State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 220018228

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) : CA00794745

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 ART3-72313(a)(3)
T22 DIV5 CH3 ART5-72523(a)
1336.2(a)(1)(2)(3A)(3B)(4)(5)
1336.2(b)

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:
Pinky Suriben
HFEN

Evaluator Signature:_____

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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.

T22 DIV5 CH3 ART3-72313(a)(3) Nursing Service- Administration of Medication
(a) Medications and treatments shall be administered as follows:

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(3) Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, shall be performed as required and the results recorded.

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:

Based on interview and record review, the facility failed to ensure adequate pain management for Patient 53 by not completing a follow-up evaluation for pain medication effectiveness, failed to provide medically related social services to attain and maintain the highest practicable physical, mental, and psychosocial well-being for Patient 53, and failed to ensure Patient 53's personal effects and valuables were handled properly upon admission and discharge. The facility failed to:
1. Ensure adequate pain management for Patient 53 by completing a follow-up evaluation for pain medication effectiveness.
2. Develop a discharge care plan for Patient 53.
3. Implement a discharge care plan for Patient 53.
4. Complete an inventory of Patient 53’s personal effects and valuables upon admission and discharge in accordance with the facility’s policy and procedures (P&P).

As a result, these failures put Patient 53 at risk for uncontrolled pain and decrease in quality of life and did not allow Patient 53 or his responsible party the opportunity to participate in the plans for Patient 53’s discharge, and had the potential to result in Resident 53 not receiving continuity of care to meet his physical, mental, and psychosocial needs. These failures also created the potential for misappropriation of property for Patient 53 and other patients residing in the facility.

Findings:

A review of the Discharge Summary for Patient 53 was a 63 year-old male, dated 6/23/22, indicated the patient was admitted to the facility with diagnoses including laryngeal cancer (cancer of the voice box), cirrhosis (end stage liver disease), HIV/AIDS, and substance use disorder (inability to control the use of legal and illegal substances).

According to the Community Forward SF website, “Medical Respite is a partnership between Community Forward SF and the San Francisco Department of Public Health (DPH). Together we provide respite beds and sobering facilities, along with temporary housing and specialized support services, for medically frail people impacted by homelessness.” (https://communityforwardsf.org/respite)

According to the facility resident assessment tool, completed on 6/1/22, Patient 53's cognition was moderately impaired with supervision required for activities of daily living (ADLs) such as bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. Patient 53 was experiencing frequent pain with pain intensity of 10 using a numeric rating scale, with zero being no pain and 10 as the worst pain.

A review of Patient 53's flowsheet record, dated 6/23/22 at 9:33 AM, under "Pain Assessment" indicated a pain score of 10 in the abdomen. There was no information entered under "Pain Interventions" and "Response to Interventions."

A review of Patient 53's Medication Administration Record (MAR) for the month of June 2022 indicated, Patient 53 was given Methadone (drug used for pain relief and treatment of drug addiction) 20 milligrams (mg) orally on 6/23/22 at 9:15 AM (18 minutes before the recorded abdominal pain assessment indicating the patient's complaint of severe pain). The MAR also indicated an order of Tylenol to be given twice a day for pain.

A review of Patient 53's physician's order, electronically signed by Medical Doctor 3 (MD 3) on 6/23/22 at 12:27 PM indicated, Discharge date and time: 6/23/2022 Midday."

According to the facility Pain Assessment and Management P&P, dated 9/14/21, the pain intensity numeric scale of 10 also means "very severe, horrible."

A review of Patient 53's care plan for Pain, dated 5/20/22, indicated the following interventions:
1. Encourage pt. to monitor pain and request for assistance.
2. Assess pain using appropriate pain scale. Weekly pain assessment done on Friday DAY shift.
3. Administer analgesics based on type and severity of pain and evaluate response.
4. Offer non-pharmacological interventions such as cold/heat application, dim lighting or request lower watt light bulb for lamp, headphones, stretching exercises or ROM (range of motion) and evaluate response.
5. Consider cultural and social influences on pain and pain management.
6. Notify Provider if interventions unsuccessful or patient reports new pain.

A review of the facility's Medical Social Services Discharge Patient Assessment dated 6/9/22, indicated, Patient 53 is "Discharge Ready" and "is his own decision-maker."

