OUT ON PASS POLICY

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to meet residents' physical and psychosocial needs to go out on pass (OOP). The Facility will make reasonable efforts to ensure ~~the~~ resident safety and uphold resident rights.

2. Residents who wish to leave the grounds of LHH shall have written orders from their attending physician and if appropriate ~~pass~~ medications the resident may take during the OOP..~~.~~

3. Determining if an OOP is appropriate for the resident is the responsibility of unit Resident Care Team (RCT) and may be granted in accordance with the resident's plan of care.

PURPOSE:

To provide residents with the opportunity to participate in family and community life in ways that support well-being and optimal functioning.

PROCEDURE:

1. Notification of Out on Pass Policy

a. LHH Admissions & Eligibility department (A&E) and Social Services shall provide each newly admitted resident/surrogate decision maker (SDM) with information regarding the Out on Pass policy.

2. Request for an Out on Pass and the Pass Order Form

a. A resident and/or Surrogate Decision Maker (SDM) or representative may request a pass from the physician at least 2 business days prior to the planned OOP.

b. A Resident Care Conference (RCC) is needed in order to evaluate the specific parameters for a request. A new RCT evaluation is valid for up to 90 days for a given type of OOP request if all parameters are exactly the same~~, and there have been no changes in condition of the resident since the last RCT.~~ A new RCC is needed if ANY of the parameters is different.

c. An OOP physician order for each request by ~~the physician~~ shall be written in the Electronic Health Record (EHR) for each request. The physician order must include ~~with~~ medications to be taken while on OOP, if appropriate. Physicians cannot write a ~~A~~ standing order for OOP.~~physician order cannot be made by a physician.~~

d. Refer~~To ensure residents will receive sufficient medications for the duration of their OOP, refer~~ to Pharmacy Services policy and procedure 02.01.04 Pass Medications when the pharmacy is open or closed.

e. Nursing staff shall check the number and appearance of the OOP medication(s) and review directions and specific OOP instructions with the resident and/or SDM.

f. The RCT shall advise the resident of consequences of not returning to the facility at~~concerning failure to return by~~ the agreed upon date~~duration of the scheduled return date~~ and time, unless ~~may result in discharge from LHH if~~ an extension is ~~not~~ obtained from the ordering physician. Failure to return at the designated time may result in discharge from LHH~~Physician~~.

g. The Medical Social Worker (MSW) will review and provide the bed hold policy and form to the resident, SDM and/or representative~~, if the OOP shall be overnight~~.

h. The nurse shall note in the EHR that the resident is on OOP, time of departure, instructions given, expected time of return, and actual time of return.

3. Documentation

a. Each request will be evaluated on the resident's current medical, physical, and mental health condition at the time the request is made to the RCT.

b. Each evaluation will take into consideration and document the following:

i. Indication (**i.e.,** "having lunch with mother improves mood")

ii. Destination

iii. Who are they going with

iv. Duration/timing of OOP (typical duration ≤4 hours, exceptions should have documented justification)

v. Benefits of OOP

vi. Risks of leave, including specific notation if risks for:

- Elopement risk
- Challenges with safe decision making
- Depression / safety risk
- Contraband

- Substance use disorder risk
- Prior non-compliance with OOP parameters
- Other (i.e., medical risk, psychiatric risk, etc.)

vii. If benefits outweigh risks, list specific mitigation strategies:

- Accompanied by a person who is responsible
- Family is aware of risks
- Able to demonstrate teach-back with strategies shared
- Family is responsive and collaborative with the RCT

viii. If the risks outweigh the benefit of the OOP, document reason(s) for declining OOP

ix. Medication safety planning during OOP, including plan for education on administration.

- Determine what education will be provided (by whom and to whom)
- Determine when education will be provided
- Determine what medications will be required and ordered for a safe OOP

x. Other caregiver safety education and planning (i.e., car transfers).

xi. Documented counseling of resident/SDM that being out past the scheduled parameters of the leave will result in discharge as Against Medical Advice (AMA).

xii. Notes: A new RCT is valid for up to 90 days for a given type of leave of absence request if all parameters are exactly the same. A new RCT meeting is needed if ANY of the parameters above is different or if a change in condition. (For example, if a resident returned from last OOP with concerning medical condition, behaviors, or contraband.)

4. Resident Education prior to an OOP

a. Nursing staff shall provide education to the resident prior to going on OOP. The education shall include:

i. Review and verification of the RCT note and OOP order.

ii. Medication education on administration, confirmation of medication teach-back, and signature obtained for receipt of medication supply.

- If resident does not demonstrate competency with meds, they are not allowed the OOP privilege unless there's a representative who can be provided education and demonstrate medication administration.
  - The RCT will document the education and return demonstration by the representative.

iii. Provision of written handout or instructions to resident (medication, treatment) prior to OOP. Use the "education" material in EHR.

iv. Instructions on special equipment (i.e., insulin pump, splints, etc.)/ special circumstances.

b. When nursing is concern that the resident condition is not safe for OOP, nursing will initiate the following steps below:

i. Notify on-call physician and document in EHR.

ii. Physician will evaluate immediately and document in the EHR.

iii. Physician will cancel the OOP order if decision is determined to not permit OOP.

iv. Nursing staff ~~shall~~ not to release ~~the~~ resident for ~~an~~ out on pass until the physician evaluation occurs.

5. Census Management

a. The Licensed Nurse/Unit Coordinator shall complete the OOP information in Unit Manager in ~~the~~ EHR under Leave of Absence (LOA). When the patient returns, the Licensed Nurse/Unit Coordinator shall mark the resident back in bed in Unit Manager in EHR.

b. In the event the resident does not return, the Licensed Nurse/Unit Coordinator shall update the LOA to discharge.

6. Compliance/Adherence with Pass Privilege

a. Resident's/SDM's obligation to participate in and comply with the procedure.

i. When leaving OOP and on returning from OOP, residents and/or SDM shall check in and out with the nursing staff on their home unit.

- The License Nurse (LN) shall check-in with the resident within an hour of returning to LHH and document~~. The LN shall complete the *Check-In Form – Resident Returning from an Out On Pass*~~ in the EHR.

- When there is a potential risk and/or reasonable suspicion that a resident possesses contraband, staff shall conduct searches of the resident, a resident's room and personal belongings, as well as property and packages brought by visitors (LHHPP 22-12 Clinical Search Protocol).

- Residents who are going OOP and would like tobacco products shall request products from the pavilion greeter. All unused tobacco products shall be returned to greeter upon return to LHH.

- Tobacco products purchased while OOP shall be surrendered in the lobby and picked up by designated unit staff.

ii. Non-adherence or non-compliance with the pass privilege shall result in a counseling meeting with the resident and/or SDM with the RCT and, if appropriate, development of an interdisciplinary care plan addressing the problem.

- Resident~~Continued~~ non-adherence~~, or~~ non-compliance, leaving ~~or if a resident leaves~~ the facility without an OOP order, or in a manner inconsistent with the specified OOP parameters, shall result in the physician discharging ~~shall discharge~~ the resident ~~as~~ Against Medical Advice (AMA).

iii. Residents who violate~~remain~~ OOP ~~in a manner outside of the specified order~~ parameters and/or residents of sound mind~~who can understand the risks of leaving the hospital grounds and~~ who leave the facility~~hospital~~ grounds without an OOP order, shall be considered an elopement and may be subject to discharge AMA.

b. If a resident has not returned as expected, the nursing staff shall attempt to contact the resident and/or SDM. The LN shall document attempts in the EHR to contact the resident and/or SDM.

7. Extension of an OOP Order

a. Extension/Re-order of an OOP may be granted provided the following conditions are all met:

i. The resident's whereabouts is known.

ii. There was a verbal contact between the resident/SDM and the Nursing Unit Staff or Physician.

iii. The reason for extension is appropriate/valid.

b. The Physician shall document the reason for the extension of the LOA in the EHR.

c. If an extension occurs, the RCT shall meet to evaluate the appropriateness of the extension and document counseling with the resident/SDM about the need to follow LOA order parameters.

8. Nursing Evaluation upon Return from OOP

a. Nursing staff shall complete an evaluation of the resident withing one hour of returning and completion of EHR documentation following the existing standard work (Resident Returning from an Out on Pass).

b. At a minimum, staff to examine for the following:

i) Customary routine

ii) ~~Observation of the resident-are they at their baseline? Are there signs of alcohol or drug impai~~Cognitive patterns ~~Does the resident seem more confused than usual?~~

iii) ~~Is the resident having difficulty with~~ Communication ~~? (Such as slurred speech, somnolence)~~

iv) Vision

~~iv)~~v) Mood and behavior patterns~~Is the resident agitated or withdrawn?~~

vi) Psychological well-being

~~v)~~vii) Physical functioning and structural~~skin~~ problems ~~Is there any bruising, skin issue or new impairment?~~

~~vi)~~viii) Continence~~Did the resident return in a soiled condition?~~

ix) Disease diagnosis and health conditions

~~vii)~~x) Dental and nutritional status ~~Has the resident had an opportunity to eat and drink while away? Do they need a snack before the next scheduled meal plan?~~

~~viii)~~xi) Skin Conditions

~~ix)~~xii) Medications

xiii)Special treatments and procedures

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-07 Against Medical Advice
LHHPP 20-14 Leave of Absence and Bed Hold
LHHPP 22-12 Clinical Search Protocol
Pharmacy Services P&P 02.01.04
Medi-Cal Provider Manual Part 2 Billing and Policy for Long Term Care related to LOA and Bed Hold

Revised: 09/10/27, 14/01/28, 14/03/25, 17/11/14, 23/08/08 (Year/Month/Day)
Original adoption: 99/04/02

LEAVE OF ABSENCE AND BED HOLD

POLICY:

The facility may ~~shall submit claims for resident bed~~ hold a resident's vacant bed during leave of absence and bed hold.~~days based on allowable reimbursement.~~

PURPOSE:

1. To accurately track and monitor residents discharged to acute facilities.
2. To accurately track and monitor residents Out on Pass (OOP).
3. To maintain bed availability for a specific resident.
4. To provide for return of the resident to his/her prior neighborhood wherever possible~~.~~
5. To comply with state and federal regulations~~.~~

DEFINITION:

1. Bed Hold: When resident is transferred from a skilled nursing facility (SNF) to a general acute care hospital, which may be either Laguna Honda Hospital and Rehabilitation Center (LHH) or an outside hospital, the SNF shall afford the resident a bed hold of up to seven (7) days.
2. Out on Pass: A planned absence of a resident from LHH authorized by a physician's order, which may extend past midnight.
3. Leaving Hospital Against Medical Advice (AMA): A resident is discharged AMA when he/she leaves LHH against the advice of the physician.
4. Absent Without Leave (AWOL): A resident who leaves LHH without notification or without an approved LOA.
5. Bed Reservation: A bed reservation is a bed designated for a resident's anticipated admission, transfer, or for a missing resident for whom LHH receives no remuneration. A bed reservation may be cancelled if, due to a bed shortage, that bed is needed for a new admission to LHH.

BACKGROUND:

1. 42 CFR §483.15 – When a skilled nursing facility transfers to an acute care facility, including LHH acute unit, the facility must provide a written notification of the facility's bed hold policy and Notice of Proposed Transfer or Discharge to the resident and

resident's representative. When the resident goes on a therapeutic leave, the facility must provide a notification of the facility's bed hold policy.

2. A resident who is receiving Medicare Part A Skilled Nursing Facility (SNF) benefits is permitted to a Leave of Absence (LOA) as necessary; however, Medicare will not provide reimbursement to the facility for that day of leave if the resident does not return to the facility by midnight.

