

ADMISSION TO LAGUNA HONDA ACUTE AND SNF SERVICES AND RELOCATION BETWEEN LAGUNA HONDA SNF UNITS

POLICY:

Prospective residents are welcome to Laguna Honda Hospital and Rehabilitation Center (LHH) regardless of race, color, creed, religion, national origin, ancestry, gender, sexual orientation, disability, HIV status or related condition, marital status, political affiliation, or age over 16. LHH shall comply with California and federal laws pertaining to non-discrimination.

1. LHH shall accept and care for those San Francisco residents:
 - a. Who meet skilled nursing facility (SNF), SNF rehabilitation, acute medical or acute rehabilitation inpatient rehabilitation facility (IRF) care criteria.
 - b. For whom it can provide safe and adequate care; and/or
 - c. Who are at least 16 years of age.
2. Applicants for admission to LHH shall be screened prior to any admission.
3. LHH shall assess the physical, mental, social and emotional needs of new and current residents to determine whether Laguna Honda Hospital's care environment is best able to meet these needs.
4. LHH shall accept pre-scheduled admissions of new and returning patients Monday through Friday.
5. LHH shall accept residents to the first available SNF bed appropriate to meet their clinical care needs when they have lost their bed hold.
6. New and returning patients may be admitted on Saturdays and Sundays if pre-arranged on Friday.
7. LHH shall centrally coordinate resident relocations to:
 - a. Optimize utilization of resources;
 - b. Optimize bed availability for new admissions; and
 - c. Minimize the potential for adverse impact on the resident.
8. LHH shall notify residents and their surrogate decision-makers of plans for relocation within the facility.

9. In case of emergency and/or medical surge conditions:
 - a. LHH physician may temporarily admit a patient to an in-patient acute care or skilled nursing facility bed.
 - b. The patient's stay shall be documented according to established procedures (i.e.: Inpatient, Acute, SNF and/or Outpatient Clinic/Rehab).

PURPOSE:

1. To assure that all San Francisco residents in need of skilled nursing, acute or SNF rehabilitation services who are admitted to LHH receive care in the most appropriate service setting.
2. To allocate services in coordination with available hospital resources.
3. To provide a standard procedure for relocation of residents within the facility.

DEFINITIONS:

1. A&E means Admissions and Eligibility Department.
2. Bed hold means a bed shall be held for a specific resident discharged to an acute unit or facility. A bed may be held up to seven (7) days, with the date of discharge being day 1. A bed hold may not be placed on LHH acute unit beds.
3. PFC means Patient Flow Coordinator.
4. RCT means Resident Care Team.

PROCEDURE:

1. Admissibility and Screening Procedures

- a. In accordance with Section 115.1 of the San Francisco Health Code, admission priority to LHH shall be given to residents of San Francisco. Exceptions may be made by the LHH Nursing Home Administrator/Chief Executive Officer (NHA/CEO), or designee based on special clinical or humanitarian circumstances. Non-San Francisco residents will be reviewed periodically, if appropriate, for return to services in their county of origin.
- b. The LHH Chief Medical Officer (CMO) or designee shall be responsible for screening patients for admission to LHH to ensure that the facility admits only those patients for whom it can provide adequate care. The LHH CMO is the ultimate authority over admissions. The following sequential priority [(d) i-v] will be followed unless the LHH CMO or designee in his/her professional judgement,

based on risk assessment and the totality of circumstances consistent with the patient's best interest determines otherwise.

