List of Hospital-wide/Departmental Policies and Procedures Submitted to JCC for Approval on April 14, 2025

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revised	LHHPP	01-01	Approval and Format of Hospital-wide and Departmental Policies and Procedures	**N. Zahir**	Deleted "The Administrative designee shall be responsible for archiving copies of the LHHPP on the designated shared network drive."
Revised	LHHPP	22-01	Abuse and Neglect Prevention, Identification, Investigation Protection, Reporting and Response	**N. Zahir**	1. Added "Quality Assurance Performance Improvement " 2. Added "Certified Nurse Assistant "
Revised	LHHPP	22-06	Residents' Council	**J. Carton-Wade**	1. Replaced "Hospital staff members" with "LHH staff" 2. Added "shall" 3. Replaced "Nursing" with "Nurse" 4. Replaced "Hospital" with "LHH"
Revised	LHHPP	22-11	Resident Freedom from Abuse on Social Media	**N. Zahir**	Replaced "his/her" with "their" throughout the document.
Revised	LHHPP	22-12	Clinical Search Protocol	**N. Zahir**	1. Replaced "Clinical or facility" with "LHH" 2. Added "San Francisco Sherrif Office "
Revised	LHHPP	23-02	Completion of Resident Assessment Instrument/Minimum Data Set (RAI/MDS)	**M. Antoc**	1. Added definitions 2. Deleted "see Standard Work for Significant Change in Status Assessment"
Revised	LHHPP	23-03	Screening and Response to Suicidal Ideation	**Y. Qian**	1. Deleted "no longer has the motivation to live" throughout the document. 2. Added "expresses thoughts regarding death " 4. Added "provider assessment" 5. Replaced "psychiatry clinician" with "consulting" 6. Deleted "SI" 7. Added "suicide" 8. Updated reference section
Revised	LHHPP	24-03	Support Surfaces	**T. Brown** **T. Grados**	1. Replaced "Central Processing Department (CPD)" with "Materials Management (MM)" 2. Deleted "Nurse" 3. Added "an Environmental Services "
Revised	LHHPP	24-06	Resident/Patient and Visitor Complaints/Grievances	**A. Fishman**	Added "In the event that the grievance cannot be resolved within 10 business days, the Grievance Official will inform the resident/patient of the plan to resolve the grievance and the estimated time frame to resolution. The Grievance Official will continue to monitor the progress until the grievance has been resolved, and communicate with the resident/patient regarding the progress to resolving the grievance."
Revised	LHHPP	24-07	Resident Visitation	**N. Zahir**	1. Added "and or their representative," 2. Deleted " (or the resident/patient representative, where appropriate)" 3. Added "the federal, state, and" 4. Deleted "CMS, CDC"
Revised	LHHPP	29-04	Cremation Assistance	**L. Conover**	1. Added "the" 2. Deleted ","

Revised	LHHPP	29-06	Caring for the Deceased, Use of Morgue, and Provision of Death Certificates	**T. Brown** **T. Grados**	1. Deleted "over the a weekend" 2. Added "on a legal" 3. Deleted "Signing the Death Certificate shall wait until the care unit attending physician/designee is available" 4. Added "The death certificate shall be signed by the primary attending physician or designee by the next business day" 5. Added "requires immediate completion of" 6. Deleted "insists on immediately receiving" 7. Added "as the “certifier" 8. Added "The name and address of the primary attending physician will be entered into block 118: Attending Physician’s Name." 9. Deleted "but the on call the house night/weekend physician shall print or type the care unit attending physician's name in the appropriate signature block."
Revised	LHHPP	29-07	Human Subject Research	**N. Zahir**	1. Added "/Nursing Home Administrator" 2. Added "/NHA" throughout the document 3. Added "active" 4. Deleted "will provide the DPH Research Proposal Approval form for completion and submission" 5. Added "will direct investigators to the UCSF Research Protocol / Approvals at ZSFG/SFDPH: UCSF Research Protocol Approvals at ZSFG/SFDPH: https://zsfg.ucsf.edu/research-protocol-applications-zsfg" 6. Deleted "(link below)." 7. Added " The research application should be completed with the appropriate signatures from LHH obtained." 8. Added "The appropriate signatures will need to be obtained to complete the UCSF Research at SFDPH Research Protocol Application."
Delete	LHHPP	29-09	Accommodation of the Family After Patient's Death	**N. Zahir**	Reason for deletion -The California Health and Safety Code Section 1254.4 does not apply to LHH
Revised	FNSPP	1.143	Food Supply & Storage	**M. Adusumalli**	1. Deleted – Established and 8/81, 1/89, 1/92, 9/94, 5/97, 9/06, 7/09, 1/10. 2. Deleted- Reviewed: 8/13,8/14 3. Deleted - Metal 4. Replaced- a with A ; 36- 38^{o}F with 40^{o}F or below 5. Replaced- b with B ; 36- 38^{o}F with 40^{o}F or below 6. Replaced- c with C ; 30- 38^{o}F with 40^{o}F or below 7. Replaced- d with D ; 10- 20^{o}F with 0^{o}F or below 8. Replaced and/or assistant Food Service Director with supervisor or designee. 9. Deleted- of time 10. Added- a in cryovac 11. Added- or per manufacturer recommendation. 12. Deleted – Operations 13. Deleted -Production 14. Updated 11/6/2015 to 7/2024
Revised	FNSPP	1.59	Authorized Personnel Only	**M. Adusumalli**	1. Deleted- Established and 3/81, 1/89, 5/97, 9/06, 7/09. Reviewed, 8/13,8/14 2. Added- 7/2024. 3. Deleted-space in non food 4. Added- when 5. Added- Authorized personal or visitors must adhere to safe food safety practices and safety precautions to prevent injury. 6. Deleted -space in non food 7. Deleted- to do so. 8. Added- Shoes must cover the entire foot (no open toe, high heel, and/ or slippery shoes or sandals). 9. Added- contractors 10. Replaced- going to with entering. 11. Added- wash their hands and 12. Added- personal protective equipment(PPE) , prior entering the department. 13. Removed- hair covering 14. Deleted footer date 11/6/2015.

Revised	FNSPP	1.165	General Cleaning and Sanitizing work Surfaces and Kitchen or Galley Equipment	**M. Adusumalli**	Deleted - 8/13, 8/14. Added -7/2024 Added – “s” to begin Replaced - are with ‘is” Replaced- Rags with “cloths”. Replaced- Tuff Suds Detergent with “department approved detergent” Replaced – MikroKlene with “department approved sanitizer” Updated footer date to 7/2024 in place of11/6/2015
Revised	FNSPP	1.93	Food Preparation Standards	**M. Adusumalli**	1. Removed- Established and revised: 5/98, 9/06, 7/09, 11/10, 11/22, 8/13, 8/14 2. Deleted – always 3. Added - at all times. 4. Replaced 140 with 135^{o}F 5. Added - ^{o}F 6. Updated Footer- 11/29/2022 with 7/2024
Revised	NSPP	E 5.0	Enteral Tube Feeding Management	**J. Selerio**	1. New policy #7 added – this was removed from HW 26-03 and added to NPP to remove duplication 2. Rulers used for measurement changed from reusable to disposable 3. Removed section re: open system due to only closed systems being used hospitalwide 4. Update reference to Elsevier 5. Removed Enteral Nutrition Charge For – no longer being used 6. Appendix 1 slated for deletion as LHH only uses closed systems 7. Appendix 2 is obsolete as new pumps go live on 3/17/2025 8. Appendix 3 = appendix

Revised Hospital-wide Policies and Procedures

APPROVAL AND FORMAT OF HOSPITAL-WIDE AND DEPARTMENTAL POLICIES AND PROCEDURES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) establishes, issues, and maintains Laguna Honda Hospital-wide Policies and Procedures (LHHPP).

2. LHHPP shall be implemented only after approval of the Performance Improvement and Patient Safety (PIPS) Committee and the Joint Conference Committee (JCC); unless resident safety may be impacted and/or there is a DPH Director of Health mandate.

3. Each department manager/supervisor is responsible for maintaining a current manual of their Departmental Policies and Procedures (DPP).

4. DPPs that impact disease/clinical care management require approval by the Nursing Executive Committee (NEC) and Medical Executive Committee (MEC) prior to implementation.

5. LHHPPs and DPPs shall be reviewed at least every year in accordance with Title 22 requirements.

6. A standardized formatting template shall be utilized for LHHPPs (refer to LHHPP 01-11).

7. The file numbers of deleted LHHPPs may be re-assigned to newly developed LHHPP the following year, after the annual review of process for LHHPPs for the calendar year.

8. LHH areas that have access to the San Francisco Health Network (SFHN) internet website are not required to maintain a hard copy of the LHHPP or Nursing DPP.