A review of Patient 53's Medical Social Services Discharge Patient Assessment, dated 6/9/22 at 2:49 PM, indicated the list of active "Care Plan Problems/Goals" as follows:

1. Verbalizes/displays adequate comfort level or baseline comfort level (Pain-Adult)
2. Patient's chronic conditions and co-morbidity symptoms are monitored and maintained or improved (Chronic Conditions and Co-Morbidities)
3. Demonstrate ability to cope with hospitalization/illness (Psychosocial Needs)
4. Collaborate with patient/family/caregiver to identify patient specific goals for this hospitalization (Psychosocial Needs)
5. Resident has a restful sleep per night without disturbance (Sleep Pattern Disturbance)
6. Resident will describe or demonstrate a decrease in depressed mood, and increased in participation in care and activities (Evidenced Depression)
7. Resident will not have thoughts of self-harm (Evidenced Depression)
8. Prevent death from unintentional Opioid Overdose (At risk for unintentional Opioid Overdose related to active or history of substance
abuse disorder coupled with numerous medical co-morbidities)

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9. Resident will maintain sobriety or harms from alcohol use be reduced (Resident has alcohol use disorder)
10. Achieve optimal ventilation and oxygenation (Respiratory-Adult)
11. Minimal or absence of nausea and vomiting (Gastrointestinal-Adult)
12. Maintains or returns to baseline bowel function (Gastrointestinal-Adult)
13. Maintains adequate nutritional intake (Gastrointestinal-Adult)
14. Free from fall injury (Safety Adult - Fall)
15. Resident will engage in alternative to preferred activity once per week (Resident activity needs)
16. Food and/or Nutrient Delivery (ND) (Impaired Nutrient Utilization)
17. Patient maintains adequate hydration (Nutrition)
18. Patient maintains weight (Nutrition)
19. Patient will not have more than 5 lbs (pound) weight change during LOS (length of stay) (Nutrition)
20. Patient will be free of physical and verbal abusive behaviors (Behavioral Symptoms)
21. Patient will require minimum dose of meds (Psychotropic Drug Use)
22. Patient will not elope from the facility (High Elopement Risk)
23. Patient will use smoking materials safety (Safety Adult - Smoker)
24. Nutrition Education (Overweight/Obesity)
25. Ability to express needs and understand communication (Communication)
26. Absence of infection during hospitalization (Infection - Adult)
27. Resident remains safe and free from harm (Safety Adult-Out on Pass)
28. Mobility/activity is maintained at optimum level for patient (ADL Maintenance)
29. Resident remain free of complications due to COVID-19 (COVID-19 Confirmed or Rule out)
30. Patient will not show a decline in psychosocial wellbeing or experience adverse effects through next review (Facility isolation Psychosocial Wellbeing)
31. Resident will remain symptom free (no signs or symptoms of influenza) (Influenza Prevention)
32. Resident will tolerate Oseltamivir without adverse effects. GI symptoms such as nausea and vomiting, allergy (Influenza Prevention).
The list did not include a discharge care plan, a requirement of the Social Service Patient Assessment.

A review of all Social Worker (SW) Notes from May 2022 to June 2022 indicated the following:
1. Date of Service: 5/5/22, at 9:33 AM, indicated, "The [Resident Care Team] met to discuss resident's potential for discharge. When resident is medically stable and has no further diagnostics, he can be discharged. [Patient 53] is homeless, so Navigation Center may be possible for him or family support." The consult notes did not indicate Patient 53 or his family were present during the RCT meeting nor document that the discharge plan was discussed with Patient 53.
2. Date of Service: 5/26/22 at 1:08 PM indicated, "Previous Living Situation: [Patient 53] has been homeless or marginally housed for the ten years. Most recently, [Patient 53] was housed in the Hotel Whitcomb in a [Shelter In Place] room. Discharge Plan: The resident was treated here for his Laryngeal Cancer and post-surgical rehab services, including advancing his communication ability. There is no discharge date at this time but he will be reviewed for any discharge potential quarterly." The notes did not indicate that the plan was discussed with Patient 53.

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3. Date of Service: 6/9/22 at 1:44 PM indicated, "...Discharge Potential: Fair. [Patient 53] has been unhoused for many years and abused alcohol...It is unlikely he would benefit from residential treatment, so most likely he will be discharge to a Navigation Center or Medical Respite, if available." The consult notes were electronically signed on "6/30/2022 11:25 AM" (seven days after the facility discharged Patient 53). The consult notes did not contain information that the plan was discussed with Patient 53 or that the patient was informed of his appeal rights before discharge.