- c. LHH cannot adequately care for prospective residents with the following:
 - i. Communicable diseases for which isolation rooms are unavailable
 - ii. In police custody unless approved by CMO, NHA/CEO, Chief Nursing Officer (CNO) or designees.
 - iii. Ventilator
 - iv. Medical problem requiring Intensive Care Unit care
 - v. Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care
 - vi. Highly restrictive restraints
 - vii. Significant likelihood of unmanageable behavior endangering the safety or health of another resident, such as:
 - Actively suicidal, residents with +SI (low, med, high) that require 1:1 observation cannot be admitted
 - Violent or assaultive behavior
 - Criminal behavior including but not limited to possession of weapons, drug trafficking, possession or use of illegal drugs or drug paraphernalia
 - Sexual predation
 - Elopement or wandering not confinable with available elopement protections
- d. People are accepted to LHH who are confirmed residents of San Francisco and in need of skilled nursing and/or rehabilitation services based on the following priority guidelines:
 - i. 1st Priority:
Residents who were involuntarily transferred and meet the criteria for care at LHH will be considered new admissions and given first priority based on LHH's admission criteria
 - ii. 2nd Priority:

Persons not in a medical facility (e.g. home) who are currently receiving skilled nursing and/or rehabilitation services (e.g. home care for wounds) and are now in need of skilled nursing / rehabilitation care in a facility

iii. 3rd Priority:

Patients at a San Francisco Health Network (SFHN) facility who need skilled nursing and/or rehabilitation services and are ready for discharge to SNF level of care.

iv. 4th Priority:

Persons not in a medical facility who are receiving skilled nursing and/or rehabilitation services and are adequately cared for in their present circumstances but might be better served in a facility

v. 5th Priority:

Patients at non-SFHN medical facilities who require skilled nursing and/or rehabilitation services.

e. Screening of applicants:

i. The Screening Committee which includes the following: CMO or designee, CNO or designee, ad Patient Flow Coordinator, A&E, Utilization Management and other members as designated by the CEO, is responsible for screening referrals to LHH and accepting residents for admission.

ii. Patient/Resident referrals to the specialty units (Rehabilitation, Positive Care, and Palliative Care) will be screened and reviewed by the unit screening physician or screener.

iii. When an immediate decision is needed outside the regularly scheduled meeting times of the Screening Committee, the CMO or designee, and the CNO or designee will screen and approve resident referrals.

iv. The Screening Committee and/or the LHH Specialty Unit will request behavioral screening of potential admissions that have behavioral or psychiatric problems and/or history of substance misuse.

f. Admission of applicants:

i. LHH shall admit a patient only on a LHH Admitting Physician's order.

ii. With the exception of admission to acute care units (Acute Rehab and Acute Medical), all admissions must meet SNF-level criteria as defined by Title 22.

iii. Decisions about admitting a resident in a setting that restricts his/her movements at LHH must be made in accordance with each resident's individual

- needs and preferences and with the participation of the resident or surrogate in the placement decision and continuing care planning. ¹Residents lacking capacity for placement decisions may not have their movements restricted on a secure unit without the participation of a surrogate or conservator.
- iv. In all cases of admission from another facility, a physician-to-physician clinical hand off and a complete discharge summary is required.
 - g. Resolution of problem screening and admissions:
 - i. Problems shall be brought to the LHH CMO and LHH NHA/CEO for resolution.
 - ii. The LHH NHA/CEO shall have the final authority over admissions to LHH.
 - h. The LHH NHA/CEO shall serve as the LHH's review board in regard to any perceived discriminatory admission practices. Allegations from staff, patients, families, or others of perceived discriminatory admission practices shall be forwarded to this Committee for investigation and review.

2. Specific Admission Procedures

- a. Pre-Admission Procedures
 - i. The Conditions of Admission agreement shall state that all residents are assessed upon admission for appropriate placement and/or relocation within the facility.
 - ii. Residents (or their representatives) shall receive a copy of the Conditions of Admission agreement upon admission to the LHH. The Conditions of Admission agreement shall be reviewed and signed by the resident or the resident's surrogate decision-maker.
 - iii. Residents (or their representatives) shall receive a copy of the Laguna Honda House Rules and Responsibilities.
 - iv. The Screening Committee shall make placement decisions based on the identified physical, mental, social and emotional needs of the resident; family connection with staff, if any; and bed availability. The Screening Committee shall communicate with the nursing unit and the RCT, including the primary physician and nurse manager admitting the new resident.