PURPOSE:

1. To provide unified and consistent statements for LHHPP and DPP.

2. To describe procedures for developing and reviewing departmental policies and procedures at LHH.

CHARACTERISTIC:

1. A LHHPP describes activities or processes:

    a. which must be executed by more than one department.

2. LHHPPs have broad application. They do not focus on the function and systems of individual departments and divisions. LHHPPs define administrative responsibility and staff performance relating to specified administrative and resident/patient care functions.

3. A DPP describes activities or processes:

   a. which occur within and need to be understood and executed only by the issuing department; or

   b. which may occur Hospital-wide but is executed only by a single department.

PROCEDURE:

1. Hospital-wide Policies and Procedures

   a. New LHHPP may be generated by:

      i. The chairperson of a medical staff committee,

      ii. The administrative liaison to a medical staff committee,

      iii. The chairperson of an administrative/clinical committee,

      iv. The chairperson of an ad hoc committee, or

      v. A member of the LHH executive staff.

   b. Revision of an existing policy and procedure may be initiated by the same person(s) identified above. The person initiating the revision shall request for the Word document of the LHHPP being revised from the Administrative designee. Track changes shall be used to mark the proposed changes in the document.

   c. The draft of the new or substantially revised policy and procedure shall be submitted to the following individuals:

      i. Chair of NEC

      ii. Chair of MEC

      iii. Co-Chairs of PIPS

      iv. Administrative designee (as determined by the Chief Quality Officer), for coordination purposes.

d. The Administrative designee shall be responsible for issuing new LHHPP file numbers.

e. The standardized formatting template shall be utilized for developing policies and procedures when creating the new LHHPP.

f. NEC and MEC shall review and approve all LHHPP to ensure that the procedures agree with sound hospital, administrative, medical, nursing and/or clinical practice.

g. The PIPS Committee shall review and ensure that the policies and procedures agree with the administrative philosophy and Department of Public Health guidelines.

h. All new and revised LHHPPs require approval by NEC, MEC and PIPS, and shall be sent to the respective chairs of these committees.

i. The Administrative designee shall send the policy to appropriate individuals, committees, departments or services for review. This will help ensure that the policy agrees with current policies and practices and does not duplicate other policies. The following factors shall be taken into consideration as appropriate in order to conduct a substantive review:

    i. Relevance to other policies and procedures,

    ii. Relevance to standards of care and standards of practice,

    iii. Ethical and legal concerns,

    iv. Current scientific knowledge, and

    v. Findings from quality improvements/assurance activities

j. The policy approval process shall be sequenced in the following order: NEC, MEC, PIPS and the governing body as soon as practical.

k. When final approval is reached, the newly developed or revised LHHPP may be posted on the intranet.

l. The Administrative designee shall place the LHHPP on the calendar for an annual review by the PIPS Committee.

m. All existing LHHPP shall be submitted for an annual review to the Chief Executive Officer (CEO), Chief Medical Officer (CMO), Chief of Staff, Physician Advisor if applicable, Division Head, and Department Manager/Coordinator at the designated Annual Policy and Procedure Review meeting each year.

n. Annual review and approval of existing LHHPP shall be scheduled for review and approval by the governing body as soon as practical.

o. The Division Heads and Department Managers are responsible for disseminating information to LHH staff about new policies and revisions of existing policies and ensuring that LHHPPs are implemented at the departmental level.

p. All LHHPPs are available on the LHH and SFHN Intranet.

i. The webpage is maintained by the Administrative designee.

ii. Staff are educated and trained on how to access the policy and procedures on the SFHN website.

~~iii. The Administrative designee shall be responsible for archiving copies of the LHHPP on the designated shared network drive.~~

2. Departmental Policies and Procedures (DPP)

a. DPP must be specific to the operation of each department and define the specific scope and activities of the Department in accordance with applicable state and federal regulations.

b. Department Heads may propose to transform a DPP to a LHHPP when appropriate.

c. Department Heads are responsible for:

i. Obtaining the approval of the responsible Division Head;

ii. Maintaining at least one copy in the Department Manager's office.

iii. Training employees to standards set forth in the manual.

iv. All existing DPP shall be submitted for an annual review to the CEO, CMO, Chief of Staff, Physician Advisor if applicable, Division Head, and Department Manager at the designated Annual Policy and Procedure Review meeting each year.

d. Each Department must have the following elements within their DPP, unless they are delineated by existing LHHPP:

i. Department structure and organization;

ii. Scope of service;

iii. Applicable policies required for licensing standards and by State and Federal regulations;

iv. Policies and procedures pertaining to administrative, resident/patient, and medical care activities unique to the Department;

v. Protocols implementing or supplementing existing LHH personnel practices; and

vi. Education and training requirements.

e. Department specific procedures may supplement existing LHHPP for the following areas:

i. Infection control guidelines;

ii. Departmental response to both internal and external disasters and emergencies (e.g., fires, mass casualty disasters, and power failures);

iii. Performance improvement;

iv. Environment of care;

v. Contract requirements (i.e., managed care contracts); and/or

vi. Health and safety requirements.

f. Approval Process for DPP

i. The Department Manager/Director gives the initial approval for the policy.

ii. When the implementation of a DPP involves other Departments, the Department Managers of these Departments review, comment, and approve the development or revision of the Policy or Procedure.

iii. When DPPs impact disease/clinical care management, the appropriate health professional and administration shall be consulted. The new or revised DPP shall be implemented after review and approval by NEC and MEC.

iv. DPPs shall be reviewed by the hospital governing body for approval as soon as practical.

g. Implementation of DPP

i. The Department Managers are responsible for implementing DPP and for ensuring that the current DPP are readily accessible to all staff.

h. The Department Manager shall be responsible for retention of the Policy and Procedures Archives.

i. The Department Manager of each unit shall be delegated the responsibility for retaining original versions of all DPP for seven (7) years from date of origin, revision or deletion.

3. List of Minor Revisions Not Subject to JCC Approval

a. Refinements to formatting and layout;

b. Correction of typographical errors;

c. Correction of grammar and punctuation;

d. Changes to procedure titles;

e. Renumbering of policies and procedures;

f. Informational updates to appendices (e.g. names of personnel, contact numbers, name of vendor(s), etc.)

ATTACHMENT:
None.

REFERENCE:
LHHPP 01-10 Departmental Responsibility and Accountability
LHHPP 01-11 Standard Formatting Template for Policies and Procedures
Standard Work for Hospital-wide and Departmental Policies & Procedures (P&P) Committee Review and JCC Approval

Reviewed: (Year/Month/Day)

Revised: 08/07/22, 10/08/24, 10/12/03, 13/05/28, 13/09/24, 15/07/14, 16/01/12, 16/09/13, 19/03/12, 20/09/08, 22/02/08, 25/02/03, 25/04/14 (Year/Month/Day)

Original adoption: 92/05/20

ABUSE AND NEGLECT PREVENTION, IDENTIFICATION, INVESTIGATION, PROTECTION, REPORTING AND RESPONSE

PHILOSOPHY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall promote an environment that enhances resident well-being and protects residents from abuse, neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

POLICY:

1. LHH employees, contractors, and volunteers shall provide a safe environment and protect residents from abuse, neglect, misappropriation of property, exploitation, and use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's condition.

2. All LHH employees, contractors, and volunteers are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse.

3. LHH employees, contractors, and volunteers shall immediately respond to observed or suspected incidents of abuse.

4. LHH employees, contractors, and volunteers shall report alleged violations to the California Department of Public Health (CDPH), the Ombudsman, and Nursing Operations within specified timeframes:

    a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or

    b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

5. The LHH Department of Education and Training (DET) shall be responsible for developing curricula for and training all employees, volunteers, and contractors on abuse prevention and timely reporting.

6. LHH Department Managers are responsible for monitoring staff compliance with this policy and LHH Quality Management (QM) and Human Resources (HR) departments shall be responsible for the process oversight.

7. LHH shall not employ or otherwise engage individuals who:

    a. have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

b. have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; and/or

c. have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

8. LHH will promote a culture of safety and open communication where retaliation against any persons who lawfully reports a reasonable suspicion of resident abuse, causes a lawful report to be made, or takes steps in furtherance of making a lawful report is strictly prohibited.

9. Pursuant to Section 1150B of the Social Security Act, LHH employees, contractors, and volunteers shall report any reasonable suspicion of a crime committed against a resident of this facility.

10. LHH shall complete their internal investigation within 5 working days of the reported incident.

PURPOSE:

1. To protect the resident from abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

2. To report incidents or alleged violations of abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms without fear of retaliation and in a timely manner.