3. If the LOA is an overnight visit (or longer) to the home of relatives or friends, LOA reimbursement by Medi-Cal is restricted as follows:

    a. Maximum time period of 18 days per calendar year for non-developmentally disabled recipients; Up to 12 additional days of leave per year may be approved in increments of no more than two (2) consecutive days when the following conditions are met:

        i. The request for additional days of leave shall be in accordance with the individual resident care plan and appropriate to the physical and mental well-being of the patient.

        ii. At least five days of SNF inpatient care must be provided between each approved overnight LOA.

        iii. Maximum of 73 days per calendar year of developmentally disabled recipients.

        iv. At the time of admission, if resident has not been an inpatient of any SNF facility for the previous 2 months or longer, the resident is eligible for the full complement of leave days (18 days per calendar year).

        v. A resident's return from overnight LOA may not be followed by a discharge within 24 hours.

4. For LOA due to acute care hospitalization:

    a. The LHH Patient Flow Coordinator shall coordinate both the LOA and bed reservation procedures in conjunction with Admissions and Eligibility (A&E) department and the neighborhood physician representing the neighborhood RCT.

        i. According to Medi-Cal rules, a bed reservation is a bed designated for a resident's anticipated admission, transfer, or for a missing resident for whom LHH receives no remuneration. A bed reservation may be cancelled if, due to a bed shortage, that bed is needed for a new admission to LHH.

    b. Medi-Cal and some insurances pay for up to seven days of LOA due to acute hospitalization. LOAs greater than seven days requires the resident to be discharged from the SNF. The physician will write a discharge order on the

Electronica Health Record (EHR) to discharge the resident to an acute facility. Further clarification regarding insurance coverage shall be routed to Utilization Management.

~~c.~~ Every effort is made for a~~A~~ resident whose hospitalization exceeds the LOA period to be~~is~~ re-admitted to ~~the facility to~~ their previous room. If the room is not ~~if~~ available, ~~or immediately upon~~ the first ~~availability of a bed in a~~ semi-private room will be offered as long as the skilled nursing ~~if the resident requires the~~ services required~~provided~~ by the resident meets the eligibility~~facility and is eligible~~ for Medi-Cal and ~~nursing facility services or~~ Medicare. ~~skilled nursing facility services.~~

~~d.~~c. The facility shall submit claims for resident LOA days based on allowable reimbursement.

PROCEDURE:

1. Notification of LOA Policy

a. Upon admission, A&E provides the resident, family member, or legal representative with the California Standard Admission Agreement which includes written information regarding LOA-acute hospitalization.

b. Nursing shall provide the bed hold information and Notice of Proposed Transfer at the time of transfer, or within 24 hours of transfer in cases of emergency transfer. Should the written information change, LHH shall reissue the new information to the resident, their family member, or legal representative.

c. The Medical Social Worker (MSW) shall provide the bed hold information to the resident, their family member, or legal representative prior to the scheduled LOA (day/overnight/weekend).

2. Process for LOA/Bed Hold

a. An order from the Physician for a LOA for day/overnight/weekend and for sending out to another facility (ED/PES/Acute Care) shall be written in the electronic health record (EHR) for each occurrence. The LOA order will have a specific date and duration. The Physician and the Licensed Nurse shall follow the process as specified in the EHR.

b. For LOAs to an acute level of care ~~or out on pass~~, the Notice of Bed Hold Policy and form shall be provided to the resident and/or representative. For an LOA to a clinic/medical appointment, the Notice of Bed Hold and form is not required.

c. LOA-admitted to Acute Care Hospital from ED/PES

i. The Physician shall write a discharge summary note and enter a discharge order with the appropriate disposition code.

d. The Licensed Nurse shall provide the Bed Hold form and policy, and the Notice of Proposed Transfer form to the resident, family member or legal representative prior to transferring the resident. If the family member or legal representative is not physically present in the facility, a telephone call will be made to review the bed hold policy and Notice of Proposed Transfer/Discharge. The Licensed Nurse will indicate the telephone call to the representative on the forms. The original form will be provided to the representative, copy with the resident, and copy to Health Information Management (HIM). Nursing Operations Manager~~Nursing Operation~~ will ensure that the notices are provided to the resident, family member or legal representative.

3. Census Management

a. Nursing Department is responsible for census management which is done in the electronic health record (EHR).

4. Bed Hold

a. Requirements for bed hold for acute hospitalization:

i. A physician's order to transfer the resident to an acute care hospital.

ii. The day of departure from SNF is counted as day 1 of bed hold; the day of return is not counted.

iii. LHH shall hold the bed up to seven (7) days during hospitalization.

iv. Bed hold must terminate on the resident's date of death.

v. LHH claims must identify the inclusive date of the bed hold.

b. LHH residents discharged to an acute care at another hospital (other than Zuckerberg San Francisco General (ZSFG),~~,~~ LHH ~~PM~~ Acute Medical):

i. The licensed nurse on the neighborhood shall call the acute care hospital after the seventh day of LOA to ensure that resident was not discharged from acute care hospital before the seventh day to reflect accurate bed hold days.

c. The resident who is returning from LOA due to an acute hospitalization within the 7 days or after 7 days of holding the bed shall be readmitted.

5. Requirements for LOA (Out on Pass – Therapeutic Leave)

a. A bed shall be held during a resident's authorized LOA/OOP for day, weekend, or overnight.

b. A current physician's order for LOA/OOP is required.

i.

~~c. LHH will not be reimbursed for bed hold in the event a resident is discharged within 24 hours of return from LOA/OOP.~~

~~i. LHH will not receive reimbursement for any LOA days exceeding the maximum number of leave days per calendar year.~~

~~d. Medicare does not provide for bed hold reimbursement.~~

6. Status of Residents Without an Approved LOA

a. Against Medical Advice (AMA)

i. A resident who leaves LHH against medical advice is considered AMA and shall be discharged.
ii. If possible, resident shall be asked to sign the AMA form where indicated.

iii. Physician writes AMA discharge order.

iv. LHH will not hold the resident's bed.

b. AWOL Elopements

i. A resident who leaves without notification or without an approved order is considered AWOL.

ii. A resident who goes AWOL past midnight shall result in a discharge from the facility. LHH is not permitted to place a bed hold for a resident who is not on an approved leave of absence or out on pass order.

iii. Physician writes discharge order: Discharged – AWOL.

iv. The nurse shall complete an Unusual Occurrence report.

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-06 Out on Pass
LHHPP 20-07 Against Medical Advice
Medi-Cal Provider Manual Part 2 Billing and Policy for Long Term Care related to LOA and Bed Hold
State Operations Manual related to Notice of bed-hold and return and Permitting residents to return to facility.

Revised: 09/07/17, 09/10/27; 14/01/28, 14/03/25, 17/11/14, 19/05/14, 23/08/08 (Year/Month/Day)
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Previously numbered LHHPP 20-02.

RESIDENT CARE PLAN (RCP), RESIDENT CARE TEAM (RCT) & RESIDENT CARE CONFERENCE (RCC)

POLICY:

1. An interdisciplinary Resident Care Team (RCT), in conjunction with the resident, resident's family, or surrogate decision-maker shall develop a Baseline Plan of Care within 48 hours of the resident's admission. It shall include instructions needed to provide effective and person-centered care of the resident, and shall at a minimum include: initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and if applicable, PASRR recommendation(s).

2. The RCT, in conjunction with the resident or representative, shall develop a comprehensive care plan, based on the care team disciplines' assessments, that includes measurable objectives and a timeframes to meet the resident's medical, nursing, and psychosocial needs, if appropriate.

3. The Resident Care Plan (RCP) shall be person-centered, evaluated during weekly or monthly summaries, when indicated for short term problems, every quarter during quarterly assessments, and revised as needed during change of condition to serve as an essential resource for improved resident outcomes. Nursing will document these summaries on the Electronic Health Record (EHR).

4. The resident, family and/or representative shall be part of the development and implementation of his or her person-centered plan of care.

5. Care problems require various professional disciplines working together in planning, implementing, and evaluating goals and interventions.

6. A Resident Care Conference (RCC) shall be conducted with the scheduled completion of an admission, quarterly, annually and/or with a significant change in condition.

7. Special Review (SR) RCC's shall be held when the review of specific care issues is clinically indicated.

8. Stable, ongoing resident needs, and resident preferences are addressed on the Baseline Care Plan in the electronic health record (EHR). Unstable, alterable problems that require a more goal directed approach are addressed on the RCP in the EHR. Together they comprise the resident's care plan.

9. Care Area Assessment (CAA) that are triggered during completion of the comprehensive MDS requires evaluation and discussion from the resident and/or representative, and RCT to develop a comprehensive care plan for the triggered care areas.

PURPOSE:

It is the policy of LHH to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessments. To promote the resident's highest possible physical, mental and psychosocial well-being.

DEFINITION:

Resident's goal: The resident's desired outcomes and preferences for admission, which guide decision making during care planning.

Interventions: Actions, treatments, procedures, or activities designed to meet an objective.

Measurable: The ability to be evaluated or quantified.

Objective: A statement describing the results to be achieved to meet the resident's goals.

Person-centered care: 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.

"Culture" is the conceptual system that structures the way people view the world – it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

"Cultural Competency" is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

"Trauma-informed care" is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.

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 Managers (or designee)

ii. Licensed Nurse

iii. Nursing Assistant

iv. Attending Physician

v. Medical Social Worker

vi. MDS Coordinator

vii. Activity Therapist

viii. Registered Dietitian

b. The resident, family and/or representative shall be part of the development and implementation of his or her person-centered plan of care, including but not limited to:

i. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

ii. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

iii. The right to be informed, in advance, of changes to the plan of care.

iv. The right to receive the services and/or items included in the plan of care.

v. The right to see the care plan.

c. In the event a special review meeting is necessary, the following disciplines must be present: nurse, physician, MDS coordinator, and social worker. The remaining RCT members shall be notified of any care plan changes, including the resident and/or representative.

d. Consultative Members may be part of the RCT if actively involved in the care of the resident and may include as appropriate:

- Chaplaincy
- Clinical Nurse Specialist
- LHH Psychiatry providers (Psychiatrist/Psychologist/Behavioral Health Clinician/mental health or substance treatment counselor)
- Occupational Therapist
- Quality Management
- Pharmacy
- Rehabilitation Services
- Dietary Technicians
- Peer Mentors
- Ombudsmen
- Any other consultants as needed~~.~~

e. The RCT shall address resident care needs and preferences through assessment of the resident and the development and implementation of the RCP.

f. The RCT shall incorporate the resident's personal and cultural preferences in developing goals of care, and address the resident's care needs through assessments such as:

i. Minimum Data Set (See LHHPP 23-02 Completion of Resident Assessment Instrument/Minimum Data Set)

ii. Admission assessments including but not limited to:

- Physician History and Physical
- Resident Social History Assessment
- Nutrition Screening and Assessment

- Admission Nursing Assessment
- Comprehensive Pain Assessment
- Behavioral Risk Assessment
- Discharge Assessment
- Pressure Ulcer Risk Assessment
- Activity Therapy Assessment
- RCT Pre and Post Elopement Event (Cross Reference LHHPP 24-22 Code Green Protocol)
- Bed Rail Order (if appropriate)
- Smoking Assessment and Plan of Care
- Social Services Psychosocial Assessment

2. Resident Care Conferences

a. The RCC shall serve as the forum for interdisciplinary development and review of the care plan. Care plan review shall be done:
   i. On a quarterly schedule with the MDS
   ii. With discharge planning
   iii. Within 14 – 21 days of a permanent relocation to another unit in LHH
   iv. Special Review(s)
      - Comprehensive MDS with CAA
      - Within seven days of new admission
      - Annually
      - Significant change in resident condition
      - Temporary relocations, I.e. Covid unit

b. RCT members shall conduct their assessments and prepare for prior to the RCC. This will allow for efficient reporting from each discipline and provide a forum for major care problems to be discussed by the team with the resident.

c. The RCT shall facilitate the inclusion of the resident and/or representative. The resident and/or representative shall be informed of the meeting, date and time. The resident shall be invited and encouraged to attend the RCC, unless contraindicated by the resident's condition. If the resident is unable to attend, a representative is required to attend on behalf of the resident.

   i. The social worker shall contact the representative about the meeting date and time in advance to ensure attendance. The RCC will be rescheduled based on the representative's availability. If the representative is unable to attend in person, attendance can occur via telephone or video call.

   ii. The resident or representative shall have the opportunity to express concerns and preferences during the RCC.

   iii. The social worker has an option to request for a public patient representative through the California Patient Representative Information System (CAPRIS) when there is no representative.

d. The nursing assistant and assigned licensed nurse shall be present, or provide information if unable to attend, at the RCC and consultants shall be invited as appropriate.

e. The Team Conference Note in the EHR shall be completed for each RCC.