¹ If stated purpose of a unit which prevents residents from free movement throughout the facility is to provide specialized care for residents who are cognitively impaired then placement in the unit is not considered involuntary seclusion, as long as care and services are provided in accordance with each residents' individual needs and preferences rather than for staff convenience, and as long as the resident, surrogate, or representative (if any) participates in the placement decision, and is involved in continuing care planning to assure placement continues to meet resident's needs and preferences." CMS Guidance To Surveyors, LTC Facilities/State Operating Manual F223(b).

- v. Referral sources may discuss the appropriateness of referrals with staff of admitting units, but no final admission decision can be made until Patient Flow has evaluated the referral packet.
- vi. The specialty unit RCTs may place and take care of residents on other units, e.g., in isolation rooms or in other satellite beds.

b. Acute Medical Unit

Policies Specific to Acute Medical Unit Neighborhood

- i. Only acutely ill LHH residents for whom appropriate medical care is available are admitted. Residents requiring surgical procedures, critical care, telemetry or hemodynamic monitoring cannot be accommodated on the Acute Medical Unit.
- ii. All admissions to the Acute Medical Unit are subject to ongoing utilization review as outlined in the Utilization Management Plan.
- iii. “Come and go” procedures or infusions for residents and patients not acutely ill will be allowed in the Acute Medical Unit only if licensed as an infusion clinic.

Procedures Specific to the Acute Medical Unit

- i. All residents admitted to the Acute Medical Unit, shall have a separate complete medical record covering the period of their acute hospitalization
- ii. Residents being evaluated for admission to the Acute Medical Unit with known or suspected Covid-19 may be admitted to PMA if specific criteria are met:
 - There is an available Airborne infection isolation room (AIIR) or an AIIR capable room can be made available within 5 hours. If there are no available AIIRs, or the acuity of the resident precludes waiting 5 hours, then the resident should be transferred to another acute care facility if within their goals of care.
 - The resident does not have comorbidities or coexisting acute conditions that might require urgent access to a level of care not available at the PMA (for example but not limited to advanced cardiac care or impending ventilatory support). These residents would require transfer to an outside acute care facility.
 - Decisions to admit/transfer Covid-19 positive or suspected residents should remain a joint discussion between the attending physicians, the resident, and their decisionmaker(s).

If the transferred resident is ruled out for Covid-19 and still meets PMA LOC, they should be moved to a non-AIIR room as soon as feasible.

Whenever a resident is admitted to the Acute Medical Unit from either a LHH SNF care unit or from the Rehabilitation Department, they are (discharged) on leave of absence from the previous care unit

- iii. A new SNF resident record shall be started upon the resident's re-admission to a SNF care unit, after the 7 days bed hold.

c. Acute and SNF Rehabilitation Care Units

Admission Criteria Specific to Acute and SNF Rehabilitation Care Units

- i. Presence of one or more major physical impairments which significantly interfere with the ability to function, and which require an inpatient interdisciplinary approach to effectively improve functional status.
- ii. Patient must be medically stable.
- iii. Patient requires rehabilitation physician management.
- iv. Patient requires the availability or supervision of rehabilitation nursing 24 hours daily in one or more of the following:
 - Training in bowel and bladder management
 - Training in self-care
 - Training or instruction in safety precautions
 - Cognitive function training
 - Behavioral modification and management
 - Training in communication

Admission Criteria Specific to Acute Rehabilitation Unit

- i. The LHH Pavilion Mezzanine Acute Rehabilitation Unit is designated as an Inpatient Rehabilitation Facility (IRF).
- ii. Patients must have significant functional deficits, as well as documented medical and nursing needs, regardless of diagnosis, that require:

