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:_____

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

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.

Name Of Evaluator:
Naida Rico
HFEN

Evaluator
Signature:_____

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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."

Name Of Evaluator:
Naida Rico
HFEN

Evaluator Signature:_____

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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. NM4 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:_____

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

Signature:_____

Name:_____

Title:_____

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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:

Name Of Evaluator:
Pinky Suriben
HFEN

Evaluator
Signature:_____

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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)

Name Of Evaluator:
Pinky Suriben
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

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.

Name Of Evaluator:
Pinky Suriben
HFEN

Evaluator Signature:_____

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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.

Name Of Evaluator:
Pinky Suriben
HFEN

Evaluator
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State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

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:_____

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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.

Name Of Evaluator:
Regina Baena

Evaluator Signature:_____

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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:

Name Of Evaluator:
Regina Baena

Evaluator
Signature:_____

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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.

Name Of Evaluator:
Regina Baena

Evaluator
Signature:_____

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Title:_____

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

CITATION NUMBER: 220018226

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) : CA00795631

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

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)(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.

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

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.

(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.

Name Of Evaluator:
Anabel Macaraig
HFEN

Evaluator
Signature:_____

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Name:_____

Title:_____

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

(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:

Based on interview and record review, the facility failed to:
1. Develop an individualized patient care plan (CP) for discharge planning, and to address risk of transfer trauma for Patient 31.
2. Implement a patient care plan to address high risk of transfer trauma for Patient 31.
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 31 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 31.
5.Take reasonable steps to transfer Patient 31 safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services for Patient 31.

These failures had the potential to result in Patient 31 not receiving continuity of care and for the patient to experience physical, mental, and emotional trauma following relocation to a different skilled nursing facility.

Findings:

On 8/2/22, at 9 AM, 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 31 was a 68 y/o female, admitted on 7/16/2013, with diagnoses including dementia (decline in memory or other thinking skills). Patient 31 is conserved under the SF Public Guardian.

A review of Patient 31's Minimum Data Set (MDS, a standardized assessment tool) dated 6/18/22, indicated severe impairment to make decisions regarding tasks of daily life. Patient 31 was described as, rarely/never understands and rarely/never understood. Under functional status, Resident 3 requires one person physical assistance in performance of Activities of Daily Living (ADL's). Patient 31 was totally dependent with mobility, transfer, dressing, eating, personal hygiene and toilet use. Patient 31 is non

ambulatory (unable to walk).

A review of Resident Care Team (RCT) Meeting notes from the transferring facility, dated 5/18/22, indicated, "…Problem: Transfer Trauma. Transfer trauma interventions: ... Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal. Refer to Psychiatry consult if needed to address transfer trauma. Goal: Demonstrate ability to cope with hospitalization/illness. Description: Assess and monitor patients' ability to cope with his/her illness. Interventions: 1. Encourage verbalization of feelings/concerns/expectations... 3. Assist patient to identify own strengths and abilities, 4. Encourage patient to set small goals for self. 4 encourage participation in diversional activities. Reinforce positive adaptation of new coping behaviors..."

A review of Physician Discharge Summary from the transferring facility, dated 7/11/22, indicated, "…Mental status/Cognitive Assessment: (Patient) is socially inappropriate but passive and cooperative with the interview as at her usual baseline. Her appearance was unremarkable, and she was alert. She has no speech or language at her usual baseline and therefore I was unable to assess her thought content or thought process or depression or hallucinations or orientation. She has no insight into her mental condition, and she has no judgement for her care. She has obvious abnormalities with attention concentration and memory…"

During an interview on 8/16/22, at 11:37 AM, with Licensed Clinical Social Worker (LCSW) related to transfer trauma intervention, "to assess Patient 31 for any emotional and/or behavioral changes such as increased anxiety or withdrawal," LCSW stated, "It is a general observation, there's no other documentation."

During an interview on 9/7/22, at 3:27 PM, with Nurse Manager 5 (NM 5) related to transfer trauma care plan interventions, NM 5 stated, "She (Patient 31) was not interviewable. She won't be able to verbalize. She couldn't express herself. We shouldn't have used the word verbalized." NM 5 acknowledged there was no evidence of documentation Patient 31 was assessed for any emotional and/or behavioral changes such as anxiety or withdrawal as related to transfer trauma.

Review of facility's policy 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…Procedure: 1. The Resident Care Team a. The RCT is an essential component of the care planning process. The RCT shall include members from those disciplines essential to the planning and delivery of care for the resident. RCT members include: i. Nurse Mangers (or designee) – Facilitator of RCC ii. Licensed Nurse iii. Nursing Assistant iv. Attending Physician v. Medical Social Worker vi. MDS Coordinator vii. Activity Therapist viii. Registered Dietitian…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…"
A review of the "Facility Closure Plan" dated 5/03/22, indicated, "…Facility Closure Team Role and Responsibilities…Each staff member that is a part of each 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 auxiliaries. Ensure that each patient's care plan is in place and continues throughout the closure process…"

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…"

Patient 31 was transferred to another facility on 7/13/2022.

During an interview on 9/27/22, at 11:05 AM, Infection Preventionist from the receiving facility stated, the facility had a COVID-19 outbreak that started on 7/12/22.

During an interview on 10/3/22, at 4:05 PM, Transfer Coordinators (TC 1 and TC 2) from the transferring facility stated that they were aware of the COVID-19 outbreak at the receiving facility when they discussed resident placement in the facility and when they transferred Patient 31 to the receiving facility.

A review of the nurse's notes at the receiving facility indicated that Patient 31 developed fever and was diagnosed with COVID – 19 Infection on 7/21/22, and shortness of breath requiring oxygen supplementation on 7/22/22.

Patient 31 passed away on 7/24/22.

In violation of the above cited standards, the facility failed to comply with its established written patient care policies and procedures, Patient Transfer and Relocation Plan, 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 31's 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 31 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:
Anabel Macaraig
HFEN

Evaluator
Signature:_____

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Name:_____

Title:_____

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 220018225

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) : CA00806421

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

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

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:_____

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

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:_____

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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

(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.

Name Of Evaluator:
Ma Corazon Sia
HFEN

Evaluator
Signature:_____

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Name:_____

Title:_____

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

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..."

Name Of Evaluator:
Ma Corazon Sia
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

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.

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State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 220018223

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) : CA00797115

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)

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.

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:

Name Of Evaluator:
Ma Corazon Sia
HFEN

Evaluator Signature:_____

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Title:_____

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

(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.

(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:

Name Of Evaluator:
Ma Corazon Sia
HFEN

Evaluator
Signature:_____

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Name:_____

Title:_____

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

1.
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 38 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 38.
2. Implement a patient care plan to address high risk of transfer trauma for Patient 38.
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 38 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 38.
These failures had the potential to result in Patient 38 experiencing mental, emotional, and physical distress after relocation to a new environment and Patient 38 not receiving continuity of care to meet his specific needs and medical conditions upon transfer due to his inability to verbalize emotions and nutrition intake concerns.

Findings:
Patient 38 was admitted with diagnoses including vascular dementia (brain damage caused by multiple strokes) with behavioral disturbance, hypertension (high blood pressure), and left sided weakness from polio (a virus that may cause paralysis).
The Minimum Data Set (MDS, a resident assessment tool) dated 4/1/22, indicated, Patient 38 had severe cognitive impairment and was totally dependent with activities of daily living (ADLs, activities related to personal care) requiring one staff assist.
The History and Physical (H&P) dated 5/27/22, indicated, "History Of Present Illness: [Patient 38] is a 77-year-old male transferred from [Name of acute hospital] after getting treatment for urosepsis from 05/20/2022 patient is a 77-year-old nonverbal male with past medical history of vascular dementia, polio with bilateral upper extremity flexion contraction deficit, hypertension, benign prostatic hyperplasia [prostate gland enlargement, a common condition as men get older]…neurogenic bladder [a problem in which a person lacks bladder control due to a brain, spinal, or nerve condition] with chronic indwelling Foley catheter [a flexible tube that a clinician passes through the urethra and into the bladder to drain urine]… Patient continued to refuse oral intake does goals of care were discussed with family son with position transition to comfort care [a patient care plan that is focused on symptom control, pain relief, and quality of life] at [Facility Name] and possible hospice [focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life] if unable to tolerate oral liquids can hold off on antibiotics … Physical Exam: Generally cachectic elderly [having

cachexia – physical wasting with loss of weight and muscle mass due to disease]… Assessment/Plan: …Patient comfort care and no transfer to acute if he refuses the antibiotics or feeding no feeding tubes no labs… Comfort care hospice care at [Facility Name] with no further workup of prostate infection abscess [collection of pus that develop as the result of acute bacterial prostatitis] Per family dysphagia (difficulty of swallowing) on lowest level diet and no feeding tubes … Family informed son agree to comfort care…"
Review of the Resident Care Team (RCT) Meeting Note, dated 6/2/22, indicated:
Meeting Type: Pre-Discharge Patient Assessment + Readmission + 5 days Medicare.
Patient/Family/SDM (surrogate decision maker)/Conservator participated: yes
"Meeting Summary: resident is oriented to his name. He is cognitive impaired with poor intake. He cannot eat or drink by himself. He has difficulty to express his needs or discomfort, e.g., [example] thirsty [sic] or hungry. He eats 25% to 50% of his meals and drinks fluids about 8000 [sic] to 1100 daily. He has [foley catheter] for his neurogenic bladder. He is at high risk for UTI and dehydration. On 05/21/22, he developed chills, nausea and low [oxygen saturation] and was transferred to acute. He was readmitted to [North 5 unit] on 5/27/22. He is still on [antibiotic] for his UTI and Bacteremia. He needs total assist for all his ADLs. He may be transferred to other [skilled nursing facility (SNF)] for long term care. Wife joined this {resident care conference (RCC)] and was notified of resident's current condition, and plan for transferring to boarding care. Wife verbalized her understanding and agreement of transferring to other SNF for long term care."