3. To promptly investigate allegations of abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

4. To provide clinical interventions to prevent and minimize abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

5. To meet reporting requirements as mandated by federal and state laws and regulations.

6. To establish coordination with the Quality Assurance Performance Improvement (QAPI) program.

DEFINITION:

1. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.

    a. "Verbal Abuse" means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.

    b. "Sexual Abuse" is non-consensual sexual contact of any type with a resident.

    c. "Physical Abuse" includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment.

    d. "Mental Abuse" includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s).

    e. Financial abuse includes, but is not limited to, wrongful, temporary, or permanent use of a resident's money without the resident's consent.

2. "Willful," means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

3. "Neglect" means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

4. "Exploitation" means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.

5. "Misappropriation of Resident Property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.

6. "Involuntary Seclusion" refers to the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs as long as the least restrictive approach is used for the minimum amount of time.

7. "Injuries of unknown source" should be classified as an "injury of unknown source" when all of the following criteria are met:

    a. The source of the injury was not observed by any person; and

    b. The source of the injury could not be explained by the resident; and

    c. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

8. "Crime" is defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township or village, or any local unit of government created by or pursuant to State law.

9. "Serious Bodily Injury" means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse.

10. "Criminal sexual abuse" is serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under State law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act.

PROCEDURE:

1. Screening of Potential Employees

a. Criminal Background Checks

i. Applicants for employment at LHH must submit to fingerprinting by federal authorities and must have a clear background check prior to processing of any appointments for hire at LHH. This is required in addition to the existing bi-annual fingerprinting and background check process in the State of California for initial certification and continued Certified Nurse Assistant (CNA) certification as a condition of employment.

ii. LHH will screen employees for a history of abuse, neglect or mistreating residents by attempting to obtain information from previous employers and/or current employers and checking with the appropriate licensing boards and registries.

iii. Registry agencies will provide documentation of screening of staff to LHH.

iv. LHH will maintain document of proof that screening occurred.

b. Experience and References

i. Applicants for employment shall provide a photocopy of certification and verification (including references) of qualifying experience. The facility will make reasonable efforts to verify previous employment and to obtain information from previous and/or current employers.

2. Education

a. Employee and Volunteer Education

i. New employees, registry staff, and volunteers, including transfers or inter-facility reassignments to LHH, shall, as a condition of employment, review and sign a statement acknowledging the prohibition against the abuse of elder and dependent adults and the obligation to report such abuse. A copy of the signed statement "Dependent Adult/Elder Abuse Prohibition and Reporting Requirement" shall be kept in the employee's/volunteer's personnel file.

ii. New employees, registry staff, and volunteers, including transfers or inter-facility reassignments to LHH, shall, as a condition of employment, participate in "The Abuse Prohibition/Prevention Program", which includes the following:

- Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation;
- Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property;
- Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators;

- Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources;
- Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as:
  - Aggressive and/or catastrophic reactions of residents;
  - Wandering or elopement-type behaviors;
  - Resistance to care;
  - Outbursts or yelling out; and
  - Difficulty in adjusting to new routines or staff.
- Facility orientation program on residents' rights, including confidentiality, preservation of dignity, identifying what constitutes abuse, and recognizing and reporting abuse without fear of retaliation;
- Nonviolent safety management and prevention of challenging behaviors**;**
- Annual in-service education provided by the Department of Education and Training (DET) to all employees, which includes a review of residents' rights, abuse and neglect prohibition/prevention, mandated reporting, and resident and employee freedom from retaliation when reporting abuse allegations.
- DET shall provide additional abuse and neglect prevention training to nursing and other staff annually, including recognition of psychological, behavioral, or psychosocial indicators of abuse, recognition of environmental factors that could potentially lead to abuse, and other pertinent abuse and neglect prevention and response educational topics.
- Annual performance appraisals will include a competency to assess knowledge of employee's abuse prevention.

b. Employees shall be informed of their rights during New Employee Orientation (NEO) and through posted information in the Human Resources Department. This shall include the right to file a complaint with the State Survey Agency if anyone at LHH retaliates against an employee who files a report of a reasonable suspicion of a crime committed against a resident to a law enforcement agency (such as the San Francisco Sheriff's Office (SFSO) at 4-2319).

i. Information on employee rights related to reporting a crime or retaliation shall be posted in HR.

ii. Retaliation includes but not limited to demotion, suspension, threats, harassment, denial of promotion or other employment-related benefit, or discrimination in the terms and conditions of employment.

iii. LHH shall not file a complaint or a report against a nurse or other employee with the appropriate state professional disciplinary agency because of lawful acts done by the nurse or employee.

c. Resident Education

i. Residents are presented on admission with a Residents' Handbook that contains information on residents' rights and responsibilities, contacting advocates, and the abuse reporting process. Residents are informed to whom they may report concerns, incidents and complaints.

ii. A listing of Residents' Rights shall be posted on each unit.

iii. Resident education topics such as reporting abuse, neglect, exploitation and/or mistreatment shall be reviewed at the neighborhood/unit community meetings at least twice a year or more frequently as determined by the Resident Care Team (RCT).

3. Prevention

a. LHH shall identify, correct, and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.

b. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.

c. LHH shall ensure the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions.

d. Staff (including registry staff) shall be trained in nonviolent safety management and prevention of challenging behaviors, which includes assessment, response techniques, and tools to prevent and identify potential crisis and/or de-escalate challenging behaviors. Training includes:

i. Nonverbal communication

ii. Para verbal communication

iii. Verbal communication

iv. Precipitating factors, rational detachment and the integrated experience

v. Staff fear and anxiety

vi. Decision making

vii. Physical interventions (disengagement skills) as a last resort

viii. Debriefing

e. Staff and families shall be provided with information on how and whom they may report concerns, incidents and grievances, as well as feedback regarding their expressed concerns (see procedure 2.a. Employee and Volunteer Education).

f. RCT members and clinical staff shall conduct ongoing resident assessments, revise care plans as needed, and monitor resident's needs and behaviors that may lead to conflict or neglect (see procedure 9 Resident Assessment and Care Planning).

4. Identification: Signs of Possible Abuse, Neglect, Misappropriation of Resident Property, or Exploitation

a. Abuse may result in psychological, behavioral, or psychosocial outcomes. The following signs may alert LHH staff to possible resident abuse and indicate the need for immediate reporting, response, and investigation:

i. Statements from a resident alleging abuse, neglect, misappropriation of resident property, or exploitation (including involuntary seclusion and unreasonable confinement) by staff, another resident, or visitor;

ii. Sounds and/or utterances that suggest physical or verbal abuse, neglect, misappropriation of resident property, or exploitation, chemical or physical restraints;

iii. Injuries, abrasions, falls, or bruises of unknown or suspicious origin and/or location;

iv. Illogical accounts given by resident or staff member of how an injury occurred;

v. Sudden or unexplained changes in resident's personality or behavior(s) such as aggressive or disruptive behavior, running away, fear of being around a

certain person or being in a particular context, withdrawal, isolating oneself, expressions of guilt and/or shame, depression, crying, talk of suicide and/or attempts, disturbed sleep;

vi. Resident asks to be separated from caregiver or accuses caregiver of mistreatment;

vii. Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning & positioning

viii. Resident-to-resident altercations;

ix. Visitor-to-resident altercations;

x. Unexplained contraction of sexually transmitted diseases, vaginal or anal bleeding, or torn and/or bloodied underclothing.

xi. Evidence of photographs or videos of a resident that are demeaning or humiliating in nature, regardless of whether the resident provided consent and regardless of the resident's cognitive status.

xii. Sudden or unexplained changes in behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame.

b. These signs may indicate that mental and/or verbal, sexual, or physical abuse, and/or the deprivation of goods and services has occurred; in the event that an indicator becomes apparent, LHH staff should immediately respond to and report the potential abuse.

