CITATION NUMBER: 220018227

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) : CA00806444

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

CLASS B **CITATION --** Patient Care

PATIENT 2:

T22 DIV5 CH3 ART3-72311(a)(1)(A) 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:
(A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.

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

Name Of Evaluator:
Regina Baena

Evaluator
Signature:_____

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

Signature:_____

Name:_____

Title:_____

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T22 DIV5 CH3 ART3-72311(a)(1)(A)
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)
T22 DIV5 CH3 ART3-72311(a)(1)(C)
T22 DIV5 CH3 ART3-72311(a)(1)(B)
T22 DIV5 CH3 ART3-72311(a)(2)
T22 DIV5 CH3 ART3-72311(a)(1)(A) 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:
(C) Reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition.

T22 DIV5 CH3 ART3-72311(a)(2) Nursing Service-General
(a)Nursing service shall include, but not be limited to, the following:
(2) Implementing of each patient's care plan according to the methods indicated. Each patient's care shall be based on this plan.

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)
1336.2(b)
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.

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(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:

On 9/22/22, at 9:40 AM, California Department of Public Health (CDPH) conducted an unannounced complaint investigation at the facility to ensure the safe discharge of Patient 2 in accordance with facility policy and procedures, and as related to the facility's certification termination and closure plan.
Based on interview 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 environment to another) for Patient 2, and
2) Comply with its written patient care policies and procedure when the facility physician failed to report the resident's conditions and care needs to the receiving facility's physician on Patient 2's day of discharge.
These failures had the potential to result in harm to Patient 2, who was identified as high risk for transfer trauma due to his dementia and increase confusion to not receive continuity of care, and experience mental and/or emotional distress due to relocation to a new environment. In addition, these failures had the potential to result in Patient 2 to not receive care and services to meet his specific needs and medical conditions.

Findings:

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Patient 2 was a 79 year old male, admitted to the facility on 3/2/22, with diagnoses that include vascular dementia (a disorder characterized by damaged brain tissue due to lack of blood flow) status post (s/p) urosepsis (urinary tract infection leading to systemic infection), failure to thrive, s/p hydronephrosis (A condition characterized by excess fluid in a kidney due to back up of urine) and nephrostomy tube (catheter inserted through the skin and into the kidney to drain urine) due to urethral dysfunction, and atrophic left kidney (A condition in which one or both kidneys shrink to a smaller size, hindering normal function).

1.

On 5/20/22, Patient 2 was transferred to the acute care hospital emergency room for urosepsis. The patient was positive for extended spectrum beta-lactamase (ESBL) (enzyme found in some strains of bacteria. ESBL-producing bacteria can't be killed by many of the antibiotics used to treat infections), Escherichia coli (E. coli- type of bacteria that lives in the intestines).

Patient 2 was re-admitted to LHH on 5/31/22, with a peripherally inserted central catheter (PICC – is a thin flexible tube that is inserted through a vein in the upper arm and guided [threaded] into a large vein above the right side of the heart. It is used to give intravenous fluids, blood transfusions, chemotherapy, and other drugs) line. He was on intravenous (IV- administered into a vein or veins) antibiotic (14-day course of antibiotic) with six more days to complete for ESBL bacteremia. Patient 2 was transferred to another skilled nursing facility on 6/10/22.

A review of Patient 2's "[Facility Name] Pre-Discharge or Pre-Transfer Physician Progress Note" dated 5/19/22, the document 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 not stable. Please see additional psychosocial care plan for details. Patient gets confused and resists treatment. He is at high risk from transfer trauma due to his dementia and increased confusion. He currently believes he is in Thailand most of the time and had a difficult adjustment to LHH, and still adjusting as he still gets disoriented."