The RCT Meeting Note, dated 6/2/22, indicated, "Recommendations: 1. Plan to transfer to other SNF facility. 2. Continue to remind and assist to drink more fluids. 3. [Patient Care Assistant] assess and address his needs q (every) 2 hours. Care plan reviewed and updated: Yes"

The RCT Meeting Note, dated 6/2/22, indicated, "If pre-discharge patient assessment RCC, review and discussion of potential transfer trauma: Problems: Risks for Transfer Trauma. Goals: minimize fear or emotional trauma of being transferring to other facility."
Under the Social Services section of the RCT Meeting Note indicated, "On 06/02/2022, team and wife discussed [discharge (d/c)] assessment; wife agreed [resident] SNF level for [possible] d/c."
Review of Patient 38's Psychosocial Needs care plan, dated 6/3/22, indicated, "Problems: Risks for Transfer Trauma Goals: minimize fear or emotional trauma of being transferring to other facility." The "Psychosocial Needs" care plan indicated the following interventions: "1. Assess and monitor patients' ability to cope with resident's illness and hospitalization. 2. Encourage verbalization of feelings/concerns/expectations. 3. Provide quiet environment. 4. Observe patient's emotional or behavioral changes. 5. Encourage participation in diversional activities Reinforce positive adaptation of new coping behaviors. 6. "I" Invite family members to join RCC to discuss the fear, concerns or questions from resident and resident's family. 7. "I" Provide the possible available facilities for resident or resident's family to select. 8. The RCT assessed for any risks of Transfer Trauma on Jun 02 and 3, 2022. 9. Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal. 10. Psychiatry consults and f/u if needed to address Transfer Trauma."
Review of Patient 38's Discharge Summary, dated 6/16/22, indicated, Patient 38 will be discharge to [Name of SNF] on 6/17/22 with discharge diagnosis of vascular dementia with behavioral disturbance. Patient 38's mental status is at baseline. Under the comment section indicated, "Awake on verbal stimuli, tracking but not follow commands, not answer

question."
Review of the clinical record from the receiving facility indicated, Patient 38 was not eating and taking his medications since admission. Patient 38 had significant weight loss of 11.9% in 1 month and was placed on IV fluid therapy. On 7/28/22, Patient 38 was transferred to the acute hospital for critical lab values and later expired on 7/30/22.
During an interview on 9/7/22, at 3:28 PM, Nurse Manager 3 (NM 3) stated, "Patient 38 has impaired cognitive. He's verbal most of the time but does not make any sense."
During an interview on 9/7/22, at 3:37 PM, NM 3 stated, Patient 38's mood and behavior was "unstable." NM 3 explained, Patient 38 was "sometimes agitated and resistance during ADLs."
During an interview on 9/7/22, at 3:40 PM, NM 3 stated, "Patient 38 has difficulty to express himself. He's advanced dementia. He's able to verbalize but does not make sense."
During a concurrent interview and record review with NM 3 on 9/7/22, at 3:50 PM, the RCT Meeting Note and Psychosocial Needs care plan were reviewed. NM 3 was unable to find documented evidence of transfer trauma risk assessment on 6/3/22 as indicated in the RCT Meeting Note and Psychosocial Needs care plan. NM 3 stated, the transfer trauma assessment was completed during the RCT meeting on 6/2/22. In addition, there was no documented evidence of Patient 38's emotional and/or behavioral assessment and monitoring as indicated in the Psychosocial Needs care plan. NM 3 stated, the facility document by exemptions, "general documentation only if behavior is stable."
Review of 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. 4. The resident, family, significant other(s) and/or conservator shall be part of the development and implementation of his or her person-centered plan of care."
According to the facility's policy, 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. Under the procedure of the resident care plan policy indicated, "1e. The RCT shall address resident care needs and preferences through assessment of the resident and the development and implementation of the RCP … 7b. Interventions are specific, individualized and describes the team member(s) responsible for carrying it out and the frequency for conducting the interventions…"
Review of LHH 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.

Name Of Evaluator:
Ma Corazon Sia
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

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..."
The facility failed to appropriately assess and plan for Patient 38 prior to transfer as required by statute and the facility's policy and procedure to minimize the risk of transfer trauma 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 38.
2. Implement a patient care plan to address high risk of transfer trauma for Patient 38.
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 38 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 38.
These failures had the potential to result in Patient 38 experiencing mental, emotional, and physical distress after relocation to a new environment and Patient 38 not receiving continuity of care to meet his specific needs and medical conditions upon transfer due to his inability to verbalize emotions and nutrition intake concerns.

Name Of Evaluator:
Ma Corazon Sia
HFEN

Evaluator
Signature:_____

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NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

CITATION NUMBER: 220018221

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) : CA00806424

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)
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 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

Name Of Evaluator:
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HFEN

Evaluator Signature:_____

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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.

(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

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services required in subdivision (a).
On 8/2/22, at 9:00 AM,, California Department of Public Health (CDPH) conducted an unannounced complaint investigation at the facility to ensure safe discharge of Patient 5 related to the facility's policy and procedures for discharge planning, along with the approved Transfer and Closure Plan certification termination pending closure.
Based on interviews 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 residential environment to another).
2) Comply with the administration service requirements by failing to implement its written patient care policies and procedures when the facility assessed Patient 5 as "not discharge ready".
These failures had the potential to result in Patient 5 not receiving continuity of care and for patient to experience emotional trauma due to leaving a familiar environment, and had the potential to result in Patient 5 not receiving care and services to meet her specific needs and medical condition(s).
Findings:
Patient 5 was admitted with diagnoses including dementia, insomnia, , and blepharitis
Patient 5 was a palliative care patient (a specialized medical care for people living with serious illness).
The Minimum Data Set (MDS, a resident assessment tool) dated 5/14/22, indicated, Patient 5 had severe cognitive impairment and was totally dependent with activities of daily living (ADL, activities related to personal care). The mood and behavior assessment, dated 5/14/22, indicated no symptoms present.
Review of Patient 5's History and Physical (H&P), dated 3/22/21, indicated a 100 year old woman initially admitted to (Name of Facility) (LHH) in 3/2018 with diagnosis of advanced vascular dementia (brain damage caused by multiple strokes) without behavioral disturbance, and insomnia. The H&P indicated, "Physical Exam – Constitutional: frail tiny thin elderly woman, curled up in bed, has contractures, has gross ectropion (an eye condition in which your eyelid sags or turns outward), does not respond to voice or touch, occasionally makes rhythmic motions with her mouth, unable to answer questions … She remains on palliative care. No intensive treatments will be ordered, she will remain on the unit for all her care. She is not to be transferred to acute hospital."
Review of Patient 5's Resident Care Team Meeting Note dated 5/18/22 indicated:
Meeting Type: Pre-Discharge Patient Assessment
Meeting Summary: "During Pre-discharge assessment, RCT reviewed and discussed potential transfer trauma … Goal: Collaborate with patient/family/caregiver to identify patient specific goals for this hospitalization … SDM (surrogate decision maker) participated with meeting via phone. Made aware re (regarding): potential discharge/relocation due to LHH potential closure. Per [Name of SDM], if ever resident will get discharge to another facility she preferred resident to be relocated in Oakland Bay area. Transfer Trauma Interventions: The RCT assessed for any risks of Transfer Trauma on May 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 need to address Transfer Trauma." The RCT Team Meeting Note indicated, recommendation to continue current plan of care; care plan reviewed and updated. Under section MD (medical doctor) Assessment indicated, "Incapacitated, dnr (do not resuscitate), comfort care, has acp (advanced car planning). Not approp (appropriate) for d/c (discharge)."

