San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Joint Conference Committee April 2024
Quality Management Department
Regulatory Affairs Report

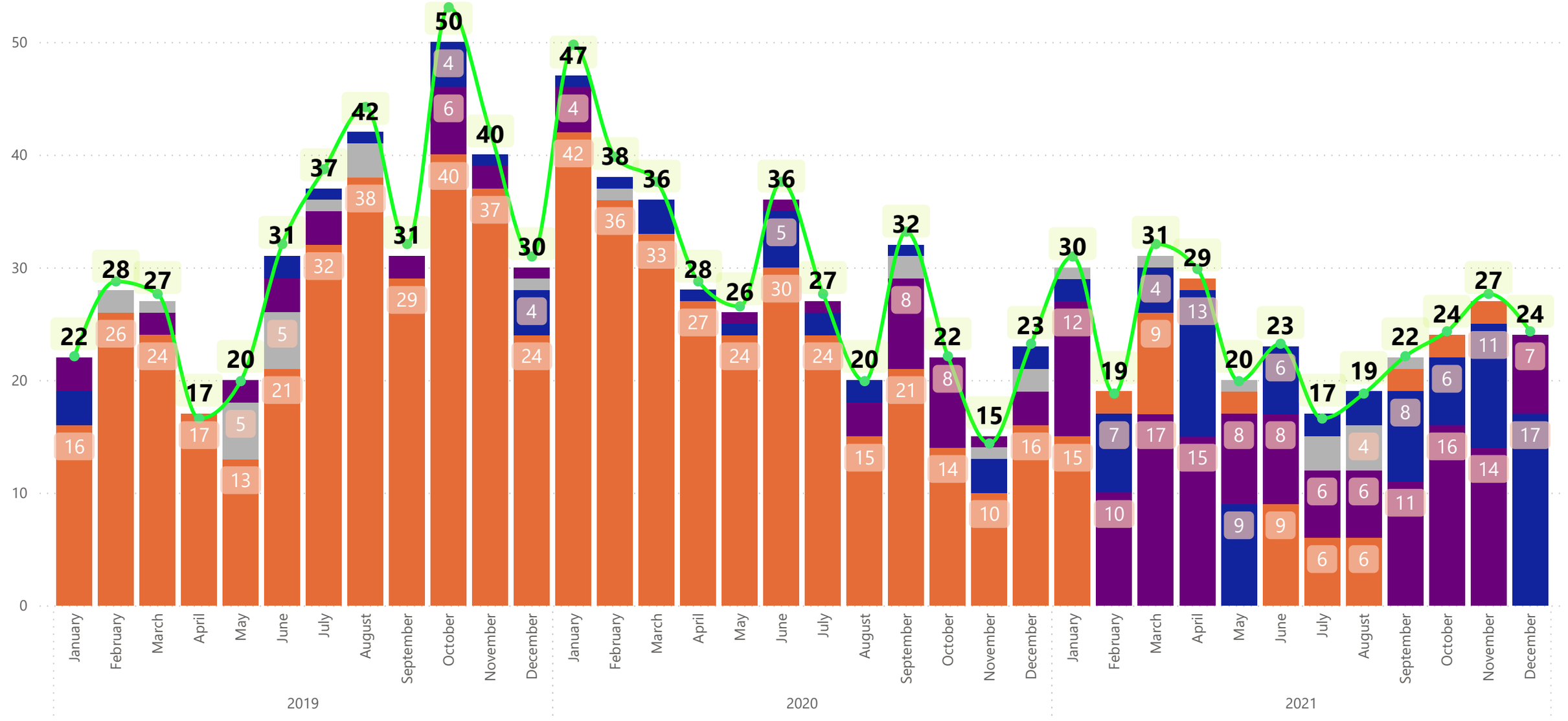
ITEM	DISCUSSION

FACILITY REPORTED INCIDENTS (FRI)	**During March 2024, LHH submitted a total of 13 Facility Reported Incidents (FRIs) to CDPH. The FRIs include allegations of abuse, adverse events, and other reportable incidents. CDPH has not initiated their investigations for cases that were reported in March 2024.**
	
	<u>March: 13 cases (13 FRI) (</u>*13 cases investigation not started by CDPH)*
	• 9 Allegations of Abuse
	  ○ Resident to Resident: 4 *(4 investigation not started)*
	  ○ Staff to Resident: 3 *(3 investigation not started)*
	  ○ Injury of Unknown Origin: 2 *(2 investigation not started)*
	• 2 Adverse events *(2 investigation not started)*
	• 1 Other event *(1 investigation not started)*
	• 1 Disease Outbreak *(1 investigation not started)*

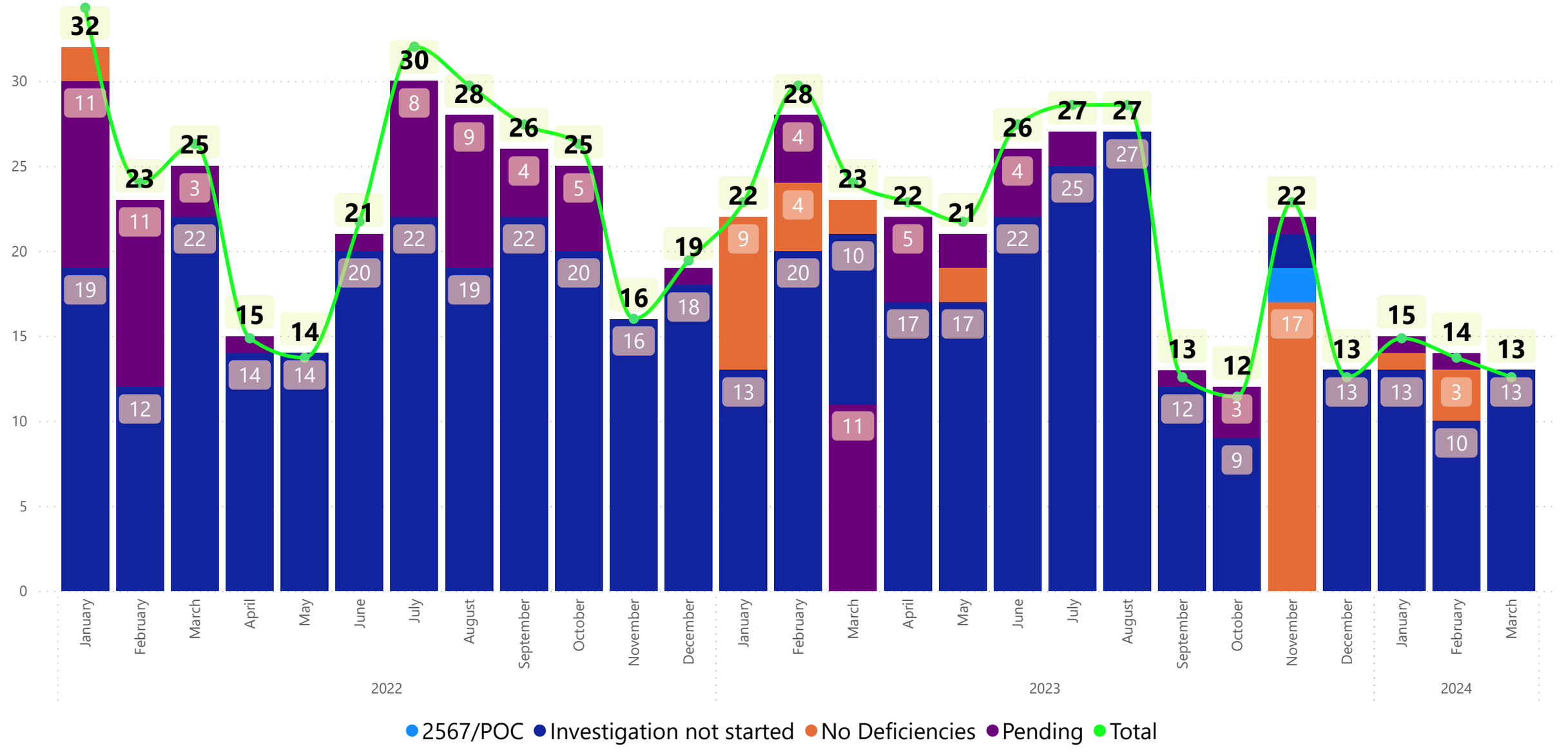
SURVEY UPDATES	**None.**
PLAN OF CORRECTION UPDATES/REPORTING	**1. Submitted POC on 3/21/24:** • **Anonymous Complaint. Site visit on 1/25/24 and 2/8/24. Investigation completed on 2/16/24.** a. F656 (SS=G) Develop/Implement Comprehensive Care Plan; F684 (SS=G) Quality of Care The facility failed to ensure Resident 1's fall care plan intervention were updated and implemented to prevent or minimize fall-related injuries for one of 20 sampled residents (Resident 1) when Resident 1 was assessed as total dependent with activities of daily living, including repositioning when in bed. The care plan interventions did not reflect the two person physical assist required by Resident 1 when repositioning and the facility did not implement effective interventions to prevent falls after identifying Resident 1 with limited Range of Motion (ROM) on bilateral upper and lower extremities, diagnosis of Seizure Disorder (a medical condition that can cause sudden, uncontrollable movements and change in level of consciousness) and poor safety awareness due to diagnosis of Dementia (impaired ability to remember, think, or make decisions). This failure resulted in Resident 1 to have an avoidable fall from her bed during personal care by Patient Care Assistant (PCA) 1 on 1/23/24, resulting in Resident 1 sustaining a laceration of 1.5 centimeter (cm - unit of measurement) and bleeding on left forehead. Resident 1 expired two hours and ten minutes after the fall. **2. Submitted POC on 3/21/24:** • **Facility Reported Incident on 12/17/23. Investigation completed on 2/28/24.** a. F689 (SS=G) Accidents