5. Protection: Staff/Volunteer Intervention

a. In the event that an employee/volunteer/contractor:

i. Observes abuse,

ii. Suspects that abuse has occurred,

iii. Observes resident–to-resident or visitor-to-resident altercation,

iv. Identifies an injury of unknown source/ origin,

v. Learns about an allegation of abuse, neglect or exploitation of any LHH resident, and/or is the first person to learn of a resident-to-resident or visitor-to-resident altercation, that employee/contractor/volunteer shall immediately attempt to identify the involved resident(s) and notify the responsible manager and the nurse manager or nursing supervisor.

b. The employee and/or responsible managers shall take immediate measures to assure resident safety as follows:

   i. In the event of alleged employee to resident abuse, neglect or exploitation, the responsible manager shall remove the alleged employee from the resident care area and inform Human Resources to place the employee on administrative leave. These measures shall be in place until the investigation is completed.

   ii. In the event of alleged resident-to-resident abuse or resident-to-resident altercation, the employee shall immediately separate the residents and move each resident to a safe area apart from one another until the incident is addressed by the responsible manager/supervisor.

c. The responsible nursing manager shall document the incident in each respective involved resident's medical record and develop or revise care plan as necessary.

d. Upon receiving a report of alleged abuse, neglect or exploitation, the licensed nurse shall assess the resident for any injury, pain, mental anguish, or potential change in condition. The attending or on-call physician shall be promptly notified of any allegation of abuse, neglect, or exploitation and shall complete a physician assessment of the resident.

   i. The physician shall document the history of abuse as relayed, any findings of the assessment and psychological evaluation, and any treatment initiated. The physician shall, in the event of a resident-to-resident altercation, perform a physical exam on both residents and record in the progress notes of both residents' medical records the history, examination findings, psychological evaluation and any treatment initiated.

e. The Medical Social Services Worker shall follow-up with the resident within 72 hours to assess and to provide psychosocial support.

6. Reporting Protocol

a. All LHH employees, volunteers, and contractors are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse.

   i. The mandated reporter shall immediately respond to the observed or suspected incident(s).

   ii. Reporting shall be completed within the specified timeframes:

   - Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or

- Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

iii. Reporting shall be to the following agencies in the above specified timeframes:

- CDPH (415) 330-6353
- Ombudsman (415) 751-9788
- Nursing Operations (415) 327-1902

iv. QM will assist the staff, contractor, or volunteer with reporting requirements and ensure specified timelines are followed accordingly for both the initial and follow-up investigation reports, and any other State level required reporting.

v. The mandated reporter may report anonymously to each internal and/or external agency.

b. LHH mandates suspected abuse to be reported to the local Ombudsman office as required by State law.

c. LHH shall report to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service.

d. LHH also requires any reasonable suspicion of a crime committed against a resident of LHH be reported to SFSO.

i. LHH will work with SFSO annually to determine which crimes are reportable.

ii. Examples of crimes that are reportable include but are not limited to the following:

- Murder;
- Manslaughter;
- Rape;
- Assault and battery;
- Sexual abuse;
- Theft/Robbery

- Drug diversion for personal use or gain;
- Identity theft; and
- Fraud and forgery.
- Certain cases of abuse, neglect, and exploitation

e. Notification requirements:

i. Within 2 hours: Events involving crimes or suspicion of crimes that result in bodily injuries; and alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.

ii. Within 24 hours: Events involving crimes or suspicion of crimes that do not result in serious bodily injury; and allegations of abuse that are not substantiated and do not result in serious bodily injury.

iii. The mandated reporter shall report the incident to CDPH, the Ombudsman and Nursing Operations.

iv. Nursing Operations shall immediately notify the Nursing Home Administrator (NHA)/Chief Executive Officer (CEO), SFSO, and QM.

f. The Abuse Prevention Coordinator, nurse manager, charge nurse, and nursing supervisor shall communicate to inform one another of the alleged abuse. The nurse manager, charge nurse, and nursing supervisor shall:

i. Immediately notify the attending or on-call physician of the alleged abuse;

ii. Immediately inform the resident and/or surrogate decision-maker that the abuse allegation is being taken seriously; identify for the resident and/or the surrogate decision-maker the steps being taken to provide for the resident's safety; and assure the resident and/or the surrogate decision-maker that an investigation is being conducted, the outcome of which will be reported to the resident and/or surrogate decision-maker.

g. If given permission by a resident with decision-making capacity, the physician or nurse manager shall contact the resident's family or representative regarding the alleged abuse. If the resident does not have decision-making capacity, the physician shall notify the resident's surrogate decision-maker.

h. If an abuse allegation involves a LHH staff person, the nursing supervisor shall notify the staff person's immediate supervisor. The staff's direct supervisor will be notified within 24 hours. The direct supervisor or nursing supervisor shall remove

the staff from the unit and inform HR to issue a Paid Administrative Leave Memo for the duration of the investigation.

i. The nurse manager or nursing supervisor shall also assess and determine if the incident warrants contacting other resources, such as the psychiatric on-call physician.

j. The nurse manager or nursing supervisor shall assess on a case-specific basis allegations of resident to resident altercations, including altercations that occur between two residents with dementia that do not result in bodily injury, or rise to a reasonable suspicion of a crime, and determine, if an incident is reportable to SFSO. The Deputy Sheriff may be consulted as necessary if the allegation warrants official notification to the Sheriff's Department.

k. In cases of alleged or factual rape the following steps must be taken:

   i. LHH staff must immediately notify SFSO (Ext. 4-2319).

   ii. The attending physician shall make a direct referral to the San Francisco Rape Treatment Center located at 2801A – 25th Street, San Francisco (Ph: 415-821-3222) and shall direct the staff to preserve physical evidence to include the resident's physical condition and related personal effects.

   iii. At the San Francisco Rape Treatment Center, the resident shall be interviewed, specimens shall be taken, and treatment for possible sexually transmitted diseases as well as HIV prophylaxis shall be prescribed as deemed appropriate.

   iv. In all cases of rape, the attending physician shall request a psychiatric consultation for the resident.

   v. If a non-employee is identified as a suspect of rape, the nursing supervisor or nurse manager shall contact the Sheriff's Department.

l. The results of the investigation shall be reported to CDPH within five working days of the incident by QM. If the alleged violation is verified, appropriate corrective actions shall be taken.

m. The respective department head, in consultation with HR, shall report cases of substantiated abuse investigations to the appropriate employee's Licensing and Certification Boards.

Federal Regulation (F-Tags)	Suspicion of a Crime 42 CFR 483.12(b)(5) and Section 1150B of the Social Security Act	Alleged Violations 42 CFR 483.12(c)
	F-609 Report of Alleged Violations	
What to Report	Any reasonable suspicion of a crime against a resident or an individual receiving care from the facility	1) All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property 2) The results of all investigations of alleged violations
Who is Required to Report	Every Employee (Mandated Reporter) shall report to: CDPH, the Ombudsman, and Nursing Operations.	
Who Will Report to CDPH and the Ombudsman	Employee (Mandated Reporter)	
Who Will Report to SFSO, QM, CEO	Nursing Operations	
When to Report to CDPH, Ombudsman and SFSO	Serious bodily injury- Immediately but not later than 2 hours* after forming the suspicion No serious bodily injury – not later than 24 hours*	All alleged violations- 1) Immediately but not later than 2 hours*- if the alleged violation involves abuse or results in serious bodily injury 2) Not later than 24 hours*- if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; and does not result in serious bodily injury Results of all investigations of alleged violations- within 5 working days of the incident

7. Investigation

a. Any nurse or RCT member involved in the investigation of a resident-to-resident altercation, or allegation of abuse, neglect or exploitation shall document in the progress notes the details surrounding the incident (e.g., the times of physician notification and visits, the time of notification of the nursing supervisor, pertinent orders and actions, relevant resident remarks and assessment of resident condition related to the situation).

b. If an abuse, neglect or exploitation allegation involves a LHH employee, the supervisor/manager shall immediately work with HR to place the employee on administrative leave, pending completion of the investigation. The administrative leave will be in place until the investigations are complete. The employee shall be formally notified of the outcome of the investigation and future employee assignment.

c. If an abuse allegation, neglect or exploitation involves a LHH employee and the conclusion to the investigation does support the allegation, the manager shall continue the administrative leave measure pending completion of the full investigation by HR. The investigating supervisor/manager may consider the following factors in determining whether the alleged employee shall be placed on leave or reassigned to non-patient care duties:

   i. Severity of the allegation,

   ii. Circumstances of the case per the investigation, and

   iii. Prior disciplinary and employment history.

d. QM staff shall forward investigation documents related to the abuse, neglect or exploitation allegation involving LHH staff to HR. The HR department shall conduct an independent investigation of any abuse allegation involving LHH staff whenever the investigating party determines that the alleged abuse is substantiated.

e. Once a suspected crime has been committed, caution will be exercised when handling materials that may be used for evidence or for a criminal investigation. LHH will reference applicable State and local laws regarding preserving evidence.

f. HR shall confer with the involved staff's immediate supervisor about the findings of the investigation to determine the appropriate administrative course of action.

g. If an employee or non-employee is identified as a suspect of a crime, the nursing supervisor or nurse manager shall contact SFSO. The nursing supervisor or manager shall initiate action to protect the resident and the SFSO and or San Francisco Police Department shall carry out the investigation.

h. The nurse manager or nursing supervisor shall inform the resident and responsible party of the findings of the investigation and provide feedback to the employee who reported the criminal incident or abuse allegation.