3. Baseline Care Plan

a. Shall be initiated by nursing within eight hours on the day of admission.

b. Shall be completed and implemented within 48 hours of a resident's admission.

c. The baseline care plan shall address the resident's immediate needs for safety, management of risks, and medical attention, including but not limited to the minimum healthcare information necessary to properly care for the resident as outlined in policy statement #1.

d. The baseline care plan shall reflect the resident's stated goals and objectives, and include interventions that address his or her current needs.

   i. It shall be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable.

ii. The baseline care plan documents the interim approaches for meeting the resident's immediate needs, professional standards of quality care shall dictate that it shall also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs, occurring prior to development of the comprehensive care plan.

iii. LHH staff shall implement the interventions to assist the resident to achieve care plan goals and objectives.

e. Is reviewed with the resident and/or representative, in their preferred language, no later than seven days after admission.

f. LHH shall provide the resident and/or resident representative with a written summary of the baseline care plan by completion of the comprehensive care plan. The summary shall include:

i. Initial goals for the resident;

ii. A list of current medication and dietary instructions; and

iii. Services and treatments that shall be administered by LHH.

g. Problems identified by the Resident Assessment Instrument (RAI), shall be care planned within seven days of the completion of the comprehensive assessment.

4. Comprehensive Care Plan

a. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally-competent and trauma-informed.

b. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale ~~for deciding whether~~ to proceed with care planning will be evidenced in the clinical record. For clinical problems, care planning will be initiated with individualized interventions based on short-term or long-term goals.

c. 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 the CAA.

i. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

ii. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment.

iii. Identify concerns in the CAA that may warrant interventions.

iv. Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well- being in the context of the resident's condition, choices, and preferences for interventions.

v. Address other important considerations, such as advance care planning and palliative care.

vi. Describe any specialized services or specialized rehabilitative services t LHH shall provide as a result of the PASRR recommendations.

vii. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate.

viii. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.

ix. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.

d. In consultation with the resident and/or representative, the comprehensive care plan shall describe:

i. The resident's goals for admission and desired outcomes.

ii. The resident's preference and potential for future discharge. LHH 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.

e. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to:

i. The attending physician or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan.

ii. A registered nurse with responsibility for the resident.

iii. A nurse aide with responsibility for the resident.

iv. A member of the food and nutrition services staff.

v. The resident and the resident's representative, to the extent practicable.

vi. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to:

- The RAI Coordinator.
- Activities Director/Staff.
- Social Services Director/Social Worker.
- Licensed therapists.
- Family members, surrogate, or others desired by the resident.
- Administration.
- Discharge Coordinator.
- Mental health professional.
- Chaplain.

f. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

g. The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative.

h. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

5. Identifying and Writing the Problem Statement

a. Problems, needs, strengths, and preferences are identified by members of the RCT and the resident as a result of careful, comprehensive, and ongoing assessments.

b. Problem statements are resident focused and not staff focused.

c. The statement may, but does not require the reason for the problem, (i.e. what the problem is related to "R/T").

d. The statement may include some, but not all, of the common observable signs and be described as "As Evidenced by (AEB)".

6. Determining the Goal Statement

a. The goal statement indicates the outcome desired by the resident or representative and aims at promoting or maintaining the resident's highest practicable physical, mental, and psycho-social well-being.

b. Goals must be realistic, specific, reflect the problem, measurable, and have a target date.

7. Developing Interventions

a. Interventions can address how to minimize the risk of problem(s), address resident's preferences, and meet the resident's goals.

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 the resident's present status and is documented in the summary notes.

b. The progress of the goal is based on the following:

i. If there is evidence or progress towards the outcome desired by the resident or representative.

ii. If the evaluation indicates that the goal is not being met, the RCT shall determine the cause for the lack of progress and make the necessary changes.

c. Consideration by the RCT should include:

i. Identification of the problem. Is it an accurate reflection of resident's present status?

ii. Measurable and realistic goals.

iii. Appropriate interventions for each goal.

iv. Additional information as appropriate.

d. The evaluation of the effectiveness of the care plan is documented in the EHR under:

i. The Team Conference note

ii. The Nursing Weekly Summary

iii. Discipline specific progress notes \

9. Behavioral Plans are a part of the Resident's Plan of Care and documented in the EHR

a. These plans are developed by the interdisciplinary RCT members. Plan development may require specialized behavioral planning meetings. Planning discussion is documented by a summary special review meeting note.

b. These plans are drafted by team members, most often the Nursing, in consultation with a LHH Psychiatry provider, and/or consultation with other key team members on different shifts.

c. The RCT is to discuss behavioral plans with the resident and/or the resident's surrogate decision-maker when appropriate.

d. Behavioral Plans are revised as needed and discontinued when the target behavior no longer poses a problem.

e. Behaviors identified for modification shall be clearly described, noted and tracked in the Behavior Monitoring Record (BMR).

10. Communication

a. The MDS Coordinator shall identify the scheduled RCC meeting based on the MDS assessments.

b. Nursing (i.e., MDS Coordinator, Nurse Manager or Charge Nurse) shall coordinate all Special Review RCC meeting dates and times.

c. The RCT shall communicate with one another in a timely manner using the EHR, email, and text paging, as needed.

d. The BMR shall be used by nursing to document resident behaviors and reviewed by the RCT to evaluate the resident's response to the behavioral plan.

e. Changes that affect the resident's care or daily routine shall be communicated to the resident or representative as soon as possible in the method that is most practical for the resident or representative and shall be repeated as needed or provided in writing.

ATTACHMENT:
None.

REFERENCE:
LHHPP 23-02 Completion of Resident Assessment Instrument/Minimum Data Set (RAI/MDS)
LHHPP 24-22 Code Green Protocol
MSPP D08-10 Behavioral Management Services by LHH Psychiatry
Long Term Care Survey, June 2006 Edition
42 Code of Federal Regulation (CFR) 483.21(a)(1)-(3) Comprehensive Person-Centered Care Planning, Baseline Care Plans
42 Code of Federal Regulation (CFR) 483.10(c)(2)-(3) Resident Rights – Planning and Implementing Care
Comprehensive User Manual Version 3.0 Resident Assessment Instrument. Chapter 4. CAA Process and Care Planning.

Revised: 01/10/20, 09/10/27, 10/05/25, 16/11/08, 19/03/12, 19/05/14, 19/07/09, 23/08/08 (Year/Month/Day)
Original adoption: 92/05/20

Restraint Free Environment

POLICY:

1. It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints.

2. LHH supports preventing, reducing, and eliminating the use of restraints and restraint-associated risk through preventive strategies, alternatives, and process improvements.

3. The restraint consent form shall be updated annually, if there is a change in condition of the resident or change in the device being used.

4. **Physical restraints as an intervention** do not treat the underlying causes of medical symptoms. Therefore, as with other interventions, physical restraints should not be used without also seeking to identify and address the physical or psychological condition causing the medical symptom.

5. Thorough evaluation shall be completed to identify a clear link between physical restraint use and how it benefits the resident by addressing the specific medical symptom. There shall be a physician order reflecting the use and specific medical system being treated.

    a. The medical record shall reflect the medical symptoms that support the use of the restraint, as well as ongoing assessments, and resident centered care plans.

PURPOSE:

To assure resident freedom from physical restraints, and if necessary to utilize the least restrictive device only for the least amount of time when other less restrictive devices have been ineffective to provide safety.

DEFINITIONS:

1. Physical restraint: Any manual method, physical or mechanical device, material, or equipment attached or adjacent to the resident's body that he or she cannot easily remove which restricts freedom of movement or normal access to one's body.

    a. Freedom of movement: any change in place or position for the body or any part of the body that the person is physically able to control or access.

2. Bed rail(s) are considered restraints when:

a. The bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently.

3. Chemical restraints are defined as any drug that is used for discipline or convenience and not required to treat medical symptoms~~.~~

4. Position Change Alarms: alerting devices intended to monitor a resident's movement. The devices emit an audible signal when the resident moves in ~~criteria~~ certain ways.

   a. Alarms are considered restraints when the resident is afraid to move to avoid setting off the alarm.

5. Trunk restraints: include any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident cannot easily remove such as, but not limited to, vest or waist restraints or belts used in a wheelchair that either restricts freedom of movement or access to his or her body.

6. Limb restraints include any manual method or physical or mechanical device, material~~,~~ or equipment that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm, wrist) or lower extremity (i.e., foot, leg) that either restricts freedom of movement or access to his or her own body. Hand mitts/mittens are included in this category~~.~~

7. Convenience: as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care and is not in the resident's best interest.

8. Discipline: any action taken by the facility for the purpose of punishing or penalizing residents.

9. Manual Method: to hold or limit a resident's voluntary movement by using body contact as a method of physical restraint~~.~~

10. Medical symptom: is defined as an indication or characteristic of a physical or psychological condition.

Compliance Guidelines

1. The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms.

2. Assessments shall be conducted by following the below steps:

    a. Determine the resident's cognitive and physical status/limitations.

    b. Considering the physical restraint definition and incorporating the definitions listed above, observe the resident to determine the effect the restraint has on the resident's normal function.

    c. Evaluate whether the resident can easily and voluntarily remove the device, material, or equipment. If the resident cannot easily and voluntarily remove the restraint, continue with the assessment to determine whether the device restricts freedom of movement or the resident's access to his or her own body.

