State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 220018229

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) : CA00806441

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 ART3-72311(a)(1)(C)
T22 DIV5 CH3 ART3-72311(a)(2)
1336.2(a)(1)(2)(3A)(3B)(4)(5)
1336.2(b)
T22 DIV5 CH3 ART5-72523(a)

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.

T22 DIV5 CH3 ART3-72311(a)(1)(C) 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.

Name Of Evaluator:
Naida Rico
HFEN

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)(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) 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.

(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.

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Evaluator
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(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 10/3/22, at 8:00 A.M., 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.
Based on interview and record review, the facility failed to:
1. Develop an individualized patient care plan (CP) for discharge planning, and to address high risk of transfer trauma (feelings or symptoms of stress, emotional shock or disturbance, hopelessness, or confusion resulting from the patient being moved from one residential environment to another) for Patient 21.
2. Implement a 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 residential environment to another) for Patient 21.
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 21 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 21.
5.Take reasonable steps to transfer Patient 21 safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services for Patient 21.
Failure to develop and implement an individualized care plan may have resulted to Patient 21 not receiving appropriate care and services to meet patient's specific needs and medical condition and to experience mental and/or emotional distress due to relocation to a new environment.
Findings:
A. Patient 21, an 87 year old female, was admitted to the facility on 2/26/18, with diagnoses that included diabetes mellitus (DM - a condition that causes the blood sugar levels in the body to rise higher than normal), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), anxiety disorder (psychiatric disorders that involve extreme fear or worry), and schizophrenia (a serious mental disorder in which people interpret reality abnormally).
The resident assessment tool, completed by the facility on 5/9/22, indicated Patient 21 had a Brief Interview for Mental Status (BIMS - a screening tool used to assist with

identifying a resident's current cognition) Score of 6, indicating severe cognitive impairment.
A public legal guardian acts as a surrogate decision maker for Patient 21. Patient 21 was discharged to another skilled nursing facility on 7/1/22.
The resident assessment tool, completed by the facility on 2/9/22, indicated Patient 21 did not need or want an interpreter to communicate with a doctor or health care staff. The resident assessment tool did not indicate Patient 21's preferred language.

During an interview with Registered Nurse (RN 4) on 10/3/22 at 9:39 AM, RN stated that Patient 21 "Could say yes or no about things she wanted/didn't want." RN 4 stated that Patient 21 spoke English.
During a concurrent interview with Nurse Manager (NM4) and review of Patient 21's clinical records, on 10/3/22 at 1:35 PM, Patient 21's "Discharge Planning" CP, dated 8/19/19 indicated, "Goal: Discharge to home or other facility with appropriate resources." The CP's interventions include, "1. Identify barriers to discharge with patient and caregiver. 2. Arrange for needed discharge resources and transportation as appropriate. 3. Identify discharge learning needs (meds [medications], wound care, etc [etcetera]). 4. Arrange for interpreters to assist at discharge as needed. 5. Refer to Case Management Department for coordinating discharge planning if the patient needs post-hospital services based on physician order or complex needs related to functional status, cognitive ability or social support system." NM 4 stated Patient 21 did not need an interpreter. NM 4 also stated that the CP's intervention #3 indicating, "Identify discharge learning needs (meds [medications], wound care, etc [etcetera])" was addressed to Patient 21, and was not applicable to Patient 21. NM 4 verified that Patient 21 was not able to take care of herself, "Not as far as meds, etc. She (Patient 21) was not able to carry on a conversation, maybe just a yes or a no."

During a concurrent interview with the Director of Social Services (DSS) and review of Patient 21's clinical records on 10/3/22 at 2:22 PM, Patient 21's "Discharge Planning" CP, dated 8/19/19 and reviewed on 6/25/22, was reviewed. The DSS stated that Patient 21 did not need an interpreter. For "Intervention #5," indicating, "Refer to Case Management Department for coordinating discharge planning if the patient needs post-hospital services based on physician order or complex needs related to functional status, cognitive ability or social support system," the DSS stated, "She (Patient 21) was not going to the community, so you don't need to have community services set up." When asked if "Intervention #5" was applicable to Patient 21, the DSS stated, "No, because she transferred to same level of care."