A review of Patient 2's "Discharge Summary" dated 6/9/22 indicated "Issues requiring follow up Urology for nephrostomy tube and hydronephrosis plastic for stage 4 L hip will need debridement. Discussed with son on the phone today that his father needs follow up for above issues that are not resolved and that he is going to be transferred to [Facility Name] for continue of care. Sick resident with multiple comorbidities and with poor prognosis" It also indicated "Pertinent Physical Exam at Time of Discharge Appearance: He is ill-appearing. Very sick man. Comments: Cachectic and now with worsening contractures"

During a concurrent interview and record review on 10/3/22 at 2:10 PM, with the Nurse Manager (NM6), Patient 2's medical record was reviewed, there was no care plan in the medical record to address Patient 2's high risk for transfer trauma. NM 6 acknowledged that there should have been a care plan if a patient was identified as a high risk for transfer trauma. There was no Resident Care Team Meeting Note (RCTMN) in the medical record after Patient 2's readmission on 5/31/22. NM 6 stated, "RCT is held within 7-14 days. Patient 2 should have had a new RCT meeting because he had a change of condition when he was hospitalized. The resident [Patient 2] was transferred before we can do the RCT meeting."

During an interview on 10/3/22 at 4:10 PM, the Chief Nursing Office (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 stated they (nursing and social services) should be updating the care plan with what the patient was doing and where the patient was going.
A review of the facility's policy and procedure, titled, "Facility Closure Plan", dated 5/3/22, the document indicated, "Facility Closure Team: Roles and Responsibilities… Facility Closure Team – 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… RN and LVN… Responsible for… Ensure that each patient's care plan is in place and continues throughout the closure process."
A review of the facility policy and procedure titled, "Resident Care Plan (RCP) Resident Care Team (RCT) & Resident Care Conference (RCC)", revised 7/9/19, the document indicated, "Policy: 1. An interdisciplinary Resident Care Team (RCT), … shall develop a baseline care plan within 48 hours of the resident's admission. It shall include instructions needed to provide effective and person-centered care of the resident… 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 timetable to meet the resident's medical nursing, and mental health needs… 4. Comprehensive Care Plan a. LHH shall develop and implement a comprehensive person-centered care plan within seven (7) days of completion of the comprehensive assessment."
Failure to develop an individualized care plan had the potential to result in Patient 2, who has history of transfer trauma when transferred to another unit at the facility and documented continued disorientation, not receiving continuity of care, and experiencing mental and/or emotional distress due to relocation to a new environment.
2.

Patient 2 was discharged from the facility on 6/10/22. Review of Patient 2's "Nursing Note" dated 6/10/22 at 9:09 AM, indicated "Resident was discharged to [Name of the Facility]. Resident is alert and oriented x 1, verbally responsive with episodes of confusion…Wound care done as ordered. Resident attempted to remove dressing but redirected…"
Review of Patient 2's "Discharge Summary" dated 6/9/22 at 2:21 PM, did not indicate the physician contacted the receiving SNF (Skilled Nursing Facility) for a physician-to-physician hand off of patient care during or prior to transfer.
During a follow up interview with MD 1 on 10/4/22, at 2:58 PM, MD 1 acknowledged that the hand off (report) with the receiving physician was not done. MD 1 stated the receiving facility did not require a hand off (report). MD 1 stated giving hand off to the receiving facility physician was important for the continuity of care of a patient.
Review of facility's policy titled, "Facility Closure Plan" dated 5/3/22 indicated, "…15. Ensure that all pertinent medical and other information is provided to the receiving facility to assure safe and effective continuity of care. In addition, the following shall be provided to the receiving facility. All instructions for special instructions or precautions, as appropriate…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 follow its policies regarding patient transfer. These failures had the potential to result in Patient 2 to not receive care and services to meet his specific needs and medical conditions.
In violation of the above cited standards, the facility failed to comply with the facility's established written 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 2's high risk for transfer trauma. These failures had the potential to result in Patient 2 not receiving continuity of care, or care and services to meet his specific needs, and for the patient to experience physical, mental, and emotional trauma following relocation to a different skilled nursing facility.

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