3. The resident/resident's representative may request the use of a physical restraint; however, the facility is responsible for evaluating the appropriateness of the request. The facility shall explain to the resident/resident's representative, the potential risks, and benefits of using a restraint, not using a restraint, and alternatives to restraint use. Potential negative outcomes should also be explained including, but not limited to:
    a. Decline in physical functioning

    b. Decreased muscle condition

    c. Contractures

    d. Increased risk for infection

    e. Pressure ulcers/injuries

    f. Delirium

    g. Agitation

    h. Incontinence

    i. Accidents such as falls, strangulation, or entrapment

    j. Loss of autonomy and dignity

    k. Withdrawal or reduced social contact

PROCEDURE:

1. **Procedure for Using Restraints Determined as Medically Necessary:**

a. Before applying a new restraint:

i. Consult with the Resident Care Team (RCT), consisting of at least the physician and nurse to discuss and document:

- RTC will discuss:
  - Circumstances leading to the use of restraints and what alternative interventions were tried first ~~.~~
    - Alternative interventions may include, but are not limited to: diversionary activities, 1:1 resident care, repositioning, pain management, reorientation to surroundings, or administration of prescribed medications
  - The degree of effectiveness of the less-restrictive alternatives and how it was decided what type of restraint to use.

b. When a decision is made to order a new physical restraint:

i. The ordering provider is accountable for evaluating the need for restraints and completing the restraint order. Orders are to be completed via EHR.

ii. The ordering provider will obtain consent for physical restraint. Consents must include discussion with the resident or resident representative regarding:

- Educate family/resident representative on risk of removing, repositioning, or retying restraint.
- Type of restraint and duration of use.
- Possible benefits and risks of using, or not using, restraints.
- Rights of resident or resident representative to accept or refuse the use of restraints at any time.

c. Obtaining a Restraint Consent is a team effort which starts with the RCT determining the need for the restraint and discussing with resident/resident decision maker to discuss potential risks and benefits. Physicians will document the medical need for the restraint and sign the form, and either the physician or other members of the RCT can complete the remainder of the form, including obtaining resident/resident representative signatures.

i. Nursing will update the resident's care plan after RCT discussion:

- The type of restraint and whether the restraint used is the least restrictive device.
- The reason for the restraint (medical symptom) and restraint use duration
- Document ongoing efforts to evaluate/eliminate use of the restraint.
- Interventions (restorative) to address potential functional decline.
- Interventions to remain free from injury while restrained, release and document every 4 hours or sooner according to the resident need.
- A plan for reduction or eventual discontinuation of the restraint.

ii. The RCT will meet in a timely manner to discuss alternatives and plan for tapering and discontinuation of restraints.

d. For continued restraint use:

i. Ongoing use of restraints shall be discussed with the RCT quarterly, or during "Special Review" which can be conducted at any time.

ii. Discussion shall include:

- Resident's response to restraint being used.
- Possible alternatives other than current restraint to be used.
- Referrals to ancillary departments, as appropriate.
- Continuation of restraint use must be renewed via EHR.

DOCUMENTATION

1. Staff will provide ongoing monitoring and evaluation for the continued use of a physical restraint, release and document every 4 hours or sooner according to resident need.

a. Assessments are to be documented by RNs via EHR and shall include, but are not limited to:

i. Any changes to circulation (including vascular checks such as capillary refill, temperature, edema, and color of skin), Skin integrity of the

restrained extremity(ies) if used.

ii. Signs of injury associated with a restraint~~.~~

b. Clinical justification and resident response that warrants the use of the restraint are to be reflected in the weekly nursing summary by the Licensed Nurse.

c. Monitoring and supervision are to be documented via EHR on the following: See Standard work for procedures in regards~~regard~~ to restraint documentation.

d. Monitoring will include:

i. Proper placement of restraint as ordered~~.~~

ii. Release of restraint for:

iii. ROM to the restrained extremity(ies) while awake if used ~~.~~

iv. Turning and repositioning

v. Hydration/meals

vi. Hygiene/elimination

(Note: a temporary release that occurs for the purpose of caring for a resident's needs, i.e., toileting, feeding, repositioning and ROM, is not considered a discontinuation of the restraint.)

2. Staff Training

a. Nursing Staff who have direct patient contact shall receive new employee orientation training and subsequent annual education and training in the proper and safe use of restraints, including, but not limited to the following:

i. Methods to reduce and eliminate restraint use;

ii. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger physical restraint use;

iii. Use of non-physical intervention skills;

iv. Choosing the least-restrictive intervention based on individualized assessment.

v. Safe application of physical restraints;

vi. Clinical identification of behavioral changes that indicate that restraint is no longer necessary; and

vii. Monitoring physical and emotional well-being of patients (e.g., respiratory and circulatory status, skin integrity, vital signs, etc.).

ATTACHMENT:
None

REFERENCE:
LHHPP 22-13 Bed Rail Use
LHHPP 24-13 Falls
State Operations Manual Appendix PP - Survey Protocol, Regulations~~,~~ and Interpretive Guidelines for Long Term Care (Rev. 173, 11-222017)

Revised: 97/04/15, 00/01/27, 02/09/06, 08/08/08, 09/01/13, 09/08/21, 10/09/24, 10/11/10, 16/01/12, 17/09/12, 19/03/12, 20/01/14, 21/10/12, 22/08/31, 22/12/13, 23/05/09, 23/08/08 (Year/Month/Day)
Original adoption: 96/07/15

SCREENING AND RESPONSE TO SUICIDAL IDEATION

POLICY:

1. The policy of Laguna Honda Hospital and Rehabilitation Center (LHH) is to provide evidence-based assessment and interventions to equip staff in the evaluation of a resident's expression of suicidal ideation. A resident may communicate passive or active suicidal ideation.

2. LHH staff shall be trained for signs of resident's expression of suicidal ideation and how to respond accordingly.

3. LHH has adopted one evidence-based tool, the Columbia Suicidal Severity Rating Scale (C-SSRS), which is used when a resident is heard or observed to verbalize any passive or active suicidal ideation, or to indicate any gesture of suicidal behavior.

4. LHH shall identify residents at risk for suicide by:

    a. Conducting a suicide risk screen using a validated stratified risk screen tool.

    b. Notify the provider for any resident or patient who screens at risk.

    c. Implementing individualized interventions to mitigate the resident or patient's risk of suicidality while considering immediate safety needs.

PURPOSE:

To ensure that each resident or patient who expresses suicidal ideation receive the necessary behavioral health care and services to attain or maintain the highest practicable level of mental, physical and emotional health.

DEFINITION:

Active suicidal ideation: An individual no longer has the motivation to live and has a plan to end their life. Active suicidal ideations sound like "It would be so easy to end my life by ___."

"Close Observation": Refer to LHHPP 24-10 Coach Use for Close Observation

Passive suicidal ideation: An individual no longer has the motivation to live but does not have a plan to take their life. Passive suicidal thoughts sound like "I just wish I could go to sleep and not wake up," or "I wish I could just wander into a fog and just disappear," or "I wish that the world just ended tomorrow."

PROCEDURE:

1. If the resident or patient expresses active or passive suicidal ideation, LHH shall initiate an evidenced-based assessment and interventions based on the level of suicide risk.

2. During the Admission, Quarterly, Annual, and Significant Change of Condition Minimum Data Set (MDS) Assessment, if Section D (Mood) is triggered (score of 7 or higher and/or Section D0200-I or D0500-I), the MDS Coordinator shall immediately relay the information to the Physician, Social Worker and Licensed Nurse for evaluation.

3. When a resident or patient is relocated to another unit, the MDS Coordinator shall assess resident's mood using the MDS Assessment under section D0200 and/or D-0500 (PHQ-9) within 2 weeks from the time of relocation. If a score of 7 or higher or a YES answer to either Section D0200-I or D0500-I, the MDS Coordinator shall immediately relay the information to the Physician, Social Worker and Licensed Nurse for evaluation.

4. A trained Licensed Nurse or Social Worker shall conduct the C-SSRS screen.

5. Residents or patients with triggered at risk of self-harm and/or history of suicidal ideation shall have a target behavior monitoring order.

6. Based on the C-SSRS screening results, individualized suicidality management interventions are implemented. Resident/Patient specific interventions are listed below.

   a. LOW RISK **(per C-SSRS screening)**

      i. Create a safe environment.

         - Staff shall assess the environment for potentially dangerous items for self-harm.

         - Consider aeroscout.

      ii. The Licensed Nurse shall inform the provider of the resident's C-SSRS score by call or page (numeric page).

      iii. Immediately notify the provider for evaluation by call or page (numeric page). Attending physician or on-call physician evaluates and determines the appropriate next step as described in section 8.

      iv. Consider other resources such as Behavioral Emergency Response Team (BERT) ~~and Psychiatry consultation~~.

v. Notify the Nursing Operations Supervisor.

b. MEDIUM AND HIGH RISK (per C-SSRS screening)

i. Create a safe environment.

- Staff shall assess the environment for potential dangerous items for self-harm.
- Provide one to one observation until the resident or patient is evaluated by the Attending physician or on-call physician and/or transferred out to a Psychiatric or Acute Emergency for further psychiatric and/or medical evaluation.
- Maintain visual contact at all times, including bathroom use.

ii. Immediately notify the physician for evaluation by call or page (numeric page). Attending physician or on-call physician evaluates and determines the appropriate next step as described in section 8.

~~iii. Ask the provider to immediately contact LHH Psychiatry for urgent discussion. The provider will call/page LHH Psychiatry.~~

~~iv.~~iii. Consider other resources such as the Behavioral Emergency Response Team (BERT).

~~v.~~iv. Immediately notify the Nursing Operations Supervisor.

~~vi.~~v. Notify the resident/patient's representative, if appropriate.

7. IF THE RESDIENT/PATIENT DECLINES C-SSRS SCREENING

a. Create a safe environment:

i. Staff will assess the environment for potential dangerous items for self-harm.

ii. Consider aeroscout.

b. The Licensed Nurse will inform the provider why the screening was indicated and that the resident declined C-SSRS screening.

c. Attending physician or on-call physician evaluates and determines the appropriate next step as described in section 8.

8. ATTENDING PHYSICIAN OR ON CALL PHYSYICIAN EVALUATION

a. The physician shall determine the clinical level of suicide risk based on medical evaluation and determine if there is a need for change in current management, including urgency of psychiatric consultation.

   i. The attending physician or on-call physician will evaluate the reasons for the screening and the results of the screening.

   ii. The attending physician or on-call physician will evaluate the resident and determine whether suicidal ideation is currently present or at risk for recurring imminently. This evaluation shall include a review of existing recommendations from PCP and psychiatry; assess the resident for the effectiveness of those interventions; and determine what updates to those interventions that may be needed.

   iii. The attending physician or on-call physician will call for urgent LHH Psychiatry Consult if deemed necessary based on risk assessment (e.g., new suicidal ideation, self-harm behavior, etc.).

   - If the resident or patient is placed on 5150, the resident/patient will be sent to a n Acute or Psychiatric Emergency facility (directly or via an Acute medical facility).

   - If the resident or patient does not meet 5150 criteria for danger to self but the physician identifies that LHHthe facility cannot safely manage the resident or patient with behavioral intervention implemented, the physician can initiate a transfer to an Acute medical facility.

     - If the clinical team identifies that LHHthe facility can manage the patient with appropriate behavioral interventions, the resident or patient shall not be transferred from LHHthe facility.

9. INDIVIDUALIZED CARE PLAN REVIEW AND IMPLEMENTATION TO ADDRESS TRIGGERS AND ENHANCE COPING SKILLS

For residents deemed to be appropriate for the level of care provide by the facility:

a. The physicians assessing the resident will within the shift review with the Licensed Nurse the existing care plan and orders to confirm documentation and implementation of any previous or newly recommended interventions, with Psychiatry input (if consult was called).

b. The physician and nurse will hand off to the next daytime shift to inform the Resident Care Team (RCT) members of the results of both the screening and evaluation results, and the recommendations. Notify LHH Psychiatry and BERT

via routine referral process.

c. The RCT will conduct a Resident Care Conference (RCC) as indicated, to discuss the resident or patient's suicidal ideation (SI) risk and update the mitigation plan that includes the psychiatry recommendations if any.

   i. Include the resident/patient's representative, when appropriate.

   ii. Other resources, such as LHH Psychiatry, Chaplain, BERT, etc. will be invited to participate in the RCC.

d. The RCT will develop a comprehensive care plan to address safety related to suicidal ideation risk.

10. IF PSYCHIATRIC EMERGENCY SERVICE CALLS THE UNIT ABOUT RESIDENT/PATIENT RETURNING TO LHH~~FOR RETURN CRITERIA~~, REFER TO PHYSICIAN, WHO DECIDES IN COLLABORATION WITH PSYCHIATRY.

a. The psychiatry clinician or on-call psychiatrist will discuss with Psychiatric Emergency psychiatrist, and determine if the resident can be cleared psychiatrically for returning to LHH and any recommendations for clinical management.

b. The psychiatry clinician or on-call psychiatrist will communicate the recommendations (clearance and management) to the attending physician or on-call physician and the Psychiatry team.

c. The attending physician or on-call physician will determine if the resident may return, and if so, will provide the order. ~~(~~The physician would only accept the resident for return after the clearance by the psychiatry clinician or on-call psychiatrist, and if not excluded by criteria in Policy 20-01 (Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units), Admissibility and Screening Procedures 1(c).~~)~~

11. IF RESIDENT IS CLEARED TO RETURN TO LHH

a. Maintain a safe environment;

   i. Staff shall assess the environment for potential dangerous items for self-harm.

      - Refer to the Patient Safety and Ligature Identification Checklist.

   ii. Consider aeroscout.

b. Ensure section 9 is completed.

c. Notify the Nursing Operations Supervisor.

d. Inform the RCT members.

e. The RCT shall conduct a Resident Care Conference to discuss the resident or patient's SI risk and identify a mitigation plan that includes the psychiatry recommendations if any.

   i. Include the resident/patient's representative, when appropriate.

   ii. Other resources, such as LHH Psychiatry, Chaplain, BERT, etc. shall be included in the RCC.

f. The RCT shall developed a comprehensive care plan to address safety related to suicidal ideation risk.

12. PSYCHIATRY PROVIDER UPDATES

~~12.~~ The psychiatry provider will alert the RCT should they have significant clinical information or recommendations.

13. DOCUMENTATION REQUIREMENTS

a. C-SSRS Screen shall be charted in the electronic health record.

b. Document the resident/patient's behavior(s) in the electronic health record.

c. The resident/patient's care plan shall be updated to reflect the resident/patient goal to remain free from self-harm.

ATTACHMENT:
A. Columbia-Suicide Severity Rating Scale
B. Patient Safety and Ligature Identification Checklist

REFERENCE:
Harmer B, Lee S, Duong TvH, et al. Suicidal Ideation. [Updated 2023 Feb 7]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://cssrs.columbia.edu/training/training-options/

LHHPP 22-09 Psychiatric Emergencies
LHHPP 22-12 Clinical/Safety Search Protocol
LHHPP 24-10 Coach Use for Close Observation
LHHPP 24-23 Behavioral Health Service Care and Services
NPP C04.0 Notification and Documentation of Change in Resident Status
MSPP D08-03 Access to LHH Psychiatry Services

Original adoption: xx/xx/xx (Year/Month/Day)

SPILL RESPONSE PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (~~Laguna Honda~~LHH) is committed to employee and resident safety, and in an effort to prevent injury and illness, will mitigate hazards associated with spills.

PURPOSE:

The Spill Response Plan has been established to ensure that spills of both hazardous and non-hazardous materials are cleaned up appropriately and that employee health and safety is not compromised in the process.

DEFINITION:

1. Hazardous Materials~~—~~– Any material with a hazardous characteristic such as flammable, combustible, oxidizing, or toxic.

2. Non-Hazardous Materials~~—~~– Any material that does not have a hazardous characteristic (as described above), such as water, food or~~,~~ drink~~, or body fluids~~.

~~2.~~ Body Fluids- Fluids excreted from the human body (ex. Blood, urine, feces, vomitus) that may shed pathogens that may result in healthcare associated infections. Body fluids spills require a two~~-~~step process of cleaning followed by disinfection. (LHH 72-01 F10).

3.

4. Emergency spill kits- Kits of long/narrow absorbent pads, other absorbent materials, PPE, disposal bags and containers, and signage, to help isolate, contain, cover, and remove spill materials. They have been issues to multiple departments and placed in areas perceived to be at highest risk for emergency spills.'

PROCEDURE:

1. CLEAN UP OF NON-HAZARDOUS MATERIAL SPILLS

a. Spills of non-hazardous materials shall be cleaned up as quickly as possible to remove any slip hazard.

b. If you spill something or notice a spill:

i. Restrict access to the area around the spill, if possible.

ii. If you can wipe up the spill with available absorbent material such as paper towels, do this as soon as possible. ~~Do not use Ultrasorbs for spills.~~

iii. Where available, utilize emergency spill kits to cordon, cover, remove, and recover spills that are too large and/or complex for personal cleaning.

~~ii.~~iv. Dispose spill kits or materials used to clean up spill according to their classification (biohazard, chemical, or general waste).

v. If the spill is too large for you to clean up or you do not have appropriate PPE, such as gloves and/or eye protection, report the spill to Environmental Services (EVS):

- EVS mainline: ~~(~~Ext ~~).~~4-4624 or 415-759-4624 (7:00 am to 3:30 pm)
- ~~Off hour~~37~~:~~30 pm to 7:00 am: Email DPH-LHH-EVSLeadership@sfdph.org or call Nursing Office.

~~iii.~~vi. Make sure that no one enters the area until EVS arrives.

- ~~EVS personnel are available daily from 6:00 a.m. until 12:00 midnight.~~
- Please secure the area and ~~Between the hours of 12:00 midnight and 6:00 a.m., individuals should~~ place wet floor signs near the spill. EVS will ~~provide~~ clean-up the spill~~s~~ after receiving the report.
- ~~the next morning.~~

2. RESPONDING TO HAZARDOUS MATERIAL SPILLS

a. Hazardous drug spills will be cleaned up according to LHHPP 25-05 Hazardous Drugs Management.

b. Any employee who spills a hazardous material that they are using will restrict access to the area of the spill and report the spill to the Department of Workplace Safety during the day time (415-759-3321) or the Watch Engineer during off hours (415-370-8259).

c. The Department of Workplace Safety & Emergency Management (WSEM) or ~~Engineering~~Facilities will respond with an emergency spill kit or call the SFDPH Environmental Health Section at 415-252-3900 for assistance.

d. After an uncontrolled spill or leak of a hazardous material, the Industrial Hygienist, Chief Engineer, or Watch Engineer will ~~be responsible for~~ call~~ing~~ the following agencies, as necessary:~~:~~

i. SFDPH Environmental Health Section – 311 or 415-252-38~~9~~00

ii. California Office of Emergency Services - 800-852-7550

iii. National Response Center - 800-424-8802

iv. Toxics Substance Control Division - 1-800-471-7127 ~~800-852-7550~~

e. In addition to calling the agencies listed above, whenever spilled hazardous materials ~~enter into~~enter the sewer, the Chief Engineer or the Industrial Hygienist will be responsible for calling: the Department of Public Works at 311 or 415-695-2020.

ATTACHMENT:
None.

REFERENCE:
LHHPP 25-05 Hazardous Drugs Management.

Revised: 02/03/06, 12/09/25, 15/01/13, 16/07/12 (Year/Month/Day)
Approved renumbering from 74-01 to 70-07: 15/01/13
Approved for renumbering to 70-01 Section A, B, and C: 18/02/23

WORKPLACE VIOLENCE PREVENTION PROGRAM

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing a safe and secure environment of care consistent with our mission, the Department of Public Health (DPH) regulations, Title 22, California Occupational Safety and Health Administration (Cal-OSHA) regulations and other applicable local, state and federal laws.

2. LHH employees, residents and visitors are prohibited from bringing weapons to the LHH campus and worksites. Weapons include, but are not limited to, firearms, knives or weapons defined in the California Penal Code Section 12020.

3. The City and County of San Francisco has a ~~zero tolerance~~zero-tolerance policy for assaults, battery or threats or acts of violence by employees in the workplace. Employees are expected to behave in a professional and courteous manner in the workplace at all times. This includes carrying out their duties on or offsite. A LHH employee who physically or verbally threatens, harasses, or abuses someone in the workplace, or uses hospital resources such as work time, workplace phones, fax machines, mail, e-mail, or other means for such activity, will be subject to corrective or disciplinary action, up to and including dismissal, and may be subject to criminal and/or civil action.

PURPOSE:

To inform the LHH community of the hospital's policy towards violence in the workplace, to implement procedures for the prevention of workplace violence, and to provide support for employees who have been subject to a verbal or physical threat and/or violent behavior.

DEFINITION~~S~~:

1. *Violence*: Behavior involving the exercise or exhibition of physical force intended to hurt, damage, or intimidate someone or something.

2. *Threat of Violence*: A statement or conduct that causes a person to fear for his or her safety.

3. *Workplace Violence*: Any act of violence or threat of violence that occurs at the work site, including the following:

   a. Type 1 Violence: Workplace violence committed by a person who has no legitimate business at the work site.

b. Type 2 Violence: Workplace violence directed at employees by residents or visitors.

c. Type 3 Violence: Workplace violence against an employee by another employee or former employee.

d. Type 4 Violence: Workplace violence committed by someone who is not an employee, but has or had a personal relationship with an employee.

4. *Psychological First Aid:* A supportive response to a fellow human being who is suffering and who may need support, including attending to employee needs for information, comfort, and time to process.

PROCEDURE

1. Workplace Violence Prevention Program Responsibilities

a. Department of Workplace Safety and Emergency Management (WSEM):

WSEM is responsible for the overall administration and maintenance of the workplace violence prevention program, for the tracking and analysis of workplace violence incidents and for eliciting the input of employees in making improvements to the program. WSEM shall maintain a log of workplace violence incidents and report incidents involving physical force to the California Department of Industrial Relations Division of Occupational Safety and Health according to CCR Title 8 Section 3342 Violence Prevention in Healthcare

b. Resident Care Teams (RCTs):

RCTs are responsible for developing and implementing resident care practices and plans aimed at prevention of Type 2 violence by minimizing aggressive behavior in LHH residents and for reviewing and for revising plans in response to aggressive behavior. Care plans shall include medically and cognitively appropriate behavioral interventions for residents who repeatedly commit acts of workplace violence. RCTs are also responsible for ensuring appropriate assignment and training of staff to care for residents at risk for aggressive behavior.

c. Department of Human Resources (HRS):

HRS is responsible for developing and implementing policies and procedures for preventing Type 3 violence and for following up with corrective/disciplinary action in the event that such violence does occur.

d. DPH Security Services Department and San Francisco Sheriff's Department (SFSO):

i. The Security Services Department will develop processes to safeguard all persons, patients, visitors, and employees by addressing threats and aggressive behavior at the earliest stage; define inappropriate and unacceptable workplace behavior; and establish an effective process for responding to, managing, and reporting acts or threats of violence or aggressive behavior.

ii. The DPH Security Director in collaboration with HRS and SFSO provides specialized personnel protection services, and specialized investigations, including conducting a risk assessment. Risks are assessed based upon all relevant information available and after consultation with experts where appropriate, a risk level will be assigned, and protection plan developed.

iii. SFSO staff also has responsibility for responding to employee calls for law enforcement assistance when experiencing violence or threat of violence. ~~SFSD~~SFSO~~ff~~ will take the lead in managing Code Silver (Active Shooter) situations that occur on the campus.

e. Campus Safety and Security (CSS) Committee

The LHH CSS Committee is comprised of clinical, administrative, health and safety, and human resources representatives who ensure that the security management program administered by the DPH Security Director, and the contracted security provider (SFSO) is aligned with the core values and goals of the organization by providing direction, set strategic goals, determine priority and assess the need for change. The committee ensures coordination, communication and integration of performance improvement for campus security and injury prevention. See LHHPP 75-01 Security Management Plan.

f. Department Managers and Supervisors:

As per the LHH Injury and Illness Prevention Program, managers and supervisors are responsible for providing a secure work environment for their staff, including the identification of security risks, staff training needs, the development and management of departmental security policies and procedures, and incident reporting, investigation and follow up.

g. All LHH Employees, DPH Employees on Campus, and Tenants:

All LHH employees and building occupants are responsible for reporting hazards and injury or illness incidents per the IIPP, including hazards and incidents related to workplace violence.

2. Prevention of Violent Incidents

a. LHH admissions criteria in LHHPP 20-01 Admission to LHH Acute and SNF Services and Relocation Between SNF Units preclude the admission of patients with a significant likelihood of unmanageable behavior.

b. Access to LHH by visitors and the public is controlled by SFSO according to LHHPP 75-11 Public Access and Defined Restricted Areas and LHHPP 75-02 Public Access and Night Security in order to prevent entrance of persons with no legitimate business at LHH.

c. LHHPP 75-03 Disorderly or Disruptive Visitors specifies procedures for the removal of disorderly or disruptive visitors and the Department of Security Services has developed a threat management plan that is incorporated into LHHPP 75-10 Security Services Standard Operating Procedures in order to manage potential threats from anyone entering the facility.

d. History of aggressive behavior and any incidents of aggressive behavior shall be documented by the RCT and the care plan shall include measures to be taken for prevention and management of these behaviors.

e. Objects that could be used as a weapon shall be removed from rooms of potentially aggressive residents.

f. ~~Buddies and/or coaches~~Coaches shall be utilized in accordance with LHHPP 24-10 Close Observation. ~~the care of residents for whom this is deemed appropriate and effective in preventing aggressive behavior.~~

g. Incidents of aggressive behavior by residents shall be communicated to care providers at change of shift.

3. Incident Reporting and Response

a. Any employee who experiences workplace violence of any type shall report the incident immediately to their manager or supervisor. If the incident involves Type 3 violence perpetrated by a supervisor, the incident may be reported to another supervisor or directly to HRS.

b. Any LHH employee who observes violence in the workplace that involves residents, staff members, volunteers, visitors and/or vendors shall:~~;~~

i. If the threat of violence is immediate or life threatening, immediately call the SFSO (ext. 4-2319) or SFPD at 911.

ii. Inform a manager/supervisor or designee.

iii. Complete an Unusual Occurrence report.

c. Upon admission to LHH, residents are informed of the policy of non-violence. Residents who violate this policy with aggressive acts toward staff or other residents shall be given immediate feedback including appropriate consequences

(as spelled out in the policy), review of expectations and rules, and review of potential consequences of future recurrence of aggressive behavior. Behavioral interventions developed by the RCT shall be implemented immediately.

d. Any manager/supervisor who receives a report from an employee of an incident involving violence in the workplace shall investigate and take the following actions:

   i. Provide Psychological First Aid as appropriate for affected individuals including victim, aggressor, and by-standers.

   ii. Refer employees to the Employee Assistance Program (EAP) as appropriate to provide additional support sessions for LHH employees and their families following a threat or violent behavior incident. EAP is contacted by calling (800) 795-2351.

   iii. Immediately complete and submit an incident report to DPH OSH according to injury reporting procedures in LHHPP 73-01 Injury and Illness Prevention Program. A copy of the report shall also be scanned to the WSEM Director by the end of the shift for logging and reporting to Cal OSHA as appropriate.

   iv. Consult with appropriate resources via HRS, EAP, WSEM, SFSO, and/or LHH Administrator on Duty (AOD).

   v. Check in with the threatened person and offer support services periodically following the incident.

e. The AOD who receives a report of violence in the workplace shall ensure that the following actions have been taken:

   i. Notification of the Director of Human Resources if the incident involves Type 3 violence.

   ii. Notification of LHH Psychiatry Consultant for evaluation, treatment, and follow up recommendations of involved resident(s), as indicated.

   iii. Notification of the SFSO if there is imminent danger or a possible crime has been committed.

   iv. Notification of DPH Security Services if an incident involves an aggressor for whom a threat assessment is appropriate.

e. The Deputy Sheriff who receives notification of an act or threat of violence will intervene according to SFSO policy.

4. Response to Threats of Violence from a Third Party

In situations where a resident's family member or other visitor is determined to be a threat to employee safety, the CEO and DPH Security Services shall be notified and a threat assessment will be completed according to the Threat Management Plan and LHHPP 75-10 Security Services Standard Operating Procedures). The following action(s) may be taken depending on the situation and level of threat.

a. A stay-away letter may be issued by the CEO notifying the individual that he/she is not to enter the LHH grounds.

b. Once a stay-away letter has been issued, it is reviewed by the RCT on a quarterly basis to assure accuracy and consistency. If revision is needed, the LHH Deputy City Attorney must be notified.

c. If a visitor poses an imminent or continuing threat to employee safety, a Temporary Restraining Order (TRO) may be secured by Deputy City Attorney. A TRO is a court order signed by a judge, which orders an individual to stop contacting, telephoning, threatening, harassing, or stalking another individual. It can also order an individual to stay a certain distance away from another individual and his/her workplace or home.

d. A TRO will remain in force until a hearing is conducted on the matter; at which time a judge can continue, make permanent, or terminate the provisions of the order. The individual requesting a TRO will be asked to sign a declaration and to testify at a court proceeding where the accused will be present.

e. Employees who are being threatened by someone with whom they have a personal relationship should notify the CEO and DPH Security Services and are encouraged to obtain a TRO preventing the threatening individual from entering their workplace.

5. Education

a. All new employees receive training during hospital wide orientation on:

   i. LHHPP 73-01 Injury and Illness Prevention Program (IIPP)

   ii. The details of this Workplace Violence Prevention Program

   iii. Procedures for reporting incidents of workplace violence

b. All employees with direct resident care responsibilities receive initial and annual non-violent crisis intervention -training, including the following topics:

   i. Aggression and violence predicting factors

   ii. The assault cycle (CPI Crisis Development Model)

iii. Verbal intervention and de-escalation techniques and physical maneuvers to prevent physical harm, including role plays and hands-on practice.

iv. Inappropriateness of use of restraints at LHH

c. All other employees also receive annual training on workplace violence appropriate to their responsibilities.

d. Clinical staff assigned to work on units with residents at risk for unintentional aggressive behavior due to health conditions affecting the brain shall receive additional education that includes role playing to increase confidence in handling these residents.

e. Managers and Supervisors shall be provided with training in Psychological First Aid by Employee Assistance Program staff annually at Leadership Forum.

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-01 Admission to LHH Acute and SNF Services and Relocation Between SNF Units
LHHPP 22-08 Threat of violence to residents by an external party
LHHPP 22-10 Management of Resident Aggression
LHHPP 24-10 Close Observation
LHHPP 60-04 Unusual Occurrences
LHHPP 73-01 Injury and Illness Prevention Program
LHHPP 75-01 Security Management Plan
LHHPP 75-02 Public Access and Night Security
LHHPP 75-03 Disorderly or Disruptive Visitors
LHHPP 75-04 ~~Calls for Assistance~~ Calls For Sheriff's Assistance
LHHPP 75-10 Security Services Standard Operating Procedures
LHHPP 75-11 Public Access and Defined Restricted Areas
LHHPP 75-12 Firearms, Dangerous Weapons and Contraband Policy
LHHPP 75-13 Forensic Residents/Patients
CCR Title 8 Section 3342. Violence Prevention in Healthcare

Revised: 05/12/20, 08/09/23, 09/01/13, 10/08/01, 10/11/09, 15/01/13, 16/03/08, 18/09/11, 19/03/12 (Year/Month/Day)
Original adoption: 05/12/20

HANDLING AND STORAGE OF MEDICAL GASES

POLICY:

~~1. All medical gases and compressed air shall be handled and stored in a safe manner.~~
~~2. Smoking is prohibited in any area where compressed gases or liquids are in use or in storage.~~

Laguna Honda Hospital (Laguna Honda) will comply with the California Code of Regulations, Article 76, Section 4650, with ~~in~~ regards to the storage, handling, and use of compressed gas cylinders. Smoking is prohibited in any area where compressed gases or liquids are in use or in storage.

PURPOSE:

~~To ensure a safe environment for residents, visitors and staff.~~
This program describes how Laguna Honda will store, handle, and use compressed gas cylinders in a manner that ensures employee safety and complies with applicable regulations, ~~.~~ ~~I~~in order to ensure a safe environment for residents, visitors, and staff.

PROCEDURE:

1. A "No Smoking" sign shall be placed on oxygen carriers or holders and posted in areas where compressed gases or liquids are stored. Before issuing each cylinder, Central Supply Room staff shall place a "No Smoking" sign around the cylinder neck. Department heads in charge of storage and use of compressed gases or liquids will be held responsible for placing of signs.

2. Persons transporting full or empty "H" gas cylinders must ensure that the cap is secured at all times except when cylinders with regulators in place are prepared and transported in the care units. "E" cylinders do not require capping for transport.

3. The gas cylinders valve protection devices shall not be used for lifting cylinders.

4. All cylinders, empty or full, shall be properly fastened at all times during site delivery and storage.

5. Empty cylinders are segregated from full cylinders

6. To prevent cylinders from falling over, the care unit personnel and staff from other areas where cylinders are used must ensure that each cylinder remains on its carrier and that each carrier rests on its wheels at all times.

7. Cylinders stored in the open are protected from weather.

ATTACHMENT:
None

REFERENCE:
Title 8, CAC Article 76, Section 4650

Revised: 99/08/23, 12/09/25, 15/01/13, 22/01/11 (Year/Month/Day)
Original adoption: 92/05/20
Approved for renumbering from 71-07 to 73-10: 15/01/13

MEDICAL WASTE MANAGEMENT PROGRAM

POLICY:

Laguna Honda Hospital (Laguna Honda) will comply with the California Medical Waste Management Act with regards to managing medical waste.~~:~~

PURPOSE:

This program describes how Laguna Honda will collect, store, and dispose of medical waste in a manner that ensures employee safety and complies with applicable regulation.~~s:~~

DEFINITIONS~~PROCEDURE~~:

~~**Medical Waste Definitions**~~

~~1.~~ **"Medical waste" means any biohazardous, pathology, pharmaceutical, or trace chemotherapy waste not regulated by the federal Resource Conservation and Recovery Act of 1976 (Public Law 94-580), as amended; sharps and trace chemotherapy wastes generated in a health care setting in the diagnosis, treatment, immunization, or care of humans or animals; waste generated in autopsy or necropsy; waste generated during preparation of a body for final disposition such as cremation or interment; waste generated in research pertaining to the production or testing of microbiologicals; waste generated in research using human or animal pathogens; sharps and laboratory waste that poses a potential risk of infection to humans generated in the inoculation of animals in commercial farming operations; waste generated from the consolidation of homegenerated sharps; and waste generated in the cleanup of trauma scenes. Biohazardous, pathology, pharmaceutical, sharps, and trace chemotherapy wastes that meet the conditions of this section are not subject to any of the hazardous waste requirements**

~~a.~~ Medical Waste specific to Laguna Honda includes:

i. Biohazardous waste (Regulated Medical Waste)

- Waste that at the point of disposal or thereafter contains recognizable blood, fluid blood products, containers or equipment containing blood that is fluid.
- Waste containing discarded materials contaminated with excretion, exudate, or other secretions in which the resident was required to be isolated by the LHH infection control authorities.

ii. Sharps waste

- Syringes, hypodermic needles, blades, needles with attached tubing, or broken glass that has been in contact with biohazardous waste.

iii. Contaminated Solid Waste

- All moist waste including products that have been in contact with bodily fluids or waste that might attract vermin (i.e., tongue blade, diaper, urine cup, moist blood-~~-~~stained dressing, non-sharp disposable instrument, or food waste that have been in contact with bodily fluids).

iv. Pharmaceutical waste

- Waste that is hazardous only because it is comprised of prescription or over-the-counter drug.

v. Chemo-contaminated waste

- Any waste that previously contained, or has come into contact with, a chemotherapeutic agent. For the purpose of waste handling, "chemotherapeutic agent" means a cytotoxic drug, or an agent that kills or~~f~~ prevents the reproduction of malignant cells.

~~2.~~ PROCEDURES:~~Collection and Disposal Procedures~~

~~a.~~1. General procedures are listed below and detailed procedures for each type of waste is given in Table 1.

~~b.~~a. Biohazardous Waste

i. Waste material must be segregated at the point of generation and placed in a labeled red biohazard bag. The bag should have sufficient strength and be impervious to moisture to preclude ripping, tearing, or bursting under normal waste handling conditions.

ii. Biohazardous w~~W~~aste ~~material~~ containers shall be leak-~~-~~resistant with tight fitting covers. When ¾ full, disposable biohazardous w~~or w~~aste bags must be tied or taped secure~~dly~~ to prevent expulsion of contents, and then placed into red bins in the waste storage room.

~~c.~~b. Body Fluids/Waste and Suctioned Fluids

i. Any volume of fluids that are not absorbed by other waste materials such as sponges and dressings must be contained in leak and break resistant containers.

ii. Liquid blood or semi-liquid waste can be poured down a public sewage system

~~d.~~c. Sharps Waste

i. All sharps must be placed in approved and labeled sharps containers.

ii. Sharps should not be disposed of directly in biohazard waste bags.

iii. Needles from syringes should not be removed or clipped.

iv. See the LHH Bloodborne Pathogen Occupational Exposure Control Plan for information on sharps injury prevention.

~~e.~~d. Pharmaceutical Waste

i. Pharmaceutical wastes should be segregated from other types of medical wastes. They should not be placed into red biohazardous bags, but placed in pharmaceutical waste bags or disposable containers marked with the words "INCINERATION ONLY."

~~f.~~e. Chemo-Contaminated Waste

i. Chemo-contaminated wastes should be segregated and collected in yellow waste containers. This includes all waste generated while caring for a resident who has taken cytotoxic drugs within 48 hours.

Table 1. Alphabetical Listing of Waste Types and Disposal Guidelines

	Waste Type (Alphabetical)	Disposal Category	Collection Method
1.	**Biologicals** Serums, vaccines, antigens, antitoxins, and all preparations made from living organisms used in treatment, immunization, or diagnosis	Regulated Medical Waste	For non-sharps, discard into covered waste container lined with a red bag. For sharps, discard into plastic puncture-resistant "Sharps" container.
2.	**Blood, blood products and other body fluids considered potentially infectious** Suction containers, pleural evacuation containers, human lab specimens, cultures and stock of infectious agents or other receptacles containing: amniotic fluid, cerebrospinal fluid, pericardial fluid, pleural fluid, saliva during dental procedures semen, synovial fluid, vaginal secretions, and any other body fluid if visibly contaminated with blood and items saturated or visibly dripping with those fluids.	Regulated Medical Waste	If free-flowing, and in a container which can be safely handled and closed, discard into red bag container. If soiled item is saturated or visibly dripping*, discard into container lined with a red bag (available in high-use areas, and all dirty utility rooms).
3.	Culture containers / mediums/ devices (used)	Regulated Medical Waste	Non-sharp items are placed into container lined with a red bag. Sharps are placed into designated plastic, puncture-resistant "Sharps" container
4.	**Chemo – contaminated waste.** This includes all waste generated in the care of residents receiving antineoplastic drug treatment for the duration of treatment plus 48 – 168 hours, depending on the drug.	Chemo-contaminated waste.	Dispose of waste in yellow pharmaceutical waste container.
5.	Diapers not saturated with blood	Standard Waste	Disposed into a container that is lined with a non-red plastic bag.
6.	Disposable gowns or dressings saturated / visibly dripping blood or other	Regulated Medical Waste	Discard into container lined with a red plastic bag.

	potentially infectious body fluid (see #2)		
7.	Disposable gowns or dressings NOT saturated with blood	Standard Wasted	Disposed into a container that is lined with a non-red plastic bag.
8.	Feces	Standard Waste	Flush down hopper/toilet into the municipal sewer system. Note: considered Regulated Medical Waste only as a lab specimen or if visibly contaminated with blood.
9.	Gloves NOT saturated with blood	Standard Waste	Discard into waste container lined with a non-red plastic bag.
10.	Human Pathology Waste Includes tissue, body fluid specimens, body parts or organs (excluding urine and feces except as lab specimens)	Regulated Medical Waste	If solid specimen, place in covered container lined with a red bag. If free-flowing liquid, flush down hopper/ toilet into municipal sewer system.
11.	Isolation Room Waste – not considered Regulated Medical Waste except as items fit into specific categories (i.e. sharps, blood, dressings saturated with blood or other designated body fluid)	Standard Waste	Dispose into waste container lined with a clear or white plastic bag, except as isolation waste fits into other categories.
12.	Isolation Room Wasted derived from highly dangerous communicable disease such as Class IV etiologic agents (Ebola, Marburg viruses, Lassa fever, etc.)	Regulated Medical Waste	Discard into covered waste container lined with a red bag which has been placed in the resident / clinic room.
13.	Instruments (Disposable) includes trocars, IV insertion guidewires, and other sharp disposable instruments	Regulated Medical Waste- Sharps	Discard into plastic, puncture-resistant “Sharps” container immediately after use.
14.	IV tubing and bags not visibly contaminated	Standard Waste	Dispose into waste container lined with a non-red bag.
15.	IV tubing and bags with visible blood	Regulated Medical Waste	Discard into container lined with a red bag (in the dirty utility room).
16.	Lab Waste – see Cultures, #3		
17.	Masks	Standard Waste	Dispose into waste container lined with a non-red plastic bag.

18.	Menstrual / Peri Pads	Standard Waste	Dispose into waste container lined with a non-red plastic bag.
19.	Pharmaceutical waste – includes unused pharmaceuticals or any pharmaceutical that has residual, free-flowing medication in it. This includes IV bags, tubing, and needles/syringes used for drug administration.	Pharmaceutical waste	Dispose in pharmaceutical waste container (white with blue top)
20.	Sharps - includes hypodermic, intravenous, and other medical needles and attached syringes, scalpel blades, disposable sharp instruments, blood vials, and other glass in contact with infectious agents (slides & cover slips) used in medical care, and also discarded unused sharps	Regulated Medical Waste Sharps	Discard immediately after use into plastic, puncture-resistant designated "Sharps" container.
21.	Shoe covers not saturated (rarely indicated at LHH except for Norovirus)	Standard Waste	Dispose into waste container lined with a non-red plastic bag.
22.	Urine - NOTE: considered Regulated Medical Waste only as a lab specimen or if visibly contaminated with blood or other potentially infectious fluid	Standard Waste	Flush liquid urine hopper/toilet into municipal sewer system. For items contaminated with urine, discard into waste container lined with a non-red plastic bag.

2. Storage

~~3.~~ Containment and storage of medical waste shall be in accordance with Chapter 9 (commencing with Section 118275) of the Medical Waste Management Act.

a. Medical waste storage locations are present on each neighborhood.

b. All medical wastes to be stored on site will be held no more than seven days in labeled containers.

c. Medical waste that is to be transported offsite shall not be subjected to trash chutes, compaction or grinding.

d. Pharmaceutical wastes may be stored on site for up to 90 days before sending them offsite for destruction by incineration. Pharmaceutical wastes totaling 10 pounds or less can be stored for up to one yearr.

~~Disposal~~

4. No person shall treat medical waste unless the person is permitted by the enforcement agency as required by this part or unless the treatment is performed by a medical waste generator and is a treatment method approved pursuant to Chapter 8 (commencing with Section 118215) of the Medical Waste Management Act of 2017.

a. Waste Hauler Information:
Stericyle, Inc. - Alameda County
30542 San Antonio Street
Hayward, CA 94544
510-471-0920
866-978-3744
866-783-7422
Transfer Permit Station #: P-114, TS - 114
EPA Identification Number: #CAD 980890321

b. All required hazardous waste manifests will be completed per Department of Transportation regulations.

5.3. Spill Cleanup

a. In the event of a spill of medical wastes:

i. Use latex or vinyl gloves as barrier. Don additional PPE if the risk of exposure to splash/spray is high.

ii. Use tongs, shovel, or other mechanical means to pick up solid waste, especially for sharps.

iii. Re-bag any regulated medical waste into the appropriate waste containera red bag.

iv. Secure the bag with tape or other means to prevent leakage. Before it is ¾ full, tie or tape the bag securely to prevent expulsion of contents.

iv.

v. Apply household bleach disinfectant to the area affected by the spill or contact EVS for assistance.

b. Sharps Container Spill

i. Recover the sharps using tongs, forceps, pliers, or other mechanical means. Do not use your hands to pick up sharps- even if gloves are worn.

ii. Place the sharps into the designated~~open~~ sharps container. If the sharps container is 2/3 filled, place the sharps into another sharps container. Do not fill the container over 2/3 full.

iii. Secure the lid and tape if necessary.

iv. Apply disinfectant in affected area if necessary.

c. Blood Leak

i. Place cones or other warning devices around the area to prevent people from walking through the blood spill and tracking blood throughout the area.

ii. Apply absorbent towels. Blood spill kits with appropriate absorbent cloths are available in CSR. Do not use UltraSorbs.

iii. Allow 10–20 minutes for the blood to be absorbed.

iv. Vinyl or latex gloves shall be worn when mopping a spill. Wear additional PPE if splash/spray is expected.

v. Place the blood--soaked absorbent materials in the biohazard bag.

vi. Mop the area with disinfectant and water. The mop shall be soaked in disinfectant bleach for 10–20 minutes after use, and then rinsed with clean water before using it again.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 Infection Control Manual
LHHPP 73-06 Bloodborne Pathogen Occupational Exposure Control Plan
California Health and Safety Code Sections 117600 – 118360: Medical Waste Management Act of 2017.

Revised: 13/05/28, 15/01/13, 16/03/08 (Year/Month/Day)
Original adoption:

Personal Protective Equipment (PPE) ~~Policy~~

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH~~aguna Honda~~) shall provide appropriate and effective personal protective equipment (PPE) to employees whenever a hazard is present, or likely to be present, which necessitates the use of PPE pursuant to CA Occupational Safety & Health Standards, CA Code of Regulations (CCR), Title 8, Section 3380.

PURPOSE:

To provide a safe and health~~fuly~~ work environment for employees.

PROCEDURE:

Each Department at Laguna Honda will implement departmental procedures for providing PPE to employees that are consistent with the following hospital-wide procedures.

1. Hazard Assessment and Equipment Selection

a. Per the L~~aguna Honda~~HH Illness & Injury Prevention Program (IIPP), Department Managers are responsible for identifying hazards to which their employees may be exposed.

b. Where hazards cannot be eliminated with the implementation of engineering and/or administrative controls, the Department will provide appropriate PPE to protect employees.

c. All PPE shall be approved for its intended use.

d. All PPE will be selected such that it fits each affected employee properly.

e. Department of Workplace Safety & Emergency Management staff are available for technical consultation in selecting appropriate PPE.

2. Required vs. Voluntary Use of PPE

a. Use of PPE is required when the Industrial Hygienist/Infection Preventionist or the Department Manager makes a determination that a hazard can~~is~~ not practically be ~~sufficiently~~ controlled without it, or when PPE is required by regulatory standard or infection control guidelines.

b. Some PPE is available for voluntary use for employees who wish to further minimize exposure to hazards that do not require the use PPE, but for which PPE is an effective control measure.

c. Each Department shouldwill keep an up-to-date table indicating what PPE is available to their staff and whether or not its use is required. A template for this table is included in Appendix A.

3. Availability and Use of PPE

a. In some cases, rReusable PPE will be provided to individual employees for their sole use or as a required part of their uniform. Exceptions to this are routine clothing and boots which also functions as PPE, and is expected to be provided by each employee. RegardingIn other cases, disposable PPE, it will be available to all employees either in the work area or from Central Supply.

b. All affected employees shall be made aware of PPE available to them, and hhow to obtain it, and trained on how to use it.

c. Employees are responsible for proper use of all required PPE as part of their job duties.

d. Defective or damaged PPE shall not be used and will either be repaired or discarded.

e. All respirators will be selected and used in accordance with the Laguna Honda Respiratory Protection Program (LHH 73-09).

e.f. Examples of PPE items include exam gloves, safety glasses, disposable N95 respirators, non-disposable elastomeric respirators with either N95 or P100 cartridges, clear face shields, tyvek suits, and many other items.

4. Employee Training

a. Staff will be trained on the following topics during their department orientation or by their supervisor prior to performing any task that requires the use of PPE.

i. When PPE is required;

ii. What PPE is required;

iii. What other PPE is available to use voluntarily;

iv. How to properly don, doff, adjust, and wear their required PPE;

v. The limitations of the PPE; and

vi. The proper care, maintenance, useful life, and method of disposal of the PPE.

b. PPE training is the responsibility of the Department Manager or Supervisor, but Workplace Safety & Emergency Management and Education staff are available to assist with training and curriculum development.

~~**ATTACHMENT:**~~
~~Appendix A: Department PPE Table Template~~

REFERENCES:
California Occupational Safety and Health (OSH) Standards, Title 8, California Code of Regulations (CCR), section 3380.

Original adoption: 16/03/08 (year, month, day)

~~Appendix A: Department PPE Table Template~~

~~Personal Protective Equipment List~~

~~**Department: _____ Revision Date: _____**~~

PPE	When/What Task	Required Yes/No	Reusable Yes/No	Uniform Yes/No	How to Obtain
~~e.g.~~ Eexam gloves	Whenever providing resident care	Yes	No	No	Available in neighborhoods and from CSR
N95 disposable respirator	When resident known or suspect to have aerosol transmissible disease				
Safety glasses					
Disposable gown					

Appendix A:

LIST OF RESIDENTS' / PATIENTS' RIGHTS

I. Exercising Your Rights

1. You have the right to a dignified existence, self-determination, and communication and access to people and services both inside and outside of Laguna Honda. You have the right to be free of interference, coercion, discrimination, and retaliation from Laguna Honda in exercising your rights as a ~~resident~~resident/patient of Laguna Honda and as a citizen or resident of the United States, and Laguna Honda shall support you exercising your rights. You have the right to equal access to quality care regardless of diagnosis, severity of condition, or payment source.

2. You have the right to designate a representative if you are competent to do so, who may exercise your rights, in accordance with, and to the extent provided by state law.

    a. Your representative has the right to exercise your rights to the extent you have delegated those rights to your representative.

    b. You retain the right to exercise any right not delegated to your representative, including the right to revoke a delegation of rights, except as limited by state law.

    c. Laguna Honda shall treat the decisions of your representative as your decisions to the extent required by either a court or as delegated by you.

    d. Laguna Honda shall not extend to your representative the right to make decisions on behalf of you beyond the extent required by either a court or as delegated by you. Laguna Honda shall report, as required by law, if it has reason to believe that your representative is not acting in your best interest.

3. ~~Resident~~Residents/Patients adjudged incompetent by a court with jurisdiction to do so, shall have their rights devolve to and exercised by the ~~resident~~resident/patient representative appointed under State law to act on the ~~resident~~resident's/patient's behalf. The court-appointed ~~resident~~resident/patient representative shall exercise your rights to the extent judged necessary by the court with jurisdiction, and in accordance with state law.

    a. In cases where a representative's decision-making authority is limited by state law or court appointment, you retain the right to make those decisions outside of the representative's authority.

    b. Your wishes and preferences must be considered in the exercise of your rights by the representative, and to the extent possible, you shall be provided with the opportunity to participate in the care planning process.

4. You have the right to exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status or the source of payment for care. The same-sex spouse or a ~~resident~~resident/patient shall be afforded treatment equal to that of an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

II. Planning and Implementing Your Care

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual and personal values, beliefs, and preferences.

2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.

3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you, and to be informed of the care to be furnished to you and the type of care giver that will furnish that care. You have the right to be informed and participate in your treatment.

4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in language you can understand. You have the right to be informed in advance of treatment of the risks and benefits of the proposed care, alternatives or options to the proposed treatment, and to choose the alternative or option if you prefer.

5. You have the right to effective communication and to participate in the development and implementation of your plan of care, and the right to receive the services and/or items included in the plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

6. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

7. Participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. You have the right to identify individuals or roles to be included in the

planning process, the right to request meetings, and the right to request revisions to the plan of care.

8. Choose your attending physician, provided that the physician meets the requirements of Code of Federal Regulations, Title 42.

9. See the plan of care and be informed in advance of any changes to the plan of care.

10. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.

11. Self-administer medications if your care team has determined that this practice is clinically appropriate.

12. Be advised if the hospital/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

13. Reasonable responses to any reasonable requests made for service.

14. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve the pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.

15. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patient rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.

III. Respect and Dignity

You have the right to:

1. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

2. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.

3. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.

4. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

5. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided with this information also.

6. Know which hospital rules and policies apply to your conduct while a patient.

7. A safe, clean, and homelike environment including receiving treatment that supports your safe daily living. You have the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other ~~resident~~residents/patients. Laguna Honda shall exercise reasonable care for the protection of your property from loss or theft.

8. Reside and receive services with reasonable accommodation of your needs and preferences except when to do so would endanger your health or safety or other ~~resident~~residents/patients.

9. Share a room with your spouse if your spouse also resides at Laguna Honda and you both consent to the arrangement.

10. Share a room with the roommate of your choice when practicable, and only when you are both ~~resident~~residents/patients at Laguna Honda and consent to the arrangement.

11. Receive written notice, including the reason for the change, before your room or roommate in the facility is changed.

12. Refuse to transfer to another room in the facility, if the purpose of the transfer is to relocate you from a skilled nursing unit to a non-skilled nursing unit within Laguna Honda, or if the transfer is solely for the convenience of Laguna Honda. This right shall not affect your eligibility or entitlement to Medicare or Medi-Cal benefits.

IV. Self-Determination
You have the right to:

1. Choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with your interests, assessments, and plan of care; and to make choices about aspects of your life at Laguna Honda that are significant to you.

2. Interact with members of the community and participate in community activities both inside and outside of Laguna Honda.

3. Organize and participate in ~~resident~~resident/patient groups within Laguna Honda. You have the right to participate in social, religious, and community activities provided that doing so does not interfere with the rights of other ~~resident~~residents/patients.

4. Receive visitors of your choosing at the time of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:

   a. Laguna Honda reasonably determines that the presence of a particular visitor would endanger the health or safety of you, other ~~resident~~residents/patients, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.

   b. You have told Laguna Honda staff that you no longer want a particular person to visit.

   c. However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

5. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household.

6. Participate in family groups and have family members or other representatives' meet with the families or representatives of other ~~resident~~residents/patients of Laguna Honda.

7. Choose to or refuse to perform services for Laguna Honda. You may perform services for Laguna Honda when:

   a. Laguna Honda has documented your need or desire for work in the plan of care;

   b. The plan of care specifies the nature of the services performed and whether the services are voluntary or paid;

   c. Compensation for paid services is at or above prevailing rates; and

   d. You agree to the work arrangement described in the plan of care.

e. At no time shall you be required to perform services for Laguna Honda.

8. Manage your own financial affairs, including the right to know in advance, what charges Laguna Honda may impose against your personal funds.

9. Examine and receive an explanation of the hospital's bill regardless of the source of payment.

V. Information, Communication, Privacy, and Confidentiality

You have the right to:

1. Be informed of your rights and the rules and regulations governing ~~resident~~resident/patient conduct and responsibilities during your stay at Laguna Honda.

2. Access your personal and medical records; and to secure and confidential treatment of all communications, personal records, and medical records pertaining to your care and stay in the hospital. You have the right to refuse the release of personal and medical records unless federal or state law requires the release of those records. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.

3. Receive notices both orally and in writing in a format and language that you understand.

4. Have reasonable access to the use of a telephone in a place where you cannot be overheard, including the right to retain and use a cellular phone at your expense. You have the right to communicate with individuals and entities within and outside of Laguna Honda with reasonable access to the internet, to the extent available within Laguna Honda.

5. Send and receive mail, including letters, packages, and other materials delivered to Laguna Honda; and to have those communications be received and sent promptly and in private. You have the right to access stationery, postage, and writing implements at your expense.

6. Have access to, and privacy in, your use of electronic communications such as email and video communications, and internet research to the extent that it is available at Laguna Honda.

7. Privacy in your medical treatment, written and telephone communications, personal care, visits, and meetings of family and ~~resident~~resident/patient groups.

8. Examine the results of the most recent survey of Laguna Honda conducted by Federal or State surveyors and any plan of correction in effect, and to receive information from agencies acting as client advocates including the right to contact such agencies.

9. Voice grievances to Laguna Honda or other agencies that hear grievances without retaliation or discrimination, and without the fear of retaliation or discrimination, including grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other ~~resident~~residents/patients, and any other concern regarding your stay at Laguna Honda.

   If you want to file a grievance with this hospital, you may do so by writing or calling:

~~Roland Pickens~~ Sandra C. Simon, LHNA, MBA

~~Interim Chief Executive Officer~~ Nursing Home Administrator and Chief Executive Officer
Administration Department
Laguna Honda Hospital
375 Laguna Honda Boulevard
San Francisco, CA 94116
(415) ~~759-4510~~682-5601

   You have the right to prompt resolution of grievances. The grievance committee will review each grievance and provide you with a written response within 10 business days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process.

10. File a complaint with the state Department of Public Health regardless of whether you use the hospital's grievance process. The state Department of Public Health's phone number and address is:

    Department of Public Health Licensing & Certification
    San Francisco District Office
    150 North Hill Drive Suite 22
    Brisbane, CA 94005
    Phone: (415) 330 6353
    Fax: (415) 330 6350