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Under section Nursing Assessment indicated, normal affect with mood and no unusual behaviors. Under section Nutrition indicated, “No aggressive nutrition intervention w/sign (with significant) wt (weight) shifts or underwt status per comfort care approach." Under section Discharge Plan indicated, “Per IDT (interdisciplinary team) meeting with friend/SDM [Name], no known d/c potential at present as Res continues to receive 24/7 nursing care. Goal remains long term, palliative. Should LHH SNF closure occur, team recommended that Res continues to require LTC SNF LOC (level of care); and friend/SDM [Name] would prefer to have Res relocate to a SNF in Oakland/Bay Area, CA. Oakland, CA would be first choice as it would be closest to [SDM Name] who is Res’ primary social support.”
1.
Review of Patient 5’s LHH Pre-Discharge or Pre-Transfer Physician Progress Note, dated 5/18/22, indicated, discharge diagnosis of dementia without behavioral disturbance. Under the section Hospital Course by Problem indicated, “No new assessment & plan notes have been filed under this hospital service since the last note was generated.” Under Relocation Stress Syndrome: Transfer Trauma Assessment indicated, “Patient was assessed for any relocation related stress. Mood and Behavior are stable. Please see additional psychosocial care plan for details." Under Disposition indicated reason for transfer, “This facility ceases to operate.”
Review of Patient 5's Psychosocial Needs care plan dated 5/18/22, 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.
[Name of SDM] participated with meeting via phone. Made aware re (regarding): potential discharge/relocation due to LHH potential closure. Per [Name of SDM], if ever resident will get discharge to another facility she preferred resident to be relocated in Oakland Bay area.
Transfer Trauma Interventions:
1. The RCT assessed for any risks of Transfer Trauma on May 17, 2022.
2. Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal.
3. Refer the patient for Psychiatry consults and f/u if needed to address Transfer Trauma.

Review of Patient 5’s “Other Orders” dated 6/8/22, indicated, “Discharge patient. Discharge date and time: 6/10/2022 Midday. Discharge disposition: Discharged/Transferred To Skilled Nursing Facility (SNF) With Medicare Certification.”
During an interview with Registered Nurse (RN1) on 8/16/22, at 1:43 PM, RN 1 stated, the Resident Care Team (RCT) assessed Patient 5 for potential transfer trauma during the pre-discharge assessment. RN 1 explained, a "general" transfer trauma care plan was developed and that all patients identified at risk for transfer trauma had the same care plan.
During an interview with NM 2 on 8/16/22, at 1:45 PM, NM 2 stated, the transfer trauma care plan was a "pre-populated" care plan for all patients. NM 2 confirmed the transfer trauma care plan was not specific to Patient 5.
During an interview with RN 1 on 8/16/22, at 1:47 PM, RN 1 explained that the

interventions for transfer trauma is to monitor patients for behavioral changes, anxiety, or irritability. During concurrent record review, RN 1 was unable to show evidence of documentation of emotional and/or behavioral monitoring in Patient 5's electronic health record (EHR).
Review of the clinical record from the receiving facility indicated, Patient 5 was admitted on 6/16/22 under palliative care and expired on 7/7/22.
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 LHH 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..."
The failure to comply with these policies and to develop an individualized care plan for this patient had the potential to disrupt Patient 5's continuity of care and to exacerbate transfer trauma caused by placement in an unfamiliar environment.

2.
During an interview on 8/16/22, at 10:55 AM, Social Worker (SW3) 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."
Review of Patient 5's Resident Care Team Meeting Note, dated 5/18/22, indicated:

Meeting Type: Pre-Discharge Patient Assessment
Meeting Summary: "During Pre-discharge assessment, RCT reviewed and discussed potential transfer trauma … Goal: Collaborate with patient/family/caregiver to identify patient specific goals for this hospitalization … SDM participated with meeting via phone. Made aware re (regarding): potential discharge/relocation due to LHH potential closure. Per [Name of SDM], if ever resident will get discharge to another facility she preferred resident to be relocated in Oakland Bay area…"

Review of Patient 5's LHH Pre-Discharge or Pre-Transfer Physician Progress Note, dated 5/18/22, indicated, discharge diagnosis of dementia without behavioral disturbance. Under the section Hospital Course by Problem indicated, "No new assessment & plan notes have been filed under this hospital service since the last note was generated." Under Relocation Stress Syndrome: Transfer Trauma Assessment indicated, "Patient was assessed for any relocation related stress. Mood and Behavior are stable. Please see additional psychosocial care plan for details." Under Disposition indicated reason for transfer, "This facility ceases to operate."
Review of Patient 5's Psychosocial Needs care plan dated 5/18/22, 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.
[Name of SDM] participated with meeting via phone. Made aware re (regarding): potential discharge/relocation due to LHH potential closure. Per [Name of SDM], if ever resident will get discharge to another facility she preferred resident to be relocated in Oakland Bay area.
Transfer Trauma Interventions:
4. The RCT assessed for any risks of Transfer Trauma on May 17, 2022.
5. Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal.
6. Refer the patient for Psychiatry consults and f/u if needed to address Transfer Trauma.

Review of Patient 5's Discharge Summary, dated 6/13/22, indicated, discharge diagnosis of dementia without behavioral disturbance. Under section Hospital Course indicated, Patient 5 was profoundly demented, unresponsive, bedbound, contracted, closed, does not make eye contact, does not speak, but still eats if fed, and sleeps nearly 24 hours a day. Under section Physical Exam at Discharge indicated, "Gen (general): nearly comatose with profound neurologic deficit (refers to abnormal function of a body area)… Profound advanced dementia, non-verbal, eyes closed." Under section Advanced Directives indicated, "She is to receive care on S3 only unless her comfort needs cannot be met on the ward. She remains on palliative care. No intensive treatments will be ordered, she will remain on the unit for all her care."
Review of Patient 5's social worker's notes, dated 6/15/22, indicated, "6.15.22: Per LHH Patient Flow/UM (utilization management), MSW (medical social worker) informed friend/SDM [Name] is now anticipated to transfer/discharge to [Name of SNF] tomorrow, Thurs. (Thursday) 6/16/22, pending ambulance transportation confirmation tomorrow morning. S3 aware. Friend/SDM [Name] remains agreeable for Res to transfer/discharge

to [Name of SNF]…"
Review of Patient 5's After Visit Summary, dated 6/16/22, indicated, Patient 5 was discharged to another Skilled Nursing Facility (SNF) via ambulance. During an interview on 8/16/22, at 1:38 PM, RN 1 stated, there was no other discharge assessment aside from the assessment completed on 5/18/22 that indicated that resident was not ready for discharge
During an interview with Nurse Manager (NM2) on 8/16/22, at 1:40 PM, NM 2 stated, Patient 5 was at the end of life in the S3 unit (the designated unit for patients on palliative care).
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 LHH 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 document.
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 DNR/DNI (do not resuscitate/do not intubate), 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 based on operations and on available beds. "It's whoever's patient assessment completed in that week."
Review of facility policy titled, Discharge Planning, dated 10/13/20, indicated, "Laguna Honda Hospital and Rehabilitation Center (LHH) 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. LHH 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

Name Of Evaluator:
Ma Corazon Sia
HFEN

Evaluator Signature:_____

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certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected ..."
The facility's Discharge Planning policy did not indicate, "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. This lack of staff training led to the failure in properly assessing Patient 5 prior to transfer to another SNF facility.
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 by the facility 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.
The lack of complete facility policies and care plans related to discharge and transfer created a lack of clarity and confusion for assessment and transfer staff that could result in Patient 5 not receiving a proper assessment of required care after transfer to a new facility. The facility failed to implement written patient policies and procedures when nursing staff failed to report the patient's conditions and care needs to the receiving facility's nursing staff on the day of transfer.
In violation of the above cited standards, the facility failed to comply with 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 5's high risk for transfer trauma. These failures had the potential to result in Patient 5 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:
Ma Corazon Sia
HFEN

Evaluator
Signature:_____

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State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 220018220

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) : CA00804188

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 ART4-72433(b)(5)
T22 DIV5 CH3 ART3-72311(a)(1)(B)
T22 DIV5 CH3 ART5-72523(a)
1336.2(a)(1)(2)(3A)(3B)(4)(5)

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 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.

T22 DIV5 CH3 ART 4-72433(b)(5) Social Work Service Unit - Services
(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.

Name Of Evaluator:
Naida Rico
HFEN

Evaluator Signature:_____

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Signature:_____

Name:_____

Title:_____

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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.

(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

Name Of Evaluator: Naida Rico HFEN	Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE
Evaluator Signature:_____	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

not obligate a facility to pay for future care and services.

The Statute is not met as evidenced by:

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 17's day of discharge, failed to develop care plan to address Patient 17's high risk for transfer trauma, and failed to develop a discharge care plan. 2. 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 residential environment to another) for Patient 17.
3. Provide medically related social services to attain and/or maintain the highest practicable physical, mental, and psychosocial well-being by failing to ensure a discharge care plan was developed for Patient 17.

4.Take reasonable steps to transfer Patient 17 safely and minimize possible transfer trauma by not ensuring that a licensed clinical social worker and nursing staff properly performed complete assessments of Patient 17.
5. Take reasonable steps to transfer Patient 17 safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services when the facility physician failed to report the resident's conditions and care needs to the receiving facility's physician on day of discharge, and when social work and nursing staff failed to develop an individual written care plan to address Patient 17's high risk of transfer trauma, and a discharge care plan.
These failures resulted in Patient 17 not receiving care and services to meet his specific needs and medical condition(s), as well as continuity of care to meet his physical, mental, and psychosocial needs following transfer. Additionally, these failures had the potential to result in Patient 17, who had a history of transfer trauma when transferred to another unit at the facility, to experience mental and/or emotional distress due to relocation to a new environment.

Findings:

On 9/22/22, at 9:40 AM, the 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.
Patient 17, a 71 year old male, was admitted to the facility on 5/12/10 with diagnoses of traumatic brain injury (TBI - brain damage), diabetes mellitus (DM - a condition that causes the blood sugar levels in the body to rise higher than normal), dementia (a term used for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and recurrent major depressive disorder (a mental health disease) in partial remission. The resident assessment tool, completed by the facility on 4/22/22, indicated Patient 17 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 acted as a surrogate decision maker for Patient 17 because patient 17 lacked the capacity to make medical decisions. Patient

17 was discharged to another skilled nursing facility on 6/30/22.
A review of Patient 17's "Pre-Discharge or Pre-Transfer Physician Progress Note," dated 5/24/2022, indicated, "Recurrent major depressive disorder (a serious mood disorder) in partial remission (symptoms have been reduced) - STATUS: no active, resolved, was a difficult time to adjust to the new unit on [sic] 2014 in the past. He took antidepressant for a prolonged period of time but now has resolved. Continue to monitor."
Review of Patient 17's 'Nursing Note," dated 6/30/22 at 10:44 AM, indicated Patient 17 was discharged to another skilled nursing facility (SNF) on 6/30/22 at 10:15 AM.
Review of Patient 17's "Discharge Summary," dated 6/29/22 at 3:45 PM, did not indicate the physician contacted the receiving SNF for a physician to physician hand off of patient care during to transfer.

During an interview on 10/3/22 at 3:32 PM, Medical Doctor (MD1) stated, "In general we call the facility and talk to the physicians. In this case, I don't remember the physician's name. I was unable to do a direct one on one with a physician. I called and there was no response, and I didn't call back." MD 1 also stated regarding handoff to the physician at the receiving facility, "For us, it's important…we do it for a continuity of care."

Review of the facility's "Standard Work Instructions," titled "Transfer to Skilled Nursing Facilities (TSNF)," revision #1, 2, 3, and 4, all dated 6/23/22, indicated, "Purpose: To prepare and coordinate the transfers of patients to other skilled nursing facilities." Further review of the TSNF indicated, "Major Steps: 17. Day of Transfer: Physician will contact the facility for physician to physician handoff."

Review of facility's policy titled, Notification of Closure and Patient Transfer and Relocation Plan (Closure and Relocation Plan) " dated 5/13/22 indicated, "…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 coordinate the safe transfer of Patient 17 to the receiving facility when the aforementioned "Standard Work Instructions" and Closure and Relocation Plan were not followed during the transfer of Patient 17.

In violation of the above cited standards, the facility failed to comply with, and implement, the facility's established written patient care policies when coordinating the transfer of Patient 17 to another SNF on 6/30/22.
As a result of these failures, the facility did not adequately prepare Patient 17 for transfer, and did not mitigate the potential for transfer trauma evidenced by the physician's documentation of Patient 17's history of negative impacts after being moved to different living arrangements in 2014 on the "Pre-Discharge or Pre-Transfer Physician Progress Note," dated 5/24/2022. This result in Patient 17 not receiving adequate care.
Additionally, the facility failed to take reasonable steps to transfer affected patients safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services when it did not perform the physician to physician handoff.
A review of Patient 17's "Pre-Discharge or Pre-Transfer Physician Progress Note," dated 5/24/2022 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 stable. Please see additional psychosocial care plan for details. But at risk of

instability, previous Hx (history) of severe depression and suicidal ideas when relocated from NM (unit at the facility) to N3 (another unit at the facility) few years ago."

A review of Patient 17's "Discharge Summary," dated 6/29/22 indicated, "Recurrent major depressive disorder in partial remission. STATUS: no active, resolved, was a difficult time to adjust to the new unit on 2014. [sic] in the past. He took antidepressant for a prolonged period of time but now has resolved. Continue to monitor." The Discharge Summary also indicated, "Issues requiring follow up: He likes music and is very happy in general. It might have a difficult time with the transition and might need treated with antidepressant."

During a concurrent interview with Registered Nurse (RN) 5 and review of Patient 17's clinical records, on 9/22/22 at 1:56 PM, the "Resident Care Team Meeting Note (RCTMN)," dated 5/24/22, indicated, "Meeting Type: Pre-Discharge Patient Assessment." The RCTMN indicated, "If pre-discharge patient assessment RCC (Resident Care Conference), review and discussion of potential transfer trauma: High risk of transfer trauma due to hx (history) decompensating when moved or relocated. Res (resident) Past longtime companion he is attached to." Further review of the RCTMN indicated, "Transfer Trauma Interventions," as follows:
? The RCT (Resident Care Team) assess risks of Transfer Trauma on 5/24/22
? 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."

RN 5 stated Patient 17's high risk of transfer trauma is, "Something probably should be care planned, probably put in the behavior, so the staff know what they should be observing, to engage the person."

During a concurrent interview with Social Worker (SW) 4 and review of Patient 17's clinical records on 9/22/22 at 2:45 PM, SW 4 reviewed the care plans of Patient 17 but was unable to provide documented evidence of a written care plan addressing risk of transfer trauma. Review of Patient 17's RCTMN indicated, "Care Plan Problems/Goals," and listed the following:
1. Mobility/activity is maintained at optimum level for patient (ADL maintenance)
2. Verbalizes/displays adequate comfort level or baseline comfort level (Pain-Adult)
3. Free from fall injury (Safety Adult – Fall)
4. Patient's chronic condition and co-morbidity symptoms are monitored and maintained or improved (Chronic condition and co-morbidities)
5. Patient will be free of physical & verbal abusive behaviors (Behavioral symptoms)
6. Glucose maintained within prescribed range (Metabolic/Fluid and Electrolytes)
7. Will not develop new pressure ulcer/injury (Pressure Ulcer/Injury or at risk)
8. Resident will participate in meaningful leisure of choice 2-3 times a week (Resident Activity Needs)
9. Mobility level is maintained or improved (ADL Maintenance)
10. Achieves stable or improved neurological status (Neurosensory – Adult)
11. Absence of seizures (Neurosensory – Adult)
12. Remains free of injury related to seizures activity (Neurosensory-Adult)
13. Achieves maximal functionality and self-care (Neurosensory-Adult)
14. Skin integrity remains intact (Skin/Tissue Integrity-Adult)

15. LTG (long term goal) – Patient will tolerate the least restrictive diet without signs or symptoms of aspiration (ADL Maintenance)
16. Food and/or Nutrient Delivery (ND) (Altered Nutrition-Related Laboratory Values)
17. Patient maintains adequate hydration (Nutrition)
18. Patient maintains weight (Nutrition)
19. Resident will optimize number of hours slept with minimal use of medication (Sleep Pattern Disturbance)
20. Maximize patient orientation and to communicate needs (Cognitive Loss/Dementia)
21. Ability to express needs and understand communication (Communication)
22. Resident will not show a decline in psychosocial wellbeing or experience adverse effects through next review (Facility Isolation Psychosocial Wellbeing)
23. Resident will not show no signs or symptoms of COVID-19 (COVID-19 Prevention and Monitoring)
24. Incisions, Wounds, or Drain Sites Healing Without S/S (signs/symptoms) of Infection (Skin/Tissue Integrity-Adult)
25. Resident will not elope from facility (High Elopement Risk AEB)

The list did not include a care plan addressing facility-identified high risk of transfer trauma for Patient 17. SW 4 stated, “There is supposed to be a care plan attached to it (RCTMN). I think it should be nursing doing the care plan for that.” SW 4 stated the care plan should have been created after the Resident Care Team Meeting held on 5/24/22.

During a concurrent interview with RN 5, SW 4, and Quality Management Nurse QMN 4, and review of Patient 17’s “Care Plan Event Log,” on 9/22/22 at 3:16 PM, QMN 4 assisted RN 5 and SW 4 in locating a care plan that addresses the risk for transfer trauma for Patient 17 in the clinical records. QMN 4 stated, “It’s not showing. There is no other areas, it’s not documented.” RN 5 stated, “I don’t see (a care plan) that specifically addresses transfer trauma. We would normally do a discharge care plan. Up until the decertification, he was not on discharge track.”

During an interview on 10/3/22 at 4:10 PM, the acting Chief Nursing Officer (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 was informed that there was no care plan for risk of transfer trauma for Patient 17. The CNO stated, “If it’s not there, it’s not there. They should be updating the care plan with what he is doing and where he is going.”

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…" Further review of the facility's Notification of Closure and Patient Transfer and Relocation Plan," dated 5/13/22, indicated, "The intent of this Closure Plan is to ensure the safe, orderly, and clinically appropriate transfer or discharge of each patient with a minimum amount of stress for patients, families, guardians, legal representatives (collectively, Representatives)." Further review of the Closure and Relocation Plan indicated, "Part 9 – Administrator and Facility Closure Team: Roles and Responsibilities…Facility Closure Team: Roles and Responsibilities:…Facility Closure Team – The Resident Care Team will have a role in the transfer/discharge process to assure a safe and orderly transfer for all patients. Nursing Services-Lead: Acting Chief Nursing Officer – Ensures that each patient's care plan is in place and continues throughout the closure process…"

The lack of a care plan that included measurable objectives and a timetable to address the high risk of transfer trauma for Patient 17 was not in accordance with 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. The facility P&P indicated, "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 a timetable to meet the resident's medical, nursing, and mental health needs."

Further review of the P&P indicated, "Purpose: To promote the resident's highest possible physical, mental and psychosocial well-being." The P&P also indicated, "Procedure: e. The RCT shall address resident care needs and preferences through assessment of the resident and the development and implementation of the RCP."

The facility failed to address Patient 17's care needs when a care plan with measurable objectives and a timetable to meet the resident's medical, nursing, and mental health needs was not developed to address his risk of instability due to previous history of severe depression and suicidal ideas when he was transferred from one unit to another at the facility in 2014.

In violation of the above cited standards, the facility failed to comply with the nursing service requirements for planning of patient care by not developing an individual, written care plan after the facility identified Patient 17 as having a high risk of transfer trauma. The facility further failed to implement its policies and procedures that require the development of a comprehensive care plan when it did not include a plan to address the patient's risk for transfer trauma. Additionally, the facility failed to take reasonable steps to transfer affected patients safely and minimize possible transfer trauma when its social work and nursing staff did not make complete assessments to address Patient 17s high risk of transfer trauma.
According to the facility resident assessment tool, completed on 4/22/22, Patient 17 had severe cognitive impairment and needed extensive assistance with bed mobility, dressing, toileting, and personal hygiene.
A review of Patient 17's "Pre-Discharge or Pre-Transfer Physician Progress Note (PPPPN)," dated 5/24/2022 indicated, "… Given his DM, poorly controlled, the need of

insulin (medication used to regulate blood sugar levels) and he is unable to inject himself given his TBI/Dementia, he is at SNF level." Further review of the PPPPN indicated, "Reason for transferred to SNF level of care TBD (location) - This facility ceases to operate…"

A review of Patient 17's "Resident Care Team Meeting Note (RCTMN)," on 9/22/22 at 1:56 PM, dated 5/24/22, indicated, "Meeting Type: Pre-Discharge Patient Assessment." The RCTMN indicated Patient 17's SDM participated in the meeting. The RCTMN indicated that the Resident Care Team (RCT) determined Patient 17 required him to be SNF level care.

Resident Social History – 5/10/22 – Covering MSW (Medical Social Worker) discussed with IDT (Interdisciplinary Team) regarding Resident's (patient) potential for d/c (discharge). Summary: Requires SNF needs. No discharge potential."

During a concurrent interview with Social Worker (SW) 4 and review of Patient 17's clinical records on 9/22/22 at 2:45 PM, SW 4 reviewed the care plans of Patient 17 but was unable to provide a documented evidence of a discharge care plan for Patient 17. Review of Patient 17's RCTMN indicated, "Care Plan Problems/Goals" (list referenced above).

The list did not include a discharge care plan, a requirement of the Social Service Patient Assessment. SW 4 stated, "Not sure about the discharge care plan. In his (Patient 17's) case we think the reason we don't have one, up to the recertification, we do not consider (Patient 17) to be as a candidate for discharge.

During a concurrent interview with RN 5 on 9/22/22 at 3:49 PM, RN 5 stated that Patient 17 was transferred, not discharged. RN 5 stated, "It's a lateral move. If it's a same facility (referring to another SNF), there would be no discharge plan. It's more a transfer with same level of care as opposed to something to lower level of care. (Patient 17) was transferred and not discharged. Transfer would be transferring someone to different level of care or same level of care. Discharged would be going to home health (medical care provided in a patient's home), RCFE (Residential Care Facilities for the Elderly), something that was not the same level. If the patient is getting discharged, they would need a care plan."

During a concurrent interview with SW 4 and RN 5 on 9/22/22 at 3:55 PM, SW 4 stated, "The thing for (Patient 17)…they (receiving facility) coordinated the time, they said we want the patient, within a matter of days he was gone on the transfer. We did not have discharge (referring to care plan), happened very fast, did not have much control of the situation…" RN 5 stated, "In the events that they (facility) would expect the patient to return to the facility, we do not look at it as a discharge, so we were doing it as a transfer…"
During a concurrent interview with Transfer Coordinator (TC) 1 and review of the facility's policy and procedure (P&P) titled, "Discharge Planning," dated 10/13/20, on 9/22/22 at 4:25 PM, the P&P indicated, "Philosophy: (Facility) has a responsibility to provide timely access to skilled nursing services to San Franciscans who are in need of such services. In order to fulfill this responsibility, (facility) continually facilitates timely and safe resident discharges to the appropriate level of care. Policy: 1. (facility) start to assist every

client/resident (hereafter "resident") keep their optimal health, functioning, and well-being and achieved discharge to the virus level of care possible. When discharge from skilled nursing unit or reliability unit is not achievable, the Resident Care Team shall continue to support maximum social integration." Further review of the P&P indicated, "Definition: Transfer and Discharge: Includes movement of the 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 the 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…" TC 1 stated, "He (Patient 17) was actually discharged…"

The resident assessment tool completed by the facility on 6/30/22 for Patient 17 indicated, "Discharge assessment-return not anticipated…Discharge Date - 6/30/22 … Discharge Status - another nursing home or swing bed."

During an interview on 10/3/22 at 4:10 PM, the Chief Nursing Officer (CNO) stated, "It's a shared responsibility (referring to the staff). Care Plans get initiated upon admission. Nursing has a portion, so does PT (physical therapy) and SW (social work). As for discharge planning, … it's not a regular discharge policy, it's our decertification plan. It is a shared responsibility, so I can understand how everyone is pointing a different way." The CNO also stated, "Honestly when we discharge someone nursing should be ensuring that with Social Work. It has to be both collaboratively…"
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: 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 EHR (Electronic Health Record) …"

A review of the facility's policy and procedure (P&P) titled, "Discharge Planning," dated 10/13/20, indicated, "Philosophy: (The facility) has a responsibility to provide timely access to skilled nursing services to San Franciscans who are in need of such services. In order to fulfill this responsibility, (the facility) continually facilitates timely and safe resident discharges to the appropriate level of care. Policy: 1. (The facility) strives to assist every client/resident (hereafter "resident") keep their optimal health, functioning, and well-being and achieved discharge to the virus level of care possible. When discharge from skilled nursing unit or reliability unit is not achievable, the Resident Care Team [RCT] shall continue to support maximum social integration." Further review of the P&P indicated, "Definition: Transfer and Discharge: Includes movement of the 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 the 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…Procedure: 4. RCT Roles and Responsibilities. a. RCT Responsibilities. The physician, social worker, nurse, activity therapist, dietitian, rehabilitation specialist, occupation therapist, physical therapist, or speech therapist with others as needed: i. Perform the discharge assessment process as described and negotiate the discharge plan…d. Nurse – i. Collaborates with the resident and family to provide assessment and interventions to maintain or improve self-care functioning. ii. Provides resident and family education to support self-care and independence, based on the care plan. Identifies and advocates for referrals to rehabilitative services to improve self-care and independence.

A review of the facility policy titled, "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)" dated 7/9/19, indicated, "...4. Comprehensive Care Plan a. LHH 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..."

As a result, the failure to develop a discharge care plan for Patient 17 had the potential to result in Patient 17 not receiving continuity of care to meet his physical, mental, and psychosocial needs.