- Close medical supervision by a physiatrist or other physician qualified by training and experience in rehabilitation.
 - 24 hour availability of nurses skilled in rehabilitation.
 - Active and ongoing intensive rehabilitation therapy program by multiple other licensed rehabilitation professionals (e.g., physical therapists, occupational therapists, speech language pathologists, and prosthetists and orthotists) in a time-intensive and medically-coordinated program. One of the therapy disciplines shall be physical or occupational therapy.
- iii. The medical and/or surgical stability and comorbidities of patients admitted to the unit must be:
- Manageable in the rehabilitation program
 - Permit participation in the rehabilitation program
- iv. Patients must be capable of fully participating in the patient rehabilitation program as evidenced by:
- Ability to respond to verbal, visual and/or tactile stimuli and to follow commands.
 - Ability to participate in an intensive level of rehabilitation (generally defined as 3 hours of therapy per day, 5 days per week).
- v. Patients must demonstrate the ability to progress towards objective and measurable functional goals that:
- Will offer practical and beneficial improvements.
 - Are expected to be achieved within a reasonable period of time.
- vi. Patients must require and intensive and coordinated interdisciplinary team approach to care.
- vii. Patients in most circumstances, have a home and available family or care providers such that there is a likelihood of returning the patient to home or a community-based environment.

Admission Criteria Specific to SNF Rehabilitation Unit

- i. The rehabilitation needs of the patient must include one of the following impairments or complex issues: impairment in activities of daily living, impairments in mobility, bowel/bladder dysfunction, cognitive dysfunction,

communication dysfunction, complicated prosthetic management, or other medical problems best addressed on the SNF-level Rehabilitation Unit.

- ii. Patient requires and has the ability to engage in at least one of the following therapies: physical therapy, occupational therapy, and/or speech therapy.
- iii. Patients must have a reasonable plan for functional improvement to achieve discharge into the community or relocation to a long term care unit.

Admission Procedures Specific to Acute Rehabilitation Unit

- i. A physiatrist or designee shall perform pre-admission screening (PAS) to assess the patient's ability to achieve significant improvement in a reasonable period of time with acute rehabilitation services. Pre-screening performed by a non-physiatrist must have a physiatrist co-sign that the patient meets the requirements for acute rehab (IRF) admission.
- ii. A new SNF record shall be started if the patient is discharged to a LHH SNF Care Unit.
- iii. Refer to Guidelines for Inpatient Rehabilitation Facility Documentation LHHPP 27- 06.

Admission Procedures specific to SNF Rehabilitation Unit

- i. The Chief of Rehabilitation Services or designee shall perform PAS to assess the patient's ability to achieve significant improvement in a reasonable period of time with rehabilitation services.
- d. Positive Care Unit

Admission Criteria Specific to the Positive Care Unit

- i. Patients who have HIV infection and require SNF level or palliative care and prefer an HIV / AIDS focused unit.
- e. Palliative Care Unit

Admission Criteria Specific to Palliative Care Unit

- i. Patients who have a terminal disease or would benefit from a palliative approach.
- f. Secure Memory Care Unit

Policies Specific to Secure Memory Care Unit

- i. The goals of the Secure Memory Care Unit are:
 - To promote the well-being and protect the health and safety of cognitively-impaired residents who might harm themselves by wandering or elopement; and
 - To meet the needs of cognitively-impaired residents with a stable and structured environment and specialized dementia programming.

Admission Criteria Specific to Secure Memory Care Unit

- i. Residents who are mobile.
- ii. Residents assessed by a physician as having serious cognitive impairment which prevents the resident from making medical decisions for themselves.
- iii. Residents assessed by clinical staff as being at risk for unsafe wandering or elopement; and
- iv. Resident who has a conservator or surrogate decision maker that agrees to placement of the resident in a secured setting, or who is a ZSFG patient or LHH resident with a conservatorship proceeding pending and the intended conservator does not disagree with placement of the resident in a secured setting.
- v. The requirements above do not preclude LHH from placing a resident in the memory care unit on an emergency basis to ensure the resident's safety but the placement must be authorized by the CMO.

Exclusion Criteria Specific to Secure Memory Care Unit

- i. Residents whose aggressive behavior cannot be safely managed in this setting.
- ii. Residents without surrogate or conservator.