8. Forms Completion and Submission

a. The Charge Nurse or designee shall complete the Unusual Occurrence report related to the suspected criminal incident or allegation of abuse and submit to QM electronically.

b. The "Report of Suspected Dependent Adult/Elder Abuse" form (SOC 341), shall be completed by the designation of Nursing Operations. The staff person may be the Nurse Manager, Charge Nurse, Medical Social Worker or Nursing Operations Nurse Manager. The completed SOC 341 shall be faxed to CDPH and Ombudsman within 2 hours from the time the incident occurred and shall be

submitted to QM including the fax receipts from CDPH and Ombudsman. (Refer to LHH SharePoint Forms page for an electronic form).

c. The "Written Notification to SFSO" form shall be completed by the Nurse Manager or designee after a telephone call is made to SFSO. The completed Written Notification to SFSO form shall be faxed to SFSO and shall be submitted to QM including the fax receipts from SFSO.

d. The supervisor/manager shall verify that the Unusual Occurrence, the SOC 341, Written Notification to SFSO forms have been completed.

e. The QM Regulatory Affairs team shall complete the Investigation of Alleged Abuse form in cases of:

   i. Resident-to-resident

   ii. Visitor-to-resident

   iii. Staff-to-resident

   iv. Injury of unknow origin

   v. Neglect

   vi. Misappropriate of resident's property

f. In cases of alleged resident abuse, neglect or exploitation by staff or visitor, the final conclusion shall be determined by the Nursing Home Administrator who serves as the Abuse Prevention Coordinator or executive designee and partnership with Chief Quality Officer (CQO).

g. QM staff shall submit the SOC 341 form to the Ombudsman Office via fax (415-751-9789) if the fax verification was not received by Nursing Operations or designee.

h. QM staff shall provide a copy of the SOC 341 form to SFSO.

9. Resident Assessment and Care Planning

a. In cases of allegations of abuse, neglect or exploitation or resident-to-resident or visitor-to-resident altercation, the nurse manager or charge nurse, with input from the RCT and the resident(s) themselves (if possible) shall take the lead in assessing and updating the residents care plan(s). Considerations for care planning may include the following:

i. Short-term and long-term interventions to provide the resident with a safe and secure environment.

ii. Interventions to mitigate the psychological impact of the incident.

iii. Characteristics, behaviors or habits that make the resident vulnerable at risk for aggression or altercations.

iv. Physiologic factor(s) involved in this incident. This should consider:

- Was the resident hungry, thirsty, constipated, in need of going to the bathroom, sleep deprived?
- Was the resident in pain?
- Did the resident have signs of an infection or delirium?

v. Treatment that may have contributed to or induced the resident's behavior.

vi. Need for psychiatric evaluation.

vii. Environmental stimulus/factor(s) contributing to this incident (excessive noise, crowded room).

viii. Staff action and/or inaction that may have contributed to the resident's behavior

ix. Ability to modify environment.

x. Likelihood of a repeat incident.

xi. Interventions to minimize the risk of recurrence.

xii. Need for frequent check-ins

xiii. Need for relocation or transfer to another level of care.

10. Coordination with QAPI

a. LHH will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program.

i. Cases of physical or sexual abuse, for example by facility staff or other residents, will be reviewed for and receive corrective action and tracking by the QAA Committee. This coordinated effort results in the QAA Committee determining:

- If a thorough investigation is conducted;
- Whether the resident is protected;
- Whether an analysis was conducted as to why the situation occurred;
- Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors); and
- Whether there is further need for systemic action such as:
    - Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation/exploitation,
    - Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about,
    - Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions,
    - Measures to verify the implementation of corrective actions and timeframes, and
    - Tracking patterns of similar occurrences.

11. **The Role of the Abuse Prevention Coordinator**

The Abuse Prevention Coordinator is responsible for the oversight for training, prevention, identification, investigation protection, reporting and response for all allegations of abuse, neglect, misappropriation and exploitation. The Abuse Prevention Coordinator serves as a central point of contact, promoting communication and collaboration among departments involved in resident care. This role should include implementing regular meetings, conducting case reviews, or convening multidisciplinary teams to share information, discuss potential abuse cases, and coordinate actions. The primary goal of coordination is to ensure abuse allegations are addressed urgently and timely.

The Abuse Prevention Coordinator:

a. Collaborates with the Resident Care Team to ensure interventions are immediately implemented and documented to ensure resident safety during the investigative process.

b. Oversees and participates in Abuse and Neglect policy updates, mandatory training and investigation training for the facility.

c. Collaborates with Quality Management to ensure that a thorough investigation process occurs.

d. Reviews all investigations prior to be submitted to regulatory agencies.

ATTACHMENT:
Appendix A: Investigation of Alleged Abuse Form

REFERENCE:
LHHPP 22-03 Resident Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 22-07 Physical Restraints Including Bed Rails
LHHPP 22-08 Threats of Violence to Residents by an External Party
LHHPP 22-10 Management of Resident Aggression
LHHPP 24-06 Resident Complaints/Grievances
LHHPP 73-05 Workplace Violence Prevention Program
SOC 341 Form

Revised: 07/15/96, 12/27/99, 05/18/00, 01/03/01, 04/18/05, 04/28/05, 06/28/05, 07/29/05, 04/05/06, 01/08/08, 12/03/27, 16/01/12, 17/09/12, 18/05/08, 18/09/11, 19/05/14, 19/07/09, 19/09/10, 20/01/14, 21/02/09, 23/03/14, 23/07/11, 23/11/14, 24/07/09 (Year/Month/Day)

Original adoption: 05/20/92

Appendix A: Investigation of Alleged Abuse Form

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Investigation of Alleged Abuse

PART I: INCIDENT INFO

TODAY'S DATE _____

Type of Alleged Abuse

☐ Injury of Unknown Origin ☐ Misappropriation of Resident's Property ☐ Neglect ☐ Other to Resident
☐ Resident to Resident ☐ Staff to Resident ☐ Other _____

Occurrence of Incident

Date of Incident: _____ Time of Incident: _____ Location of Incident: _____

Brief Description of Incident
PLEASE INCLUDE WHO, WHEN, WHERE, WHAT AND WHY.

List of Witnesses

☐ No witnesses were identified.

Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached
Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached

PART II: REPORTER INFO

Date of Report: _____ Name of Reporter: _____ Job Class/Title: _____
Reporter is: ☐ LHH Staff ☐ Other (specify): _____ Contact Number: _____
Reported to: _____ Job Class/Title: _____

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Investigation of Alleged Abuse

PART III: PERSONS INVOLVED

Resident A (Alleged Victim)

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

☐ Own Decision Maker (ODM) ☐ Cognitively Impaired (CI) ☐ Surrogate Decision Maker _____

Resident B (Suspected Abuser) ☐ N/A

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

☐ Own Decision Maker (ODM) ☐ Cognitively Impaired (CI) ☐ Surrogate Decision Maker _____

Staff/Other ☐ N/A

First Name _____ Last Name _____ Contact Number _____

Job Class/Title _____ Relationship to Resident _____

PART IV: PROTECTIONS TAKEN

Staff to Resident ☐ N/A

☐ Reassignment of alleged staff to a non-patient area.

☐ Staff sent home or on administrative leave.

Resident to Resident / Other to Resident ☐ N/A

☐ Involved parties were separated and counseled. If not, please explain why:

☐ One of more residents moved or relocated.

☐ Other. Please explain:

Other Types of Alleged Abuse ☐ N/A

☐ Please describe action taken:

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Investigation of Alleged Abuse

PART V: NOTIFICATION TO BE COMPLETED

***Notification Requirements* to CDPH, CEO/AOD, Ombudsman, QM Staff and SFSD based on criteria below:**

***Within 2 hours:* Events involving crimes or suspicion of crimes that result in bodily injuries; and alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.**

***Within 24 hours:* Events involving crimes or suspicion of crimes that do not result in serious bodily injury; and allegations of abuse that are not substantiated and do not result in serious bodily injury.**

Notification of Resident's Responsible Party ☐ N/A

Resident A: Name _____ Date _____ Time _____

Resident B: Name _____ Date _____ Time _____

LHH Staff Notification Checklist *(Check appropriate boxes)*

- ☐ Charge Nurse, Nurse Manager, and Nursing Director
- ☐ Physician
- ☐ Director of Social Work or Designee
- ☐ Urgent Psych for Evaluation (415-327-5130)
- ☐ Administrator/AOD
- ☐ Quality Management Department
- ☐ UO Documentation Complete
- ☐ Other _____

External Notification Checklist *(Check appropriate boxes)*

- ☐ Sheriff's Department (415-759-2319)
- ☐ SFSD Notification Form Faxed (415-759-3019)
- ☐ SOC-341 Completed and Faxed (415-751-9789)
- ☐ Rape Treatment Center (415-821-3222)
- ☐ Other _____
- ☐ CDPH Office (415-330-6353)
  - Name _____ ☐ Answering Machine
  - Date _____ Time _____
- ☐ Local Ombudsman Office (415-751-9788)
  - Name _____ ☐ Answering Machine
  - Date _____ Time _____

Sample call to CDPH:

This is ___ (your name and title) at Laguna Honda Hospital. This call is to notify you that on___ (date and time), a report of alleged resident abuse involving ____ (name of resident) was received.