Patient 17 was discharged from the facility on 6/30/22. At the receiving facility, Patient 17 had a weight loss of 9.4 pounds from 7/13/22 to 8/22/22 (5.9% weight loss in one month). Patient 17 expired on 8/24/22.
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 provide a physician to physician handoff on the day of discharge, develop a care plan to address Patient 17's hjgh risk of transfer trauma, 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 had the potential to result in Patient 17 not receiving continuity of care and for the patient to experience mental and emotional trauma due following relocation to a different skilled nursing facility.

Name Of Evaluator:
Naida Rico
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

CITATION NUMBER: 220018218

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) : CA00806432

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 ART5-72523(a)

CLASS B **CITATION --** Patient Care

Cal. Code Regs., tit. 22, § 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.
Health & Safety. Code § 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

Name Of Evaluator:
Aurora Liganor

Evaluator Signature:_____

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Signature:_____

Name:_____

Title:_____

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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.
(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.

(b) The facility shall provide an appropriate team of professional staff to perform the services required in subdivision (a).

Based on interview and record review, the facility failed to:
1. Comply with written patient care policies and procedures when:
a. Patient 24, who was originally assessed to be discharged to Board and Care (B&C) level of care, was not reassessed prior to transfer to a skilled nursing facility (SNF), and
b. The Registered Nurse (RN) failed to report the patient's conditions and care needs to the receiving facility's RN on Patient 24's day of discharge.
2. Take reasonable steps to transfer Patient 24 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 24.
These failures had the potential to result in Patient 24 not receiving appropriate care and

services to meet patient's specific needs and medical condition(s).
Findings:
On 8/16/22, at 9:30 AM, 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.
a. Review of the Physician Discharge Summary, dated 7/5/22, indicated, Patient 24 was a 93-year-old female with dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), unsteady gait and poor balance, no safety awareness and is a high risk for falls, with several falls over the last three years. Patient 24 was exposed to COVID and was COVID positive on 6/8/22 with minimal symptoms. Disposition: Board and Care.
Review of Patient 24's "LHH Medical Social Services Discharge Assessment" dated 5/24/22 indicated, Discharge status had discharge barriers of: totally dependent with ADLs (activities of daily living) and mobility; cognitively impaired and/or displays at risk behaviors such as AWOL risk, wandering; history of recurrent falls; incontinent. Patient 24 had chronic progressive disease and cognitive impairment. Evaluating relocation needs: Board and Care Home level with close supervision. Team Recommendation: Board and Care Home.
Review of Patient 24's "Resident Care Team Meeting Note" (RCTMN), dated 5/24/22, indicated, resident was medically stable but she was confused and had no safety awareness. She was a good candidate for boarding care. Daughter joined the resident care conference and was notified of resident's current condition, and possible transferring to boarding care. Daughter verbalized her understanding. The RCTMN under social services indicated, "On 5/24/22, team discussed with daughter possible discharge plan, B&C home level. Family agreed."
During an interview on 8/16/22 at 10:39 AM, Social Worker (SW2) stated that Patient 24 was dependent, needed a lot of assistance with ADLs. SW2 further said, Patient 24 was cognitively impaired (confused, doesn't know name) and had history of falls. SW2 explained that for Board and Care (B&C) level of discharge, patient can be independent for certain things. SW2 stated, "Patient 24 can eat by herself." SW2 said that Patient 24's condition is between B&C and SNF and stated, "But SNF is more protected environment. She's a little bit different."
During an interview on 8/24/22 at 1:26 PM, Transfer Coordinator (TC1) stated, "Discharge Barriers" are factors to consider for discharge. TC1 explained that the LHH Medical Social Services Discharge Patient Assessment form was a template meant for patients to be discharged to the community.
During an interview on 8/24/22 at 1:26 PM, the Director of Social Services (DSS) explained that B&C facilities can cater to higher level needs. DSS acknowledged Patient 24 was not going to lower level of care.
During an interview on 8/24/22 at 2:34 PM, TC1 stated, "They do not need to do re-assessment because they pursued discharge to SNF level."
During an interview on 9/7/22 at 3:58 PM, with Nurse Manager (NM3), NM3 said that Patient 24 was moderately impaired, able to verbalize concerns, lower extremities are weak, and had a history of stroke. NM3 stated, "Better to discharge to SNF."
During a review of facility's "Discharge Planning" policy revised 10/13/20, indicated, "Laguna Honda Hospital and Rehabilitation Center (LHH) has a responsibility to provide timely 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. LHH provides inter-

disciplinary discharge planning services that meet the resident's health and 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 do 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..."
The facility's Discharge Planning policy did not indicate, "Discharge Status: Discharge Barriers" 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. This lack of staff training led to the failure in properly assessing Patient 24 prior to transfer to another SNF facility.
During a review of facility's "Discharge Planning" policy revised 10/13/20, indicated, "...Procedure: 1. Discharge assessment and planning is initiated on admission and re-assessed, at a minimum, quarterly, or sooner..."
During a review of facility's closure plan titled, "Laguna Honda Hospital and Rehabilitation Center Notification of Closure and Patient Transfer and Relocation Plan" dated 5/13/22, indicated, "... Part 2-Patient Assessments...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..."
Failure to perform a reassessment to determine the appropriate level of care prior to discharge to a Skilled Nursing Facility (SNF) for Patient 24 after an initial assessment indicated she should be discharged to a Board and Care had the potential to result in Patient 24 not receiving continuity of care, and experiencing mental, emotional, and physical distress due to transfer to a new environment that may not meet the needs for her care.
b. Patient 24 was discharged to another (SNF) on 7/5/22. Review of Patient 24's nursing discharge summary note, dated 7/5/22, indicated, "...Resident is alert and oriented to self...Verbally responsive well in Cantonese...VS (vital signs) stable...Resident discharged at 10:30...". The clinical record did not indicate nursing service contacted the receiving SNF for a RN-to-RN hand-off.
During an interview on 9/7/22 at 4:20 PM with NM3, NM3 said that on the day of patient discharge, nurses perform an assessment, then call the facility and give the report. NM3 further said, there are three reports made to the receiving facility, namely, MD to MD (physician), RN to RN, and SW to SW. NM3 stated, "We need to communicate. It's very important for patient's safety." NM3 acknowledged that there was no documentation of RN-to-RN hand-off, and stated, "None."
Review of facility's policy titled, "Facility Closure Plan", dated 5/3/22, indicated, "...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...".
Review of facility document titled, "Standard Work Instructions Title: Transfer to Skilled Nursing Facilities" dated 6/23/22 revision #:4, indicated, "...Major Steps...17. Day of Transfer: Nursing will contact the facility for RN-to-RN hand-off...".
Review of an undated facility document titled, "Transfer to Skilled Nursing Facility Checklist" indicated, "...Day of Transfer...RN to RN Hand-off...".
Patient 24 was transferred from the facility to another certified SNF facility on 7/5/22. On

Name Of Evaluator:
Aurora Liganor

Evaluator
Signature:_____

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

Signature:_____

Name:_____

Title:_____

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7/22/22, Patient 24 had a change in condition of poor oral intake (decreased or unable to eat and/or drink adequate amounts). Patient 24 expired on 7/24/22, after experiencing symptoms commonly associated with transfer trauma response, including reduction in fluid and nutrition intake, and an exposure to COVID-19.
In violation of the above cited standards and the facility's written patient care policies and procedures, a Registered Nurse (RN) failed to report the patient's conditions and care needs to the receiving facility's RN on Patient 24's day of discharge to another skilled nursing facility on 7/5/22.
In violation of the above cited standards, the facility failed to comply with its established written patient care policies and procedures, Patient Transfer and Relocation Plan, Title 22 regulations, and Health and Safety Code section 1336.2, including but not limited to failing to reassess Patient 24, failing to report the patient's conditions and care needs to the receiving facility's RN on the day of discharge, 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 24 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:
Aurora Liganor

Evaluator
Signature:_____

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Title:_____

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State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 220018217

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) : CA00806430

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 ART3-72325(a) 1336.2(a)(1)(2)(3A)(3B)(4)(5) T22 DIV5 CH3 ART3-72311(a)(1)(B)

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 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

Name Of Evaluator:
Aurora Liganor

Evaluator Signature:_____

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Signature:_____

Name:_____

Title:_____

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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.

(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.

The Statute is not met as evidenced by:

Name Of Evaluator: Aurora Liganor	Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE
	Signature:_____
Evaluator Signature:_____	Name:_____
	Title:_____

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Based on interview and record review, the facility failed to:
1. Develop an individual, written patient care plan to address high risk for transfer trauma (term used to describe the stress that a person with dementia may experience when changing living environments) for Patient 11.
2. Comply with written patient care policies and procedures when:
a. Patient 11 who was identified as "Not Discharge Ready," was not reassessed prior to discharge, and
b. The Registered Nurse (RN) failed to report the patient's conditions and care needs to the receiving facility's RN on Patient 11's day of discharge.
3.Take reasonable steps to transfer Patient 11 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 11.
4.Take reasonable steps to transfer Patient 11 safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services for Patient 11.

Failure to develop an individualized care plan may result in Patient 11 not receiving appropriate care and services to meet patient's specific needs and medical condition(s) and to experience mental and/or emotional distress due to relocation to a new environment.

Findings:

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 and discharge of patients related to the facility's certification termination and pending closure.
Review of the "Physician Discharge Summary," dated 6/16/22, indicated Patient 11 was a 95 year-old female who was initially admitted to the facility in 2015 from a Board and Care, with a long history of mixed Alzheimer's disease with advanced vascular dementia (brain damage caused by multiple strokes), with the agreement of her Public Guardian. She was unresponsive to verbal stimulation. She progressed in her medical conditions over the past 7 years. Transferred to the facility for comfort-based care. She doesn't get out of bed, mostly unconscious, she doesn't interact or engage or have any meaningful connection.
Patient 11's nursing discharge summary note dated 6/23/22 indicated, "…Resident non verbal, unresponsive to verbal stimuli, unable to make needs known…"
During a concurrent interview and record review on 9/7/22, at 12:08 PM, with Registered Nurse 2 (RN2) , Patient 11's Minimum Data Set (MDS- an assessment tool) dated 6/23/22, indicated Patient 11's cognitive status was rarely/never understood and they had a short term memory problem. RN2 stated Patient 11's decision making was severely impaired.
Review of Patient 11's "Pre-Discharge or Pre-Transfer Physician Progress Note," dated 5/26/22, 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…High risk for trauma from transfer, fragile, elderly…"
Review of Patient 11's "Resident Care Team (RCT) Meeting Note," dated 5/25/22, indicated: "During pre-discharge patient assessment, reviewed and discussed potential transfer trauma. Team discussed potential transfer trauma: at risk for skin break down, fx

(fracture) with movement, decompensation without care from regular providers, increased pain and discomfort. Transfer trauma interventions: The RCT assessed for any risks of Transfer Trauma on May 26, 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. Resident was admitted on 1/9/15 for comfort-focused, palliative care."
Review of Patient 11's "Psychosocial Needs" care plan, dated 5/25/22, indicated, "Problem: Psychosocial Needs…Goal: Demonstrate ability to cope with hospitalization/illness." The care plan 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 need." The care plan also included Transfer Trauma Interventions: The RCT assessed for any risks of Transfer Trauma on May 26, 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.
During an interview with Nurse Manager 2 (NM2) on 8/16/22 at 1:45 PM, NM2 said that the transfer trauma care plan was a "pre-populated care plan for all patients."
During an interview with NM2 on 8/24/22 at 4:04 PM, NM2 stated that interventions to "mitigate transfer trauma" is addressed in the psychosocial care plan and discharge barrier care plan. NM2 added, "We don't have a template specific to transfer trauma."
Review of facility's policy 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…Procedure: 1. The Resident Care Team a. The RCT is an essential component of the care planning process. The RCT shall include members from those disciplines essential to the planning and delivery of care for the resident. RCT members include: i. Nurse Mangers (or designee) – Facilitator of RCC ii. Licensed Nurse iii. Nursing Assistant iv. Attending Physician v. Medical Social Worker vi. MDS Coordinator vii. Activity Therapist viii. Registered Dietitian…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…"
Patient 11 was discharged from the facility on 6/23/22. At the receiving facility, review of physician's certification for hospice indicated, on 6/24/22, Patient 11 was admitted to hospice with evidence of progressive malnutrition with significant weight loss. Patient was cachectic and pale. She was lethargic and hardly arousable. Patient 11 expired on 7/9/22.
In violation of the above cited standards, the facility failed to comply with Title 22 regulations and written policy and procedure by not developing an individualized, written care plan to address transfer trauma after the facility identified Patient 11 as having a high risk of transfer trauma. Failure to develop an individualized care plan may have resulted in Patient 11 not receiving appropriate care and services to meet the patient's specific needs and medical condition(s) and to experience mental and/or emotional distress and/or

Name Of Evaluator:
Aurora Liganor

Evaluator
Signature:_____

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rapid decline of medical status without customized mitigation measures to reduce the effects of relocation to a new environment.
Review of Patient 11's "LHH Medical Social Services Discharge Assessment" dated 5/26/22, indicated, "Not Discharge Ready" related to chronic progressive disease, cognitive impairment, palliative care and other unspecified reason.
During an interview on 8/24/22 at 1:26 PM, Transfer Coordinator 1 (TC1) stated that "discharge" refers to a discharge in the community for patients needing lower level of care while "transfer" refers to a lateral transfer in another skilled nursing facility (SNF) for patients needing SNF level of care. TC1 explained that the "LHH Medical Social Services Discharge Patient Assessment" form was a template meant for patients to be discharged to the community. TC1 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 8/24/22 at 1:26 PM, the Director of Social Services (DSS) stated, "Not Discharge Ready is related to not going to community discharge. It summarized what prevents resident from going to the community."
During a review of facility's "Discharge Planning" policy revised 10/13/20, indicated, "Laguna Honda Hospital and Rehabilitation Center (LHH) has a responsibility to provide timely 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. LHH provides inter-disciplinary discharge planning services that meet the resident's health and 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…"
The facility's discharge Planning policy did not indicate, "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. This lack of staff training led to the failure in properly assessing Patient 11 prior to transfer to another SNF facility.
During an interview on 9/7/22 at 12:55 PM with Registered Nurse 2 (RN2) , RN2 said that "not discharge ready" meant patient was not dischargeable. RN2 further said, if patient is not ready for discharge, it needed reassessment. RN2 acknowledged that Patient 11 was not reassessed and stated, "That's the latest one I see (dated 5/26/22). There's none after that."
During a review of facility's "Discharge Planning" policy revised 10/13/20, indicated, "…Procedure: 1. Discharge assessment and planning is initiated on admission and re-assessed, at a minimum, quarterly, or sooner…"
The facility failed to implement written patient policies and procedures when it did not reassess Patient 11 for discharge prior to transfer to a different skilled nursing facility. u
Patient 11 was discharged to another skilled nursing facility (SNF) on 6/23/22. Review of Patient 11's nursing discharge summary note dated 6/23/22 indicated, "…Conservator aware of residents discharge transfer. All belonging sent with resident, transferring via ambulance…". The clinical record did not indicate nursing service contacted the receiving

SNF for a RN to RN hand -off.
During an interview on 9/7/22 at 12:41 PM with RN2, RN2 said that on the day of patient discharge, the nurse calls the receiving facility to give report (hand-off). RN2 acknowledged there was no documentation that a hand-off was done on the day Patient 11 was discharged. RN2 stated, “Can’t find the documentation. We usually try to get the nurse’s name. I don’t see it on this one. They usually need to document it when they give report to the other charge nurse.” RN2 said a hand-off is important so the receiving facility can continue the care that patients need.
Review of facility’s policy titled, “Facility Closure Plan” dated 5/3/22 indicated, “…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…”.
Review of facility document titled, “Standard Work Instructions Title: Transfer to Skilled Nursing Facilities” dated 6/23/22 revision #:4, indicated, “…Major Steps…17. Day of Transfer: Nursing will contact the facility for RN to RN hand-off…”.
Review of an undated facility document titled, “Transfer to Skilled Nursing Facility Checklist” indicated, “…Day of Transfer…RN to RN Hand-off…”.
Patient 11 was discharged from the facility on 6/23/22. At the receiving facility, review of physician’s certification for hospice indicated, on 6/24/22, Patient 11 was admitted to hospice with evidence of progressive malnutrition with significant weight loss. Patient was cachectic and pale. She was lethargic and hardly arousable. Patient 11 expired on 7/9/22.
The facility failed to implement written patient policies and procedures when nursing staff failed to report the patient’s conditions and care needs to the receiving facility’s nursing staff on the day of transfer.
In violation of the above cited standards, the facility failed to comply with its 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 11’s high risk for transfer trauma, reassess for discharge readiness, provide a nurse to nurse handoff on the day of transfer, 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 11 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:
Aurora Liganor

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

CITATION NUMBER: 220018216

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) : CA00797118

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 ART3-72311(a)(2)
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)(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.

Name Of Evaluator:
Aurora Liganor

Evaluator Signature:_____

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

Signature:_____

Name:_____

Title:_____

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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.

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.

(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:

Based on interview and record review, the facility failed to:
1. Develop an individual, written patient care plan to address high risk for transfer trauma (term used to describe the stress that a person with dementia may experience when changing living environments) for Patient 3.
2. Comply with written patient care policies and procedures when Patient 3 who was identified as "Not Discharge Ready," was not reassessed prior to discharge.
3.Take reasonable steps to transfer Patient 3 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 3.
4.Take reasonable steps to transfer Patient 3 safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services for Patient 3.

Failure to develop and implement an individualized care plan and to properly assess for discharge had the potential to result in Patient 3 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. On 8/11/22, at 10:20 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.
Review of the Physician Discharge Summary dated 6/10/22 indicated, Patient 3 was admitted with diagnoses including hemorrhagic stroke (condition in which a ruptured blood vessel causes bleeding inside the brain) and atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to blood clots in the heart). Patient has a gastrostomy in place (a tube inserted through the belly that brings nutrition directly to the stomach).
During a concurrent interview and record review of Patient 3's Minimum Data Set (MDS- an assessment tool) dated 6/10/22, on 9/7/22 at 3:22 PM with RN 2, the MDS indicated, Patient 3's cognitive status was rarely/never understood and had short term memory problem. RN 2 stated Patient 3's decision making was severely impaired, was incapacitated. Patient 3's daughter was the surrogate decision maker.
A review of Patient 3's "Pre-Discharge or Pre-Transfer Physician Progress Note" dated 5/18/22, 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 stable. Please see additional psychosocial care plan for details. Concern for trauma: Family lives nearby and visits daily. Their father/husband is an important part of their daily life. It would be traumatic to the family and the patient (who often declines if family is able to come in for a few days and becomes withdrawn) if he was moved further from their home. The family members all work and live nearby. We expect transfer to another facility would decrease visits and decrease the health of the patient."

Review of Patient 3's "Resident Care Team (RCT) Meeting Note" dated 5/25/22, it indicated: "During pre-discharge patient assessment, RCT reviewed and discussed potential transfer trauma. There would be concern if resident is transferred away from where family lives. Family would prefer San Francisco, CA area if relocation is needed; otherwise it would create distress and hardship for family to provide love and support to resident. Transfer trauma interventions: The RCT assessed for any risks of Transfer Trauma on May 18, 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."

Review of Patient 3's "LHH Medical Social Services Discharge Assessment" dated 5/17/22 indicated, "Not Discharge Ready" related to chronic progressive disease, cognitive impairment, and palliative care. Risk Factors: Per chart: Resident is of advanced age and currently 84 year old with complex comorbidity (disease or medical condition that is simultaneously present with another in a patient), including history of stroke, atrial fibrillation, gastrostomy in place. Mostly non-verbal.

A review of Patient 3's "Psychosocial Care Plan," dated 5/19/22, indicated, "Problem: Psychosocial Needs…Goal: Demonstrate ability to cope with hospitalization/illness." The care plan 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." The care plan also included Transfer Trauma Interventions: The RCT assessed for any risks of Transfer Trauma on May 18, 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.

During an interview with NM2 on 8/16/22 at 1:45 PM, NM2 said that the transfer trauma care plan was a "pre-populated care plan for all patients."

During an interview with Nurse Manger (NM2) on 8/24/22 at 4:04 PM, NM2 stated that interventions to "mitigate transfer trauma" is addressed in the psychosocial care plan and discharge barrier care plan. NM2 added, "We don't have a template specific to transfer trauma."

During a concurrent interview and record review of Patient 3's "Psychosocial Care Plan" on 9/7/22 at 3:46 PM with RN2, RN2 said Patient 3 was not verbally responsive. RN2 acknowledged that the care plan was not individualized and stated, "Not an individualized care plan, not for him." RN2 further said that the care plan should have been updated/revised.

Review of the facility's policy 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…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…"
Patient 3 was discharged from the facility on 6/10/22. At the receiving facility, on 6/17/22, Patient 3 had a change in condition for skin tear with skin discoloration on the side of his left wrist. On 6/24/22, Patient 3 had a change in skin condition for moisture-associated skin damage (MASD-general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine) to inner right and left buttocks. On the same day, Patient 3's G-tube clogged, was sent and admitted to the hospital. Review of physician's certification for hospice indicated, on 7/6/22, Patient 3 was admitted to hospice, noted to be lethargic, opens his eyes only when his name is called. Currently pale, frail and cachectic. Patient 3 was transferred to an acute care facility (hospital) on 7/15/22 and expired at the hospital on 7/16/22.
In violation of the above cited standards, the facility failed to perform complete assessments of the patient and did not develop and implement an individual, written care plan after the facility identified Patient 3 as having a high risk of transfer trauma.

B. Review of Patient 3's "LHH Medical Social Services Discharge Assessment" dated 5/17/22 indicated, "Not Discharge Ready" related to chronic progressive disease, cognitive impairment, and palliative care. Social and Physical Functioning Risk Factors: Per chart: Resident is of advanced age and currently 84 year old with complex comorbidity (disease or medical condition that is simultaneously present with another in a patient), including history of stroke, atrial fibrillation, gastrostomy in place. Mostly non-verbal.
During an interview on 8/24/22 at 1:26 PM, Transfer Coordinator (TC1) stated that "discharge" refers to a discharge in the community for patients needing lower level of care while "transfer" refers to a lateral transfer in another skilled nursing facility (SNF) for patients needing SNF level of care. TC1 explained that the LHH Medical Social Services Discharge Patient Assessment form was a template meant for patients to be discharged to the community. TC1 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 8/24/22 at 1:26 PM, the Director of Social Services (DSS) stated, "Not Discharge Ready is related to not going to community discharge. It summarized what prevents resident from going to the community."
During a review of facility's "Discharge Planning" policy revised 10/13/20, indicated, "Laguna Honda Hospital and Rehabilitation Center (LHH) has a responsibility to provide timely 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. LHH provides inter-disciplinary discharge planning services that meet the resident's health and 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…"
The facility's discharge Planning policy did not indicate, "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. This lack of staff training led to the failure in properly assessing Patient 3 prior to transfer to another SNF facility.
During an interview on 9/7/22 at 12:55 PM with Registered Nurse (RN2), RN2 said that "not discharge ready" meant patient was not dischargeable. RN2 further said, if patient is not ready for discharge, it needed reassessment.
During a review of facility's "Discharge Planning" policy revised 10/13/20, indicated, "…Procedure: 1. Discharge assessment and planning is initiated on admission and re-assessed, at a minimum, quarterly, or sooner…"
During a concurrent interview and record review on 9/7/22 at 3:23 PM with RN2, RN2 acknowledged that Patient 3's "LHH Medical Social Services Discharge Assessment" dated 5/17/22 indicated, "Not Discharge Ready" related to chronic progressive disease, cognitive impairment, and palliative care. RN2 said, Patient 3 was not ready for discharge, meaning that the discharge process was decided by the daughter. RN2 further said that usually the facility will do the referral to the SNF but it was his daughter who was the one looking for a facility for him. During further review of the Social Services Discharge Assessment, it indicated: Evaluating Relocation Needs: Per daughter, family would prefer San Francisco, CA Area if relocation is needed; otherwise it would create distress and hardship for family to provide love and support to resident. The document did not indicate that the discharge process was decided by the daughter.
Review of Patient 3's "LHH Pre-Discharge or Pre-Transfer Physician Progress Note" dated 5/18/22 indicated, "…Discharge Arrangements in Progress: Discharge Services: TBD…". The clinical record did not indicate if Patient 3 was ready for discharge.
Patient 3 had an infected PEG site (Percutaneous Endoscopic Gastrostomy – is used to provide enteral access in patients who are unable to swallow. The most common complication of PEG placement is infection at the site) during his course of stay at the facility. Patient 3 was transferred from the facility to another certified SNF on 6/10/22. At the receiving facility, Patient 3 was sent to the emergency room (ER) on 6/24/22, 7/9/22, and 7/13/22 for G-tube (gastrostomy - tube inserted through the belly that brings nutrition directly to the stomach) blockage. Review of physician's certification for hospice indicated, on 7/6/22, Patient 3 was admitted to hospice, noted to be lethargic, opens his eyes only when his name is called, pale, frail and cachectic (a "wasting" disorder that causes extreme weight loss and muscle wasting, and can include loss of body fat). On 7/15/22, Patient 3 was transferred to the ER for low oxygen level. Patient 3 expired in the hospital on 7/16/22.
In violation of the above cited standards, the facility failed to comply with the facility's established written patient care policies regarding discharge planning, to ensure safe coordination of transfer of Patient 3 to another SNF facility on 6/10/22.
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 3'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

Name Of Evaluator:
Aurora Liganor

Evaluator
Signature:_____

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

Signature:_____

Name:_____

Title:_____

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failures had the potential to result in Patient 3 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:
Aurora Liganor

Evaluator
Signature:_____

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

Signature:_____

Name:_____

Title:_____

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