Procedures Specific to Secure Memory Care Unit

- i. The Screening Committee personnel will coordinate admission in collaboration with the Secure Memory Care Neighborhood RCT.
- ii. On admission the attending physician will coordinate an interdisciplinary assessment including cognitive and/or behavioral consultation.

- iii. The RCT shall reevaluate residents for unit appropriateness one month after admission, then quarterly. The RCT shall explore interventions that may reduce the wandering/elopement risk and permit relocation to another unit. For cognitively incapacitated residents whose movements throughout the facility are restricted, the RCT shall document participation of the conservator or surrogate decision-maker in placement decision-making and care planning.
- iv. A resident of the LHH Secure Memory Care Unit shall be relocated as soon as practicably feasible to other LHH units or transferred to another facility or the community if the resident's status changes such that the resident is no longer mobile, the resident's cognitive status improves such that secured placement no longer is needed; or the resident's cognitive impairment is discovered to be caused primarily by a psychiatric rather than organic brain disorder.
- v. Permissible Exception: If a resident ceases wandering but demonstrates or expresses preferential adaptation to the unit and benefits from the specialized programming, continued residence in the unit may be allowed at the discretion of the physician and RCT. To ensure availability of Secure Memory Care Unit beds when needed, attempts shall be made to adapt such a resident to another unit.

3. Weekend Admissions

a. From ZSFG

- i. For readmissions, LHH primary physician shall refer the ZSFG team to LHH A&E once the patient is accepted.
- ii. Pre-scheduled admissions shall be accepted for Palliative Care, Positive Care, SNF and Acute Rehab (IRF) patients on the weekend.
- iii. Weekend admissions from ZSFG must be approved by the LHH admissions Screening Committee, and reviewed by the primary LHH team (including primary physician) by the Friday afternoon preceding admission.
- iv. LHH A&E shall inform ZSFG (UM and MSW) via LHH tracking and text page by 3pm on Friday of admissions scheduled for the weekend. LHH A&E shall inform ZSFG MSW of LHH primary physician's pager number.
- v. Approval by LHH weekend admitting physician is not required for admission.
- vi. LHH A&E shall complete the admission referral sheet and deliver this along with the referral packet to the unit scheduled to receive the weekend admission by Friday afternoon.

- vii. LHH primary physician shall receive clinical hand off from ZSFG physician by the Friday preceding the weekend admission, and a discharge summary must be available at the time of admission.
- viii. LHH nursing shall receive report from ZSFG nursing on the day of transfer.
- ix. LHH A&E shall remind ZSFG MSW to arrange ambulance transport to leave ZSFG no later than 11 am.
- x. Admissions are scheduled to arrive to LHH early in the day and no later than 12 noon.

4. Procedures Related to Coming and Going from the Hospital

- a. Return of current residents after come-and-go procedures at other acute facilities.
 - i. Before return of a LHH resident who has been referred to another facility for come-and-go surgery or other invasive medical care, the physician responsible for the resident at the other facility must provide a summary of information on the procedure that includes:
 - Procedures done
 - Complications, if any, both intra- and postoperative
 - New orders recommended for the first 24 hours at LHH
 - Recommendations for special studies and follow-up care
 - ii. A checklist reminding the responsible physician of the need for this information shall be sent with the resident from LHH to the other facility. The physician responsible for the resident at that facility may complete either the checklist or another form from their facility that provides the same information.
 - iii. If a resident is returned from another facility after come-and-go surgery or other medically invasive procedure without recommendations for follow-up care, the Laguna Hospital attending physician shall contact the physician responsible for the resident at the other facility and shall document the information in the medical record. If the regular unit attending physician is not present when the resident returns, the charge nurse will contact the on-call physician to carry out this policy.

5. Relocation of Current Resident From One SNF Unit to Another SNF Unit

- a. Relocation Guidelines

- i. Nurse Manager will explain process. Upon admission to a resident care unit, the nurse manager shall be responsible for explaining to the resident or surrogate decision maker (SDM) the process by which the RCT assesses the resident for the purpose of appropriate placement.
- ii. Decision criteria. Criteria for determining the appropriate unit shall be based on an assessment of the resident's needs, services available in the facility, including available shift staffing and skills within the respective care units. Decisions regarding resident relocation between units shall be made by the PFC in collaboration with the CMO or designee and CNO or designee and the respective referring and receiving resident care teams of the neighborhoods.
- iii. Relocation requests. Requests for relocation to another unit by the resident, surrogate, or RCT shall be evaluated by the PFC who facilitates the decision-making process.
- iv. Relocation. In the event that a resident is to be relocated involuntarily in order to better match the resident's needs with unit focus and resources, the nurse manager shall give the resident or representative notice in advance of relocation. This shall be documented by completing the Transfer of Room Notification form, which includes:
 - Reasons for the relocation;
 - Date the relocation will occur; and
 - The care unit to which the resident will be relocated.

The RCT shall take into consideration the resident's response in deciding whether to continue with the relocation. This discussion must be documented in the medical record. In a contested relocation the medical social worker (MSW) shall notify the ombudsman. Relocations shall not be proposed for the sole purpose of staff convenience, and solely for the purpose of medical/care needs.

- v. Problem resolution. Prior to making a relocation referral to the PFC for a reason other than a change in level of care, the RCT shall utilize resources at its disposal to resolve the problem, address the concern, or meet the need behind the referral.
- vi. Re-evaluation of problematic relocations. RCTs shall re-evaluate complex or problematic relocations and roommate assignments at least one month after the relocation.
- vii. Appeal route for conflict intervention. Conflicts about relocation process shall be referred to the CNO and CMO for joint resolution.

viii. Neighborhood moves. When large scale, permanent or temporary care unit moves are anticipated, the details of the move, such as how and when residents and families shall be informed, must be worked out in advance by the RCT.

ix. Relocation for Reasons of Transmissible Disease. Urgent permanent or temporary relocation to another unit may be necessary to mitigate spread of disease (e.g. COVID, active TB). When this is necessary, resident and appropriate family/surrogate decision maker(s) will be notified as soon as possible understanding that the relocation may need to occur prior to notification.

b. Relocation Procedures

i. All relocation requests, including plans for relocation to and from specialty units which accept direct admission from the community, shall be routed through the designated PFC. For relocations to specialty units, the PFC shall communicate with the unit RCT and A&E.

ii. The resident and appropriate family/surrogate decision maker(s) shall be notified in writing when the relocation is being planned and be informed of the reason and the estimated waiting period, if known. They shall be offered an opportunity to visit the new location and ask any questions that may arise.

iii. The sending unit nurse manager shall communicate with the receiving unit nurse manager prior to relocation and the sending physician shall communicate with the receiving unit physician, if possible, at least one day in advance of the relocation.

iv. Once an appropriate bed becomes available, the PFC shall confirm relocation plans and confirm that the sending and receiving care units are notified.

v. A physician's order is required for the relocation.

vi. To promote continuity in care, the sending physician shall document in the medical record, a relocation note.

vii. The receiving RCT shall review the existing treatment plans initiated by the previous team and review the plan and all changes with the resident.

viii. Each discipline shall take appropriate measures to assure continuity of care.

ix. Ancillary Service departments, who receive the Daily Census report, shall make this information available to clinical staff on a daily basis so that caregivers can track resident transfers and readmissions.

ATTACHMENT:

Appendix A: Relocation Checklist for Individual Resident

Appendix B: Behavioral Screening

Appendix C: LHH Palliative Care Program

REFERENCE:

LHHPP 20-10 Transfer and Discharge Notification

LHHPP 22-03 Resident Rights

LHHPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)

LHHPP 24-06 Resident and Visitor Complaints/Grievances

LHHPP 70-01 C04 Laguna Honda Hospital Medical Surge Plan for Nursing Home Incident Command Activation Due to Public Health Emergency / Mass Casualty Event

Internet Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual

Internet Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual

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