	The facility failed to adequate supervision for one of the four sampled residents (Resident 1) when Resident 1 was ambulating (walking) in the facility independently without any assistive devices (objects used to help stabilize someone for safer movement). This failure resulted in Resident 1 sustaining a left femoral neck fracture requiring a left hemiarthroplasty (surgery necessary to replace part of the hip joint).
EMAIL/TELEPHONE REQUESTS IN LIEU OF SITE VISITS	**None.**
ONGOING SITE VISITS	**1. Site visit on 3/26/24 to 3/27/24** • Five CDPH surveyors investigated a total of nine (9) Anonymous Complaints from 2022. ○ 2 - Quality of Care, Resident Abuse, Injury of Unknown, Residents Rights ○ 2 – Admission, Transfer, Discharge ○ 1 – Restraint ○ 2 – Quality of Care ○ 1 – Death ○ 1 - Staffing • Investigation completed with preliminary findings of "No Deficiency" on the nine (9) Anonymous Complaints that were investigated.
PENDING SITE VISITS	**223 FRI pending without document request or call/visit.**
UPCOMING SURVEYS	**None.**

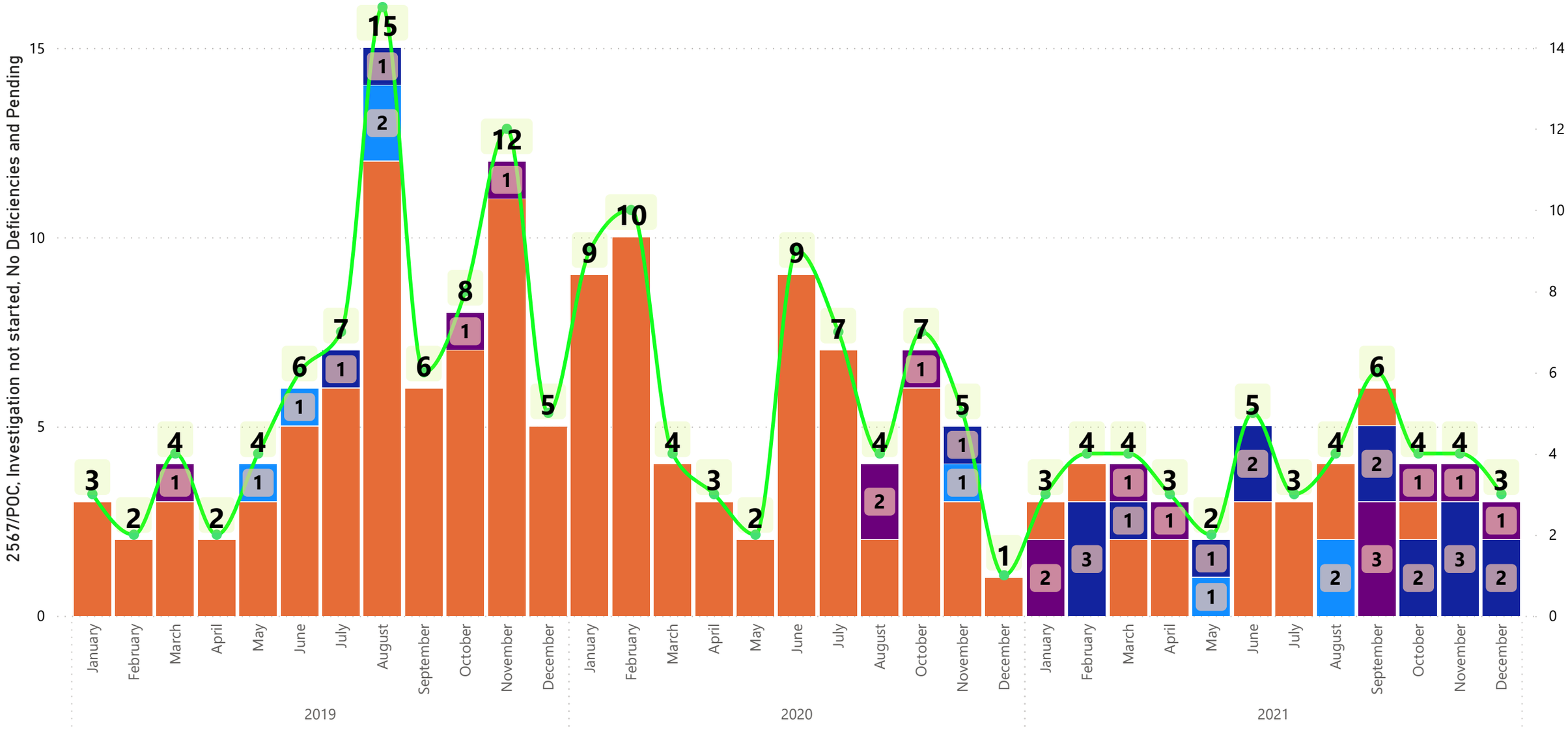
Outcome of FRIs 2019,2020,2021



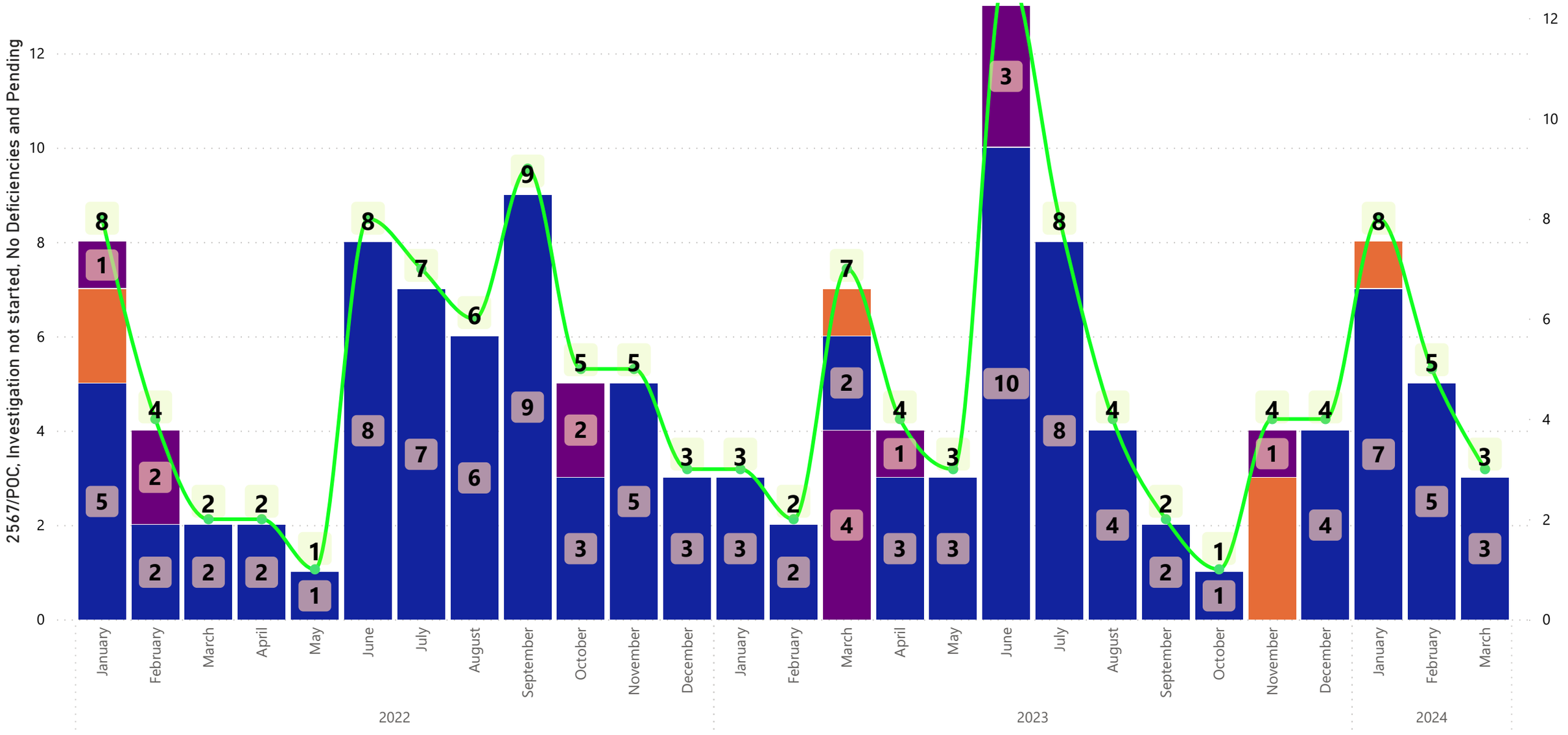
Outcome of FRIs 2022,2023,2024



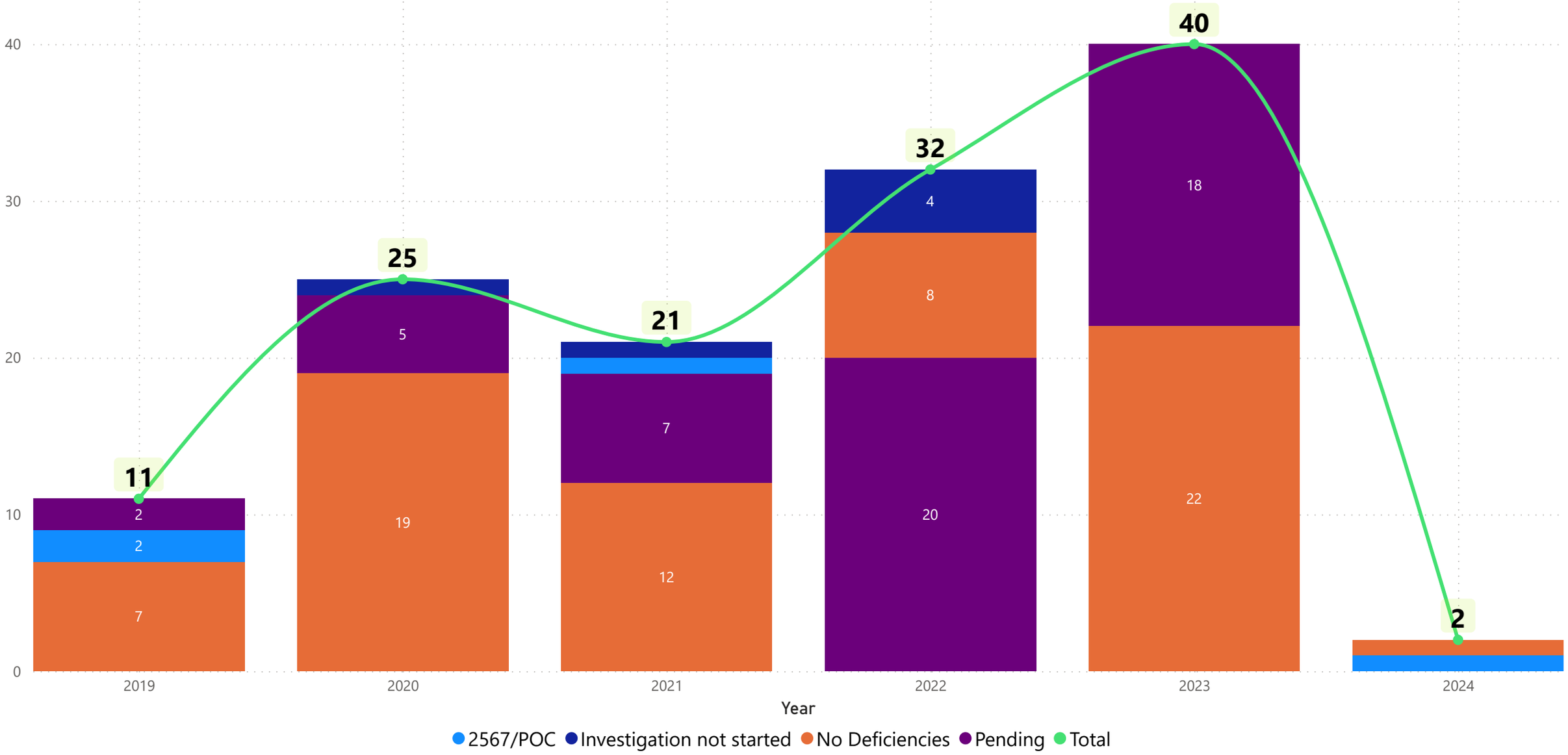
Staff to Resident Abuse Allegations 2019,2020,2021



Staff to Resident Abuse Allegations 2022,2023,2024



Anonymous Complaints



Staff to Resident theft 2019-2024