Please spell the resident's name(s) and give the resident's date of birth when reporting the incident. Specify if there was any resident injury that occurred. State that an investigation of the incident has been initiated.

If there are any questions, please contact Quality Management at ext. 4-3055, ext. 4-3057, ext. 4-3575, or ext. 4-3530.

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Investigation of Alleged Abuse

PART VI: ASSESSMENT

Medical Assessment of Resident A ☐ N/A

Name of Physician _____ Date _____ Time _____

Brief Statement of Findings:

Medical Assessment of Resident B ☐ N/A

Name of Physician _____ Date _____ Time _____

Brief Statement of Findings:

Resident to Resident Incident Assessment(s) ☐ N/A

Please complete ONLY if incident is Resident to Resident.

	Resident A	Resident B
Behavior Risk Assessment current and complete.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Care plan discusses problem behavior or risk of being a target of aggression.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Order for any scheduled psychotropic medications.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Order for any PRN psychotropic medications.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Received PRN psychotropic medications within 6 hours prior to incident.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
History of problem behaviors within the last 3 months.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Prior psych consult completed within the last 12 months.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Additional psych consult necessary.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A

Resident Interview

Resident MUST be interviewed unless comatose, discharged, or expired.

Resident A: Date _____ Time _____ ☐ Statement Attached ☐ Unable to Interview

Resident B: Date _____ Time _____ ☐ Statement Attached ☐ Unable to Interview

Analysis

Was this a deliberate act? ☐ Yes ☐ No If no, please explain: _____

If yes, did the deliberate act result in:

Physical Harm ☐ Yes ☐ No Pain ☐ Yes ☐ No Mental Anguish ☐ Yes ☐ No

Describe any physical injury, pain, and/or mental anguish:

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Investigation of Alleged Abuse

PART VII: CONCLUSION

Based on the interviews and other information available at this time, and in the exercise of my clinical judgment:

☐ I conclude that the abuse is substantiated.
☐ I conclude that the abuse is NOT substantiated.
☐ I conclude that the theft occurred.
☐ I conclude that the theft did NOT occur.

Please explain the reason for your conclusion below.

Reason(s) for my conclusion:

PART VIII: SUPPORTING DOCUMENTS

Additional Required Notifications

(Check appropriate boxes)

Resident/responsible party has been notified of the outcome of this investigation.	☐ Yes	☐ No	☐ N/A
Resident/responsible party was satisfied with the outcome of the investigation.	☐ Yes	☐ No	☐ N/A
Employee(s) has been notified of the outcome of this investigation.	☐ Yes	☐ No	☐ N/A
Reporter of alleged abuse has been notified of the outcome of this investigation.	☐ Yes	☐ No	☐ N/A
Human Resources has been notified when staff to resident alleged abuse is substantiated.	☐ Yes	☐ No	☐ N/A

Additional Required Documents

(Check appropriate boxes)

I have attached a copy of the staff reassignment/ send home letter.	☐ Yes	☐ No	☐ N/A
I have attached a copy of the resident's current and revised care plan.	☐ Yes	☐ No	☐ N/A
I have attached a copy of the staff assignments.	☐ Yes	☐ No	☐ N/A
I have attached a copy of the RCT special review and revised/reviewed the resident's care plan.	☐ Yes	☐ No	☐ N/A

Name / Title: _____ Date Completed: _____

Signature: _____

Name / Title: _____ Date Completed: _____

Signature: _____

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Investigation of Alleged Abuse

ADDITIONAL SPACE

Please use space as needed. Indicate the section additional detail is being provided for.

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RESIDENTS' COUNCIL

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) provides residents a forum including space, promotion and coordination to attend in order to express concerns, issues and needs for joint problem resolution and/or decision making that affect resident care and quality of life.

PURPOSE:

To provide an effective forum for residents to participate in decisions that affect resident care and quality of life at LHH.

PROCEDURE:

1. ~~Hospital staff members~~LHH staff are responsible for encouraging and enabling resident participation in Residents' Council meetings. This is done without regard to any resident's culture, religion, sexual orientation, gender identification, disability, age, socioeconomic status, and expressed beliefs or opinions.

2. Residents' Council shall generally occur~~s~~ monthly.

3. Processes and procedures related to the Residents' Council and its meeting is at the discretion of the Residents' Council and may refer to bylaws that residents have created and approved.

4. Staff representation at the Residents' Council meetings and responsibilities related to the Residents' Council are as follows:

    a. Activity Therapy Supervisor

        i. Assist Residents' Council officers to fulfill their roles to lead and facilitate Residents' Council meetings.

        ii. Assist residents to attend Residents' Council meetings to communicate their opinions, issues and/or concerns.

        iii. Reserve private space for the Residents' Council meetings and facilitate room set-up.

        iv. Post notices of upcoming Residents' Council meetings in a timely manner to encourage attendance and participation.

        v. Ensure recording of meeting minutes.

vi. Maintain three most recent years of Residents' Council records.

vii. Forward meeting minutes to staff as identified below.

viii. Facilitate elections of officers as requested by Residents' Council

b. Representative from Administration

i. Acts as the communication liaison between Residents' Council Officers and hospital departments.

ii. Responds directly to questions and concerns related to hospital departments, operations and/or administration.

iii. Reports to the Executive Administration when further action is needed to facilitate and/or address communications.

iv. Reports on items related to hospital operations of interest to the Residents' Council.

c. ~~Nursing~~Nurse Director and/or designee

i. Responds directly to questions and concerns related to nursing care or accommodation of needs raised by residents during the meeting.

ii. Takes input from residents and for consideration during clinical and operational decision making of the Nursing Division.

5. Staff, visitors or other guests wishing to attend a Residents' Council meeting and address Residents' Council members must obtain express permission from the Residents' Council President/Co-leader prior to the meeting date.

6. Activity Therapy Supervisor distributes Minutes of the Residents' Council no later than two weeks after the meeting, to the following:

a. Residents' Council Officers

b. Executive Committee

c. Department Managers

d. Directors of Nursing and Nurse Managers

e. Activity Therapists

7. The Residents' Council may request that an issue be addressed by hospital staff. The Residents' Council meeting minutes will designate the Hospital staff responsible for the area of resident concern and the request for response.

8. ~~Hospital~~LHH staff shall promptly address issues raised at the Residents' Council Meeting by either submitting a written response or asking the Council for time at the next month's meeting agenda. The LHH staff response shall include the rationale for their response.

9. Activity Therapy staff may review Residents' Council minutes with residents on their assigned units at the neighborhood community meetings, during hospital-wide cultural and social group activities, as appropriate.

10. A copy of the Residents' Council Minutes is made available to any resident upon request to the Activity Therapist.

ATTACHMENT:
Attachment A: Laguna Honda Hospital and Rehabilitation Center Residents' Council Bylaws (Last approved May 3, 2019)

REFERENCE:
Appendix PP/Guidance to Surveyors for Long Term Care Facilities. F243 and F244/Section 483.10 (f) (5) (1) – (iv)

Revised: 09/08/14, 10/04/27, 16/07/12, 16/11/08, 17/07/11, 17/09/12, 19/05/14, 25/04/14 (Year/Month/Day)

Original adoption: 07/12/18

RESIDENT FREEDOM FROM ABUSE ON SOCIAL MEDIA

POLICY:

The Resident Freedom from Abuse on Social Media policy provides guidance to Laguna Honda Hospital and Rehabilitation Center (LHH) staff regarding a resident's right to personal privacy and dignity of not only ~~his/her~~their own physical body, but also of ~~his/her~~their personal space, including accommodations and personal care.

Taking photographs or recordings of a resident and/or ~~his/her~~their private space without the resident's, or designated representative's prior written consent, is a violation of the individual's right to privacy and confidentiality.

Posting photographs or recordings of a resident and/or ~~his/her~~their private space that demean or humiliate them is mental abuse and is prohibited even if the resident or designated representative granted verbal or written consent.

PURPOSE:

It is the intent of this policy to support the effective and responsible use of social media, to protect the privacy and dignity of LHH residents and staff, and to ensure compliance with Federal Health Insurance Portability and Accountability Act (HIPAA) and State privacy regulations.