Review of Patient 21's "Discharge Summary," dated 6/29/22, and "Resident Care Team Meeting Note," dated 5/17/22, both indicated Patient 21 had a high risk for psychiatric decompensation (when someone with a mental illness, who was maintaining their mental illness well, starts to worsen) esp (especially) if she is transitioned to another facility or caregiver setting."

Review of Patient 21's "Medical Social Services Discharge Patient Assessment," dated 5/19/22 indicated, "Social and Physical Functioning - Risk Factors: Per conservator, resident is at risk for transfer trauma with potential for increased paranoia and hallucinations, depression, withdrawal and fear of new caregivers due to changed environment. Will advocate for 1:1 psychological support if placement imminent."

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During concurrent interview with NM 4 and review of Patient 21's clinical records on 10/3/22 at 1:35 PM, Patient 21's "Psychosocial Needs" CP, dated 5/17/22, indicated, "Goal: Residents [sic] concerns regarding transfer/relocation will be identified and addressed." The CP's interventions include:
1. Resident and SDM (surrogate decision maker – name redacted) were informed of resident's potential relocation from (name of facility).
2. Monitor resident for non-verbal signs of distress including but not limited to marked decrease in appetite/poor PO (by mouth) intake, withdrawal from activities that resident used to participate in, change in mood, refusal to get out of bed or room, aggression towards staff/peers, etc.
3. Monitor meal intake QS (every shift), notify MD (Medical Doctor) if unexplained decrease in intake.
4. SDM provided with list of possible facilities for resident to relocate to
5. Monitor any other general change in behavior from established baseline. Notify MD/RCT (Resident Care Team) to allow them to determine whether it is related to transfer trauma or some other medical condition.
6. Nursing Weekly Summary to monitor resident condition.
7. Update resident (patient)/SDM accordingly for new developments in (facility name) situation.
8. Refer to the patient for psychiatry consult if needed to address Transfer Trauma.

Patient 21's "Psychosocial Needs" CP, dated 5/17/22, also indicated, "Transfer Trauma Interventions:
The RCT assessed for any risks of Transfer Trauma on 5/17/2022. Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal. Refer the patient for Psychiatry consult if needed to address Transfer Trauma." NM 4 stated, "They were standardized," referring to the interventions for Transfer Trauma CP. NM 4 was asked if the interventions were specific for Patient 21. NM 4 stated, "May or may not be. It depends on the condition of the resident." NM 4 acknowledged that a patient's CP is supposed to be individualized and tailored to the patient's needs.

Review of facility's policy and procedure (P&P) titled, "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)," revised 7/9/19, indicated, "Policy…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…" Further review of the RCP indicated, "Purpose: To promote the resident's highest possible physical, mental and psychological well-being… Definition: … 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…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…"
Review of [the facility's] Notification of Closure and Patient Transfer and Relocation Plan,

submitted to the Department and Centers for Medicare and Medical Services (CMS) on 5/13/22, under Part 1 - Notification Requirements indicated, “Notice to Individual Patient of Proposed Transfer/Discharge (per Health and 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 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 consideration and the changes in condition or clinical/nursing care needs that may affect the patient’s level of care. The 3-month cadence of the re-assessments will continue until the patient is transferred for discharge 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…”
Review of the receiving facility’s clinical records for Patient 21, indicated Patient 21 was admitted to the receiving facility on 7/1/22. The receiving facility’s “Nutrition/Dietary Note,” dated 8/22/22, Weight variance note for Patient 21: Presents with significant wt (weight) loss of 20.6 lbs (pounds)/15.8% (weight loss) x (times) 1 (one) month. The “Weights and Vitals Summary,” indicated Patient 21’s 15.8 % weight loss occurred between 7/3/22 and 8/24/22. Patient 21’s “Order Summary Report,” dated 9/7/22, indicated Patient 21 was admitted to hospice on 9/3/22. Patient 21 expired on 9/6/22.
The facility failed to developed patient care plans (CP) for discharge planning, and risk of transfer trauma to include interventions addressing specific care needs of Patient 21. This is not in compliance with facility’s P&P indicating, “Interventions are specific, individualized.”
In violation of the above cited standards, the facility failed to comply with the nursing service requirements and its written policies and procedures for planning of patient care by not developing an individualized discharge care plan, and care plan to address the risk of transfer trauma after the facility identified Patient 21 as having a high risk of transfer trauma.
This failure resulted in Patient 21 not receiving continuity of care, and experiencing mental, emotional, and physical distress after relocation to a new environment due to her documented concerns about transfer trauma associated with her physical and mental health diagnoses.
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B. A review of Patient 21’s “Discharge Summary,” dated 6/29/22, and “Resident Care Team Meeting Note,” dated 5/17/22, both indicated Patient 21 had a high risk for psychiatric decompensation (when someone with a mental illness, who was maintaining their mental illness well, starts to worsen) esp (especially) if she is transitioned to another facility or caregiver setting.

A review of Patient 17’s “Resident Social History,” dated 5/17/22, indicated Patient 21’s, “Conservator identified that resident (patient) would have significant transfer trauma do to a move including changes in behavior, withdrawal, possible increased paranoia and delusions and fear of new caregivers.”

A concurrent interview with Nurse Manager (NM4) and review of Patient 21’s clinical records on 10/3/22 at 9:58 AM, indicated “Nursing Weekly Summary (WNS),” dated as

follows:
- 5/19/22
- 5/28/22
- 6/11/22
- 6/18/22
- 6/25/22

There was no WNS for 13 consecutive days after WNS dated 5/28/22 was created. NM 4 was unable to provide documented evidence of WNS for the week of 5/29/22 to 6/10/22. NM 4 stated the WNS is supposed to be done every week and documented in Patient 21's clinical records.

During a concurrent interview with Nurse Manager (NM4) and review of Patient 21's clinical records, on 10/3/22 at 1:35 PM, Patient 21's "Psychosocial Needs," dated 5/17/22, indicated, "Goal: Residents [sic] concerns regarding transfer/relocation will be identified and addressed." The CP's interventions include, "Nursing Weekly Summary to monitor resident condition." Further review of the CP indicated, "Transfer Trauma Interventions - Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal." NM 4 stated that emotional and/or behavioral changes are identified through assessment and is supposed to be documented in Patient 21's clinical records. NM4 stated, "We're continuing to assess if there are increased anxiety or withdrawal." NM 4 was unable to provide documented evidence of assessment of Patient 21 for emotional and/or behavioral changes.

Review of the facility's policy and procedure (P&P) titled, Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC), dated 7/9/19, indicated "Purpose: To promote the resident's highest possible physical, mental and psychological well-being." Further review of the P&P indicated, "Procedure: 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."

The facility failed to provide any evidence that they had implemented a care plan to mitigate transfer trauma prior to transferring Resident 21. This failure had the potential to result in Resident 21 experiencing transfer trauma upon discharge to another skilled nursing facility, which could have negatively impacted her health.

In violation of the above cited standards, the facility failed to comply with its established written patient care policies and procedures, Title 22 regulations, and Health and Safety Code section 1336.2, including but not limited to failing to develop and implement an individualized care plan to address Patient 21's high risk for transfer trauma, and take reasonable steps to minimize possible transfer trauma by performing complete assessments and arranging for appropriate future medical care and services. These failures had the potential to result in Patient 21 not receiving continuity of care and for the patient to experience physical, mental, and emotional trauma following relocation to a different skilled nursing facility.

Name Of Evaluator:
Naida Rico
HFEN

Evaluator
Signature:_____

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