CITATION NUMBER: 220018225

Date: 12/20/2022 12:00:00 AM

Type Of Visit:

Incident/Complaint No.(s) : CA00806421

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

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

CLASS B **CITATION --** Patient Care

72311 Nursing Service

(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.

72523 Patient Care Policies and Procedures

(a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved.

 72433. Social Work Service Unit--Services.

Name Of Evaluator:
Anabel Macaraig
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

(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.

Health and Safety Code section 1336.2
(a) Before residents are transferred due to any change in the status of the license or operation of a facility, including a facility closure or voluntary or involuntary termination of a facility's Medi-Cal or Medicare certification, the facility shall take reasonable steps to transfer affected residents safely and minimize possible transfer trauma by, at a minimum, doing all the following:
(1) Be responsible for ensuring that the resident's attending physician or the facility medical director, if the resident does not have an attending physician, completes the medical assessment of the resident's condition and susceptibility to adverse health consequences, including psychosocial effects, prior to written notice of transfer being given to the resident. The assessment shall not be considered complete unless it 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.
(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.

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 7's day of discharge, staff failed to develop a care plan to address Patient 7's high risk for transfer trauma, and staff failed to develop a discharge care plan.
2. Develop an individual, written patient care plan to address risk of transfer trauma for Patient 7.
3. Develop a discharge care plan for Patient 7.

4.Take reasonable steps to transfer Patient 7 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 7.
5.Take reasonable steps to transfer Patient 7 safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services for Patient 7. These failures resulted in Patient 7 not receiving continuity of care, and experiencing mental, emotional, and physical distress after relocation to a new environment due to

transfer trauma.

On 8/2/22, at 9:00 A.M., the California Department of Public Health (CDPH) conducted an unannounced complaint investigation at the facility to ensure the safe transfer of residents related to the facility's certification termination and pending closure.

Patient 7 was a 79-year-old male, admitted to the facility on 6/10/2003, with diagnoses including dementia (decline in memory and decision-making abilities) and neuroleptic induced parkinsonism (medication used for treatment of mental illness resulting in a condition causing movement problems such as tremors, slow movement, and stiffness). Patient 7 was transferred to another SNF on 6/21/22. Patient 7 passed away on 7/1/22.

The Minimum Data Set (MDS, a standardized assessment tool) dated 5/26/22, indicated Patient 7 had severe impairment to make decisions regarding tasks of daily life. Patient 7 was described as rarely/never understood and rarely/never understands. Patient 7 was dependent with all activities of daily living (ADL's) including, mobility, transfer, eating, personal hygiene, toileting, and was not ambulatory (not able to walk).

Review of Resident Care Team (RCT) Meeting Note dated 5/24/22, indicated, "...review and discussion of transfer trauma: possible transfer to another Skilled Nursing Facility (SNF) in San Francisco (SF) recommend familiar staff to care for him. At risk for transfer trauma due to advanced dementia, long term care resident of (name of facility) ... Interventions:" ... Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal. Refer the patient to psychiatry consult if needed to address Transfer Trauma..."

Review of the transferring facility's document titled Pre-discharge or Pre-Transfer Physician progress notes dated 5/31/22, indicated, "...Relocation Stress Syndrome: transfer trauma assessment. Patient was assessed for any relocation related stress. Mood and behavior were not stable...He (Patient 7) is at risk of deteriorate [sic] given the change to another facility due to his fears of unfamiliar faces..."

A review of the facility's Medical Social Services (MSS) Discharge Patient Assessment dated 6/1/22, indicated discharge barriers as follows: "Totally dependent with activity of daily living and mobility, cognitively impaired, history of recurrent falls, Not Discharge Ready."

Under Social and Physical functioning, the following was indicated: "Risk factors: Resident requires total care with ADL's and is incontinent. He suffers from advanced dementia and lacks decision making capacity. However, he has lived at (name of facility) for 19 years and is familiar with staff and the environment. Staff can anticipate his needs. Resident would be at risk for transfer trauma..."

During a concurrent interview and record review with the Licensed Clinical Social worker (LCSW) from the transferring facility, on 8/16/22, at 11:37 AM, LCSW stated, "The Not discharge ready shouldn't have been marked, it was a mistake."
LCSW also stated monitoring for residents emotional and behavioral changes is "done as a general observation and there was no other documentation."

Review of Physician Discharge Summary notes dated 6/17/22 from the transferring facility, indicated, Patient 7 had been at the facility, "...for more than 20 years. He has established relationships here...Now his dementia is advanced to total dependent in all ADL's. It is sad to see him go..."

During a concurrent interview and record review on 9/7/22, at 11:30 AM, the Discharge Patient Assessment dated 6/1/22 that indicated Patient 7 was not discharge ready was presented to Charge Nurse (CN 1). CN 1 stated, "Generally I will reassess my patient."

During a concurrent interview and record review of Patient 7's electronic record with CN 2 on 9/7/22, at 12:43 PM, CN 2 acknowledged and verified there was no evidence of documentation a reassessment was completed to address readiness for discharge. CN 2 stated they were required to discharge a number of patients a day. CN 2 acknowledged there was no evidence of documentation an individualized plan of care was completed to address transfer trauma for Resident 7.

A review of nurse's notes dated 6/21/22, indicated Patient 7 was transferred to another SNF on 6/21/22.

During a review of the transfer documents that the facility provided to the receiving facility at time of transfer, there was no evidence of documentation that a reassessment was completed to address readiness to transfer for Patient 7 prior to his transfer to another SNF.

A review of Patient 7's medical record after transfer to the receiving facility indicated the patient displayed behavior of transfer trauma, including a reduction in nutrition intake of approximately 25% for multiple meals between 6/21/22 and 6/25/22.

A review of the "Facility Closure Plan" dated 5/3/22, indicated, "...Facility Closure Team Role and Responsibilities...Every staff member that is a part of each patient's Resident Care Team, will have a role in the transfer and relocation process to assure a safe and orderly transfer for all patients...Nursing Services...Implement the general scope of nursing practice, including promotion of health, prevention of illness, and care of physically ill. Supervises other health care auxiliaries. Ensure that each patient's care plan is in place and continues throughout the closure process... Social Services...Conduct and provide social and psychosocial assessments and support to all patients. Coordinate and conduct patient and/or representative meetings regarding the closure plan. Identify discharge options and services needed..."

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 and Safety Code1336.2(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 considerations any changes in condition or clinical/nursing care needs that may affect a patient's level of care. The 3-month cadence of re-assessment will continue until the patient is transferred or discharged from Laguna Honda...To achieve the overall goal of helping patient's 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..."

Failure to perform an assessment of discharge readiness prior to the transfer of Patient 7 after an initial assessment indicated he was not ready for discharge to another facility resulted in Patient 7 not receiving continuity of care, and experiencing mental, emotional, and physical distress after relocation to a new environment due to his documented fear of unfamiliar faces related to his dementia.

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 develop a care plan to address Patient 7's risk of transfer trauma, complete discharge assessments and planning, 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 resulted in Patient 7 not receiving continuity of care and for the patient to experience mental and emotional trauma following relocation to a different skilled nursing facility.

Name Of Evaluator:
Anabel Macaraig
HFEN

Evaluator
Signature:___________________________

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