DEFINITION:

For the purpose of this policy LHH staff includes employees, consultants, contractors, volunteers, and other caregivers who provide care and services to residents on behalf of the facility.

PROCEDURE:

1. Prior to recording a resident, complete a written Consent to be recorded / Authorization for publication form. This form can be found https://www.sfdph.org/dph/comupg/oservices/medSvs/HIPAA/HIPAAPolicies.asp

2. Protecting Resident Privacy – Prevention of Abuse on Social Media

    a. Abuse Prohibition

        i. A photograph or recording of a resident that demeans or humiliates the individual, regardless of whether the resident has provided written consent and regardless of the resident's cognitive status is mental abuse.

            - Photographs or recordings that demean or humiliate include photographs and recordings of residents that contain nudity, sexual and intimate

relations, bathing, showering, toileting, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the resident, showing a body part without the individual's face whether it is the chest, limbs, or back, labeling resident's pictures and/or providing comments in a demeaning manner, directing a resident to use inappropriate language, and showing the resident in a compromised position.

ii. LHH staff shall not take or use photographs or recordings in any manner that demean or humiliate a resident.

iii. LHH staff shall not keep, distribute, or post a photograph or recording, or link to a photograph or recording, in any format including on social media that demeans or humiliates a resident is prohibited.

iv. LHH staff shall not post statements that demean or humiliate a resident on social media.

b. If an employee sees social media posting(s) that demeans or humiliates a resident as described in Procedure 1, the employee is responsible for reporting such posting to their supervisor and/or to the Quality Management (QM) department and shall submit an incident report.

c. Protecting Resident Confidentiality

i. LHH employees shall comply with all LHH and San Francisco Department of Public Health (SFDPH)-wide policies regarding the confidential information of a patient/resident and relating to the use of social media, including:

- LHHPP 21-01 Medical Records Information: Confidentiality and Release;
- LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response;
- SFDPH HIPPA Compliance – Patient/Client Resident Rights regarding Protected Health Information (PHI); and
- SFDPH HIPPA Compliance – Social Media Policy.

3. Compliance

a. DPH and LHH reserve the right to request to have online communications stop if DPH or LHH believe communications from an employee, physician, fellow, patient, resident, volunteer, and/or students are in violation of organizational policies, values or local, state or federal laws privacy laws.

b. Violations of this policy shall be reported to the Compliance Office and to the QM department.

c. Violations shall be investigated to determine the nature, extent and potential risk to the hospital. Refer to LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response for investigation procedures.

d. All LHH staff who witness or are informed of a violation of this policy, including suspected abuse as clarified in this policy, shall follow the protection and reporting protocols, and other processes outlined in LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response.

e. All LHH staff who violate this policy shall be subject to the investigation protocol and other processes outlined in LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response.

f. LHH units shall conspicuously post signage reminding individuals of the photography or video recording prohibition.

ATTACHMENT:
None.

REFERENCE:
LHHPP 21-01 Medical Records Information: Confidentiality and Release
LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response
CMS Survey & Certification: 16-33-NH
SFDPH HIPPA Compliance – Patient/Client Resident Rights regarding Protected Health Information (PHI)
SFDPH HIPPA Compliance – Social Media Policy

Revised: 20/10/13, 23/05/09, 25/04/14 (Year/Month/Day)

Original adoption: 16/11/08

CLINICAL/ SAFETY SEARCH PROTOCOL

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall act to ensure the safety of residents and staff, and to provide necessary care for each resident to attain or maintain their highest practicable physical, mental, and psychosocial well-being.

2. Active substance use, drug dealing, unsafe smoking and use of dangerous objects endangers the safety of residents and staff and does not promote a resident's well-being.

3. For the safety of residents and staff, and the well-being of residents, dangerous objects, illegal drugs, non-prescribed medications, cigarettes, lighters, matches, electronic cigarettes (e-cigarettes), and other devices that ignite, light, or fuel a flame, alcohol and/or drug paraphernalia are prohibited at LHH.

4. Facility staff will have knowledge of signs, symptoms, and triggers of possible prohibited substance use, which includes but is not limited to:

    a. Changes in resident behavior

    b. Increased, unexplained drowsiness

    c. Lack of coordination

    d. Slurred speech

    e. Mood changes

    f. Loss of consciousness

5. When there is a potential risk and/or reasonable suspicion that a resident possesses contraband, clinical or facility staff shall conduct searches of the resident, a resident's room and personal belongings, as well as property and packages brought by visitors as described below, only if the resident or their representative provides consent for each separate search. This policy shall not in any way prohibit or limit law enforcement from conducting lawful searches.

    a. Including but not limited to:

        i. Out on pass

        ii. Return from appointment and resident and/or escort verbalizes any deviations from the appointment

iii. Leaving campus without out on pass

1. ~~Clinical or facility~~LHH staff may also conduct a search after completion of the *Check-In Form – Resident Returning from an Out On Pass* (OOP) when a resident returns from leave and when there is a potential risk and/or reasonable suspicion that a resident possesses contraband, only if the resident or their representative provides consent for each separate search. This policy shall not in any way prohibit or limit law enforcement from conducting lawful searches.

6. If facility staff identifies items or substances that pose risks to residents' health or safety and are in plain view, they will confiscate them.

PURPOSE:

To outline the process of contraband clinical search protocol at LHH to maintain resident/visitor/staff safety, protect our residents from error and harm, and providing the safest care possible in protection of the well-being of each resident

BACKGROUND:

LHH recognizes that residents have a right to (1) privacy, dignity, and to be free from unnecessary searches; and (2) retain and use personal property. However, residents, staff, and visitors also have the right to a safe and therapeutic environment, which under certain circumstances necessitates taking steps to ensure residents are not in possession of items that may present a hazard to personal safety or the therapeutic environment. LHH also recognizes that some of its patients may have substance use disorders, and possession of contraband may be related to symptoms of that condition.

DEFINITION:

Contraband: Illegal or prohibited items, such as dangerous objects, prohibited drugs (including cannabis and cannabis products) and drug paraphernalia, unapproved alcohol, and smoking or tobacco paraphernalia.

Dangerous objects: Items which can be used to inflict harm to self or others (sharps, knives, firearms, etc.).

Illicit or illegal drug: A drug or substance that cannot be obtained legally or by prescription, or any substance prohibited by code or statute.

Prohibited drug: A medication or substance that is illegal or is not prescribed or otherwise authorized for the resident by a LHH provider.

Drug Paraphernalia: Medical apparatus or over-the-counter items that are commonly used in illicit drug activity such as syringes, needles, drug pipes, hemostats, etc.

Smoking or tobacco paraphernalia: lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame, etc.

PROCEDURE:

1. Indications for Searches

For each of the following situations, clinical or facility staff may search the resident and/or their belongings **only if the resident or their representative provides consent** for each instance, and for each separate search, when a search is warranted. This policy shall not prohibit or limit law enforcement from conducting lawful searches.

a. All packages for residents who are smokers, ~~-~~and/or those who have a diagnosis of substance use disorder shall be searched in the presence of the resident. Packages brought into the unit that clinical staff reasonably suspect contain contraband shall be searched in the presence of the resident before giving the package to the resident.

   i. Staff may search a resident, their property, and their room when clinical staff believes there is a potential risk and/or reasonable suspicion that the resident is in possession of contraband.

b. Staff may search a resident, their property, and their room upon reasonable belief by clinical staff that the resident is suicidal, homicidal, or necessary to prevent serious harm to themselves or to others.

c. Residents who return from pass privileges may be asked to empty their pockets and their packages may be searched if contraband is reasonably suspected.

d. Staff may search a resident's property and their room when staff reasonably suspects that a resident has taken another person's property. If the property is found, the property may be returned to the owner.

e. Staff may conduct unit-wide searches when there is a potential risk and/or reasonable suspicion that drug using/dealing may be occurring on a unit or multiple units.

f. Staff may search a resident, their property, and their room when a resident exhibits a change in mental status or behavior and substance use is suspected.

g. Staff may search a resident, their property, and their room when a resident exhibits unsafe smoking practices such as smoking while on, or near an oxygen delivery device.

