF) for hydration; at 1:30 PM, Patient 39 was noted with pale skin and no vital signs appreciated.

During an interview with Nurse Manager 2 (NM 2) on 8/24/22, at 4:04 PM, NM 2 stated interventions to "mitigate transfer trauma" is addressed in the psychosocial care plan and discharge barrier care plan. NM 2 added, "We don't have a template specific to transfer trauma."
During an interview with NM 2 on 8/24/22, at 4:14 PM, NM 2 stated, "[The Psychosocial Needs care plan dated 6/6/22] is the only care plan that I have. This is all I have."
During concurrent interview and record review with Registered Nurse 2 (RN 2) on 9/7/22, at 2:59 PM, RN 2 reviewed the Psychosocial Needs care plan for Patient 39 and was unable to find interventions addressing potential transfer trauma. RN 2 stated, "[The Psychosocial Needs care plan] should be this one." RN 2 confirmed the Psychosocial Needs care plan was not specific for Patient 39. RN 2 added, Patient 39 was "non-verbal, alert to himself only, withdrawn, no orientation, and very confused."
During an interview on 8/16/22, at 10:55 AM, Social Worker 3 (SW 3) 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."
During an interview on 8/16/22, at 2:05 PM, NM 2 stated the discharge assessment for Patient 39 was completed on 6/6/22. NM 2 further stated, Patient 39 did not require a reassessment since there was no change in condition since the first assessment was completed.
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 [facility's] 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. TC 1 explained, the facility is not licensed for hospice care but rather provide palliative care. TC 1 stated S3 is the palliative care unit in the facility. TC 1 added, other units can also provide palliative care for their long term patients for continuity of care, staff and environment.
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 [do not resuscitate, DNR]/[do not intubate, DNI], 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 more on operations and based on available beds. "It's whoever's patient assessment completed in that week."
Review of the facility's undated document titled, "[The Facility's] Hospital Palliative Care Program", indicated, "Palliative Care: Patient and family centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care occurs throughout the continuum of illness… and addresses physical, intellectual, emotional, social and spiritual needs and … facilitates patient autonomy, access to information and choice."
Review of the facility policy titled, Discharge Planning, dated 10/13/20, indicated, "[The facility] 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. [The facility] 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 certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected ..."
There was no documented evidence in the facility's Discharge Planning policy dated 10/13/20 that "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.
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… 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.
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 [the facility’s] 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..."

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