A review of the Documentation from the Medical Respite and Sobering Center, with an encounter date of 7/12/22, and electronically signed on 8/11/22 at 4:58 PM, indicated, “[Patient 53] was found by security on the toilet in the bathroom at the back of the big dorm. Call was received by support staff that RNs were needed. Patient was located sitting on the bathroom toilet in the back dorm area…There was no signs of respiratory effort, and carotid pulse was checked and un-palpable, pupils were fixed bilaterally, and facial skin color was ashen. Resuscitation was initiated by RNs present along with [Automated External Defibrillator (AED)], and [Cardiopulmonary Resuscitation (CPR)] continued until paramedics arrived…An additional cycle of CPR was performed until [Emergency Medical Services (EMS)] confirmed death.”

During an interview with the Registered Nurse 3 (RN 3) and concurrent review of Patient 53's electronic record on 9/7/22 at 11:12 AM, RN 3 verified that Patient 53 had abdominal pain with intensity of 10 on 6/23/22 at 9:33 AM. RN 3 also acknowledged there was no documentation under "Pain Interventions" and "Response to Intervention" in the flowsheet and stated, "I cannot find it [in the record]. No re-assessment." RN 3 explained, "Maybe he was not given [medication] because he tend to be sleepy with strong medication, oversedation. He was also given Methadone 20 mg. It also covers the pain."

On 10/3/22 at 11:45 AM during an interview with the Pharmacist 1 and Pharmacist 2 and concurrent review of Patient 53’s medication profile, Pharmacist 1 stated the indication of Methadone dose for Patient 53 was for Substance Use Disorder (SUD). Pharmacist 1 added that Patient 53 was receiving Tylenol twice a day for pain.

During an interview with the Nurse Manager 1 (NM 1), RN 5, and RN 6, on 10/3/22 at 1:50 PM, RN 6 was the nurse in charge of Patient 53’s care on 6/23/22 (the day of the patient’s discharge from the facility). According to RN 6, Patient 53 refused his routine morning medication on 6/23/22 and wanted to have Methadone first before taking his routine medications. MD 3 was present that day and ordered a one-time dose of Methadone 20 mg. RN 6 further stated, “The Methadone is for substance abuse. That’s my own understanding. It was given because he requested for it. He is about to be discharge I just want to make sure he gets his routine medications. I assessed him but his concern was not pain.” NM 1 stated, “Ideally [staff] supposed to do a post [pain] assessment [after an intervention]. Ideally yes, post assessment should be part of the flowsheet.” NM1 also verified that there is no care plan for the use of Methadone. RN 6 added, “[The facility] [is] in the process of revising pain assessment [policy].”

An interview with NM 1 and Social Worker 1 (SW 1) was conducted on 8/16/22 at 1:58 PM. NM 1 and SW 1 reviewed Patient 53's electronic record and were not able to provide documentation that the discharge plan was discussed with Patient 53, aside from the notification on the day of the discharge (6/23/22). According to SW 1, the SW in charge of

Patient 53's discharge planning, and who assisted Patient 53 during discharge, was no longer working in the facility.

During a follow up interview with the SW 1 and NM 1, and review of Resident 53's care plan on 8/16/22 at 2:59 PM, NM 1 verified a discharge care plan was not developed for Resident 53 and stated, "I don't see [the discharge care plan] here." NM 1 explained the discharge care plan should be initiated on admission by the SW.

During an interview with the NM 1 and SW 1 on 8/16/22 at 1:58 PM, NM 1 and SW 1 stated Patient 53 was discharged to Medical Respite on 6/23/22. According to NM 1, Patient 53 had two boxes of personal belongings and stated, "I helped him pack his things." In a concurrent review of Patient 53's online record, NM 1 confirmed there was no documentation of an inventory list of Patient 53's personal belongings and stated, "I don't see it here."

During a concurrent interview and record review on 8/16/22, at 4:15 PM, Quality Management Nurse 3 (QMN 3) acknowledged there was no documentation of an inventory list for Patient 53's personal belongings on admission and upon the patient's discharge from the facility on 6/23/22.
During an interview with the Director of Whole Person Integrated Care (DWPIC) of the Medical Respite program on 8/8/22, at 4:12 PM, DWPIC explained that "Medical Respite is part of San Francisco Department of Health program to provide care for patient that has health care issue in the community." According to DWPIC, Resident 53 was admitted to the Medical Respite on 6/23/22. On 7/17/22 Resident 53 was "Found deceased in the toilet. [He was] found unresponsive, staff called 911."A review of the facility Pain Assessment and Management P&P dated 9/14/21 indicated, "Policy: 1. Residents have the right to appropriate assessment and management of pain...Procedure…2. Pain Reassessment a. Monitor pain intensity...c. Reassess and document pain location and pain intensity before PRN (as needed), and record pain intensity only after each PRN medication administered...4. Documentation...e. Breakthrough pain scores are recorded on the MAR and include location and intensity (reason for PRN) and change in intensity (as response to PRN) ...f. The nurse evaluates resident's response to pain management care plan side effects, analgesic use and other data and progress toward goals (e.g., impact of pain to ADLs or sleep), on the weekly and monthly summaries and on progress notes when appropriate..."

The Joint Commission Requirement, Rational, References Publication Issue 21, dated 12/21/18, titled, "Pain Assessment and Management Standards for Nursing Care Centers" indicated, "...PC.01.02.07, EP 7: Based on the patient' s or resident ' s condition, the organization reassesses and responds to the patient' s or resident' s pain through the following: - Evaluation and documentation of response(s) to pain intervention(s) - Progress toward pain management goals including functional ability (for example, improved pain, improved or preserved physical function, quality of life, mental and cognitive symptoms, sleep habits) - Side effects of treatment - Risk factors for adverse events caused by the treatment.
Rationale Reassessment should be completed to determine if the intervention is working or if the patient or resident is experiencing adverse effects. Unidimensional reassessment based on pain intensity rating alone is inadequate. The Joint Commission' s technical

advisory panel stressed the importance of reassessing how pain affects a patient' s/resident' s function and ability to make progress toward treatment goals. For example, the goal of pain management may be improved or preserved ability to perform daily activities. Among adults with cognitive impairment, monitor behavioral indicators of pain to assess response to treatment..."
(https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_21_pain_standards_ncc_12_21_18_final.pdf).

A review of the facility P&P 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: 1. All residents on admission will be assessed by Social Services for discharge potential…If there is a discharge potential, 1) a care plan will be completed under the Care Plan tab in the [Electronic Health Record] …”

A review of the facility P&P titled, "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)" dated 7/9/19, indicated, "...4. Comprehensive Care Plan a. [the facility] shall develop and implement a comprehensive person-centered care plan within seven days of completion of the comprehensive assessment. b. The comprehensive care plan shall include measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment
specifically in CAA...c. In consultation with the resident and/or the resident's representative, the comprehensive care plan shall describe: i. The resident's goals for admission and desired outcomes. ii. The resident's preferences and potential for future discharge. [The facility] shall
document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. iii. Discharge plans in the comprehensive care plan, as appropriate..."

A review of the facility P&P titled, “Handling Resident's Property and Prevention of Theft and Loss”, dated 5/10/22, indicated, "...1. General Guidelines a. Upon admission, relocation, annually, and transfer or discharge from LHH, nursing staff and the resident and/or his/her representative shall complete an inventory of the resident's property. Inventory of the resident's property shall be recorded on a form entitled "Inventory of Resident's/Patient's Property" (Form Nos. MR311 and MR311b (hereinafter IRP). b. The completed IRP shall be printed and signed by the resident or the resident's representative, and by a staff member on behalf of LHH. The signed document shall be scanned into the electronic health record... 3. Resident's Property on Transfer and Discharge a. Nursing staff shall assist the resident with gathering the resident's property from the resident's bedside stand, locked drawer, and wardrobe. b. The IRP in the electronic health record shall be updated to include property not previously listed and those that are not present with stated disposition of the property date and a signature. c. The resident and nursing staff shall review the IRP and the resident / surrogate decision maker and staff shall sign off, signifying return of the property to the resident or his/her surrogate decision maker..."

A review of the Facility Closure Plan P&P, dated 5/3/22, indicated, “…17. Ensure that

each patient's personal possessions are accounted for prior and during the transfer…"

The facility failed to ensure adequate pain management for Patient 53 by not completing a follow-up evaluation for pain medication effectiveness, failed to provide medically related social services to attain and maintain the highest practicable physical, mental, and psychosocial well-being for Patient 53, and failed to ensure Patient 53's personal effects and valuables were handled properly upon admission and discharge. The facility failed to:

1. Ensure adequate pain management for Patient 53 by completing a follow-up evaluation for pain medication effectiveness.
2. Develop a discharge care plan for Patient 53.
3. Implement a discharge care plan for Patient 53.
4. Complete an inventory of Patient 53's personal effects and valuables upon admission and discharge in accordance with the facility's P&P.

As a result, these failures put Patient 53 at risk for uncontrolled pain and decrease in quality of life and did not allow Patient 53 or his responsible party the opportunity to participate in the plans for Patient 53's discharge, and had the potential to result in Resident 53 not receiving continuity of care to meet his physical, mental, and psychosocial needs. The failures also created the potential for misappropriation of property for Patient 53 and other patients residing in the facility.

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