2. Search Procedures

a. LHH clinical or facility staff may initiate searches to ensure the health and safety of residents and staff only if the resident or their representative provides consent for each separate search. This policy does not in any way prohibit or limit law enforcement from conducting lawful searches.

b. Searches shall be conducted in a reasonable manner that respects the individual's dignity and privacy. A search should be conducted only to the extent required to assure contraband is not present. The method and purpose of the search shall be explained to the resident.

c. To the extent possible, residents shall be present while their property (including intended packages) and rooms are being searched.

d. The permission of the resident must be requested prior to any search. t is recommended that a member of the Behavioral Response Team, BRT, be present to support the behavioral health of the resident and to prevent escalating behavior during the search. Additional support will be provided by the contract-security-provider to assistance as a deterrent or backup to the hospital staff's actions, and under the direction of a physician, affiliated professional, or nurse, moderate or prevent any escalating behavior.

e. A San Francisco Sherrif Office (SFSO) deputy should be contacted when there is reasonable cause to believe that a resident presents a danger to themselves and others.

b. Repeated searches of resident's rooms and property are permitted when there is a potential risk and/or reasonable suspicion that they are in possession of contraband, but only if the resident or their representative provides consent–. Examples include but are not limited to:

   i. Resident appearing to be under the influence of drugs or alcohol;

   ii. Reasonable suspicion that contraband is in a resident's possession (Risk factors may include the resident having history of bringing and/or selling alcohol, street drugs and/or other contraband in LHH);

   iii. Resident having current suicidal or homicidal ideation or expressed feelings of inflicting serious harm to themselves or others;

   iv. Reasonable suspicion of theft (Risk factors may include resident history of theft while on the unit, credible witness report, etc.); and/or

   v. Resident deemed an unsafe smoker and/or smoking while on, or near an oxygen delivery device.

f. Staff shall take Universal Precautions such as wearing double gloves, a mask, a gown, and face shield or eye protection when handling resident belongings or suspected contraband. Staff shall avoid reaching into any pockets. Instead, staff shall pour out the contents of bags, boxes, packages, or other personal belongings, ask the resident to empty their pockets, and/or gentle patting.

g. A minimum of two staff shall be present during a search.

c. When a resident is assessed as suicidal or homicidal~~,~~ or has a history of drug use or violent behavior, or is suspected of having contraband, a search may be initiated by clinical or facility staff only if the resident or their representative provides consent for each separate search. Staff shall notify SFSO of the search and request stand-by for support, if needed. Types of searches which may be conducted by clinical or facility staff include:

i. Pocket Searches – resident shall be asked to empty his/her pockets and contents shall be inspected by staff for contraband.

ii. Pat Down or Frisk Searches – shall be conducted by designated staff who are of the same sex as the individual being searched in the presence of a witness. If during the pat-down search a suspicious object is discovered, which reasonably could be, for example, a weapon, pills or other contraband – staff may remove the object for closer inspection.

iii. Clothing Searches – the resident shall be escorted to a private area accompanied by two staff members, at least one staff member of the same sex whenever possible and requested to change into a hospital gown. The clothing shall be checked for contraband. Once contraband objects are removed, the clothing can be returned to the resident.

iv. Room Searches – the resident's room and furniture/belongings in the room, including assistive devices such as canes and wheelchairs, shall be inspected by designated staff.

v. Food Searches – inspecting packaging of food intended for residents

vi. Belongings Search – belongings such as purses, bags, backpacks, and packages brought in by visitor or via mail/delivery shall be inspected by staff for contraband.

vii. Unit-Wide Search – Nurse manager or designee shall call for a team huddle. The team shall identify the type of search and which rooms will be searched up to and including the great room and common areas.

3. Unit Searches of the Resident Rooms and Common Areas

a. Preparation

i. Staff shall notify SFSO of the search and request stand-by support if the resident has a history of aggressive behavior or has exhibited aggressive behavior previously during a clinical search. On such instances, at least one LHH SFSO deputy shall be stationed outside the entrance/exit of the resident's room to provide support in the event:

- the resident threatens or becomes verbally or physically aggressive toward staff, or other residents;
- staff observe that the resident has a dangerous object in their possession;
- staff observe that the resident has illicit or illegal drugs in their possession.

ii. Staff shall review basic safety search procedures before proceeding, including nonviolent safety management and prevention of challenging behavior principles as needed.

iii. Search teams shall be identified (at least 2 staff per room search) by the nurse manager or designee.

iv. One staff shall be assigned to monitor the unit entrance/exit.

v. Staff may request canine search assistance as needed from SFSO (refer to procedure 4).

vi. A mandatory community meeting shall be called to announce the safety search and instruct the residents to wait in the Great Room until called to their bedside for the search.

b. During the Search

i. Two staff shall provide support for each neighborhood being searched. The duties shall include escorting residents from the Great Room to the residents' rooms, working with agitated residents, collecting confiscated substances and paraphernalia, communicating with staff at entrance/exit, etc.

ii. At least one staff shall observe the residents in the Great Room. If available, Activity Therapy may run an activity group during the wait.

iii. Residents who have been searched may leave the unit, however, shall not be able to return until the search is concluded, or may be asked to wait in a separate dining room.

iv. All confiscated substances and paraphernalia shall be bagged and labeled. The Transfer Form for Contraband Items must be completed for all confiscated items.

v. Staff shall help with de-escalation and provide support as needed.

vi. SFSO shall provide support:

- When a resident becomes verbally or physically aggressive toward staff or other residents;
- exhibits behavior that threatens the safety or well-being of other residents or staff;
- staff observes that the resident has a dangerous object in their possession; and/or
- staff observes that the resident has illicit or illegal drugs in their possession.

c. After the Search

i. All confiscated contraband shall be catalogued by the staff member that conducts the clinical search, have a completed corresponding Transfer Form, be disposed of in the manner described below, and documented in the resident's medical record:

- Confiscated illicit substances and/or drug paraphernalia, including cannabis, shall be bagged, labeled, and transferred to SFSO within the same shift.
- Confiscated alcohol shall be bagged, labeled, and transferred to SFSO within the same shift.
- Cigarettes confiscated from unsafe smokers shall be held or disposed of based upon the resident's care plan for smoking.
- E-cigarettes, lighters, matches, and other devices that ignite, light, or fuel a flame shall be bagged, labeled by nursing staff and secured by Social Services for safekeeping.

- Dangerous objects (including, but not limited to, box cutter, scissors, guns, or objects with a blade regardless of length) require immediate notification to SFSO. Items shall be bagged, labeled, and transferred to SFSO.
    - Should the resident or a surrogate decision-maker indicate that the dangerous object(s) are of sentimental value, then said item(s) shall be bagged and labeled by nursing staff~~,~~ and secured by SFSO for safekeeping.
        - Said items shall be stored in a secured and locked location on LHH property for safekeeping.
        - Dangerous object(s) shall be transported to and from the secured and locked location by SFSO only.
        - The dangerous object may be released to the resident by SFSO upon discharge or to a person identified by the resident or the resident's surrogate decision-maker or personal representative.
        - Only SFSO shall retrieve the dangerous object from the storage location on the LHH campus.
        - Dangerous objects shall not be released to the resident, person identified by the resident, resident's surrogate decision-maker, or personal representative if the attending physician or SFSO reasonably determines that the person would be a safety threat to themselves or to others if the dangerous object was released to them.
        - LHH shall keep any such confiscated dangerous objects for a maximum period of ninety (90) days after discharge.
    - Any confiscated substances in pill, patch, or capsule form that cannot be identified shall be transferred to the pharmacy for identification and proper disposal.
        - If the pharmacy is closed: transfer the confiscated substances to SFSO.
    - Any other confiscated substances that cannot be identified shall be given to SFSO.
    - Confiscated sharps shall be disposed in the sharp's container by nursing staff, witnessed by at least two staff members, and indicated on the Transfer Form for Contraband Items.

d. Documentation

i. When a clinical safety search is conducted it shall be documented in the resident's electronic health record using the Clinical Safety Search SmartPhrase.

ii. Staff shall submit an Incident Report describing:

- The facts constituting a reasonable suspicion to conduct the search
- Resident consent or refusal
- Staff who conducted the clinical safety search and witnesses
- The results of the search
- Items found and seized
- Disposition of confiscated items
- Completion of Transfer Form of Contraband Items

d. If the Sheriff issues a citation ticket number, include in the incident report description

iii. The Resident Care Team (RCT) shall be informed when searches were conducted. The RCT shall review the incident and assess if the resident's care plan shall be modified.

e. Additional Clinical Safety Searches

i. An additional clinical safety search shall be conducted within 3 to 5 days after the first clinical safety search only if the resident or their representative provides consent for each separate search, when:

- A resident is found with illicit substances during the first clinical search
- A resident's urine confirmation (not screening) toxicology result is positive for amphetamine, methamphetamine, cocaine, heroin, cannabinoid, or fentanyl

ii. If during the additional clinical safety search another illicit substance is found, another search shall be conducted within 3-5 days. This shall continue until no illicit substances are found.

4. Canine Searches

a. LHH has access to canine assistance for drug searches when needed.

i. A request by LHH administrative staff can be made to the SFSD for unit-wide or hospital-wide searches.

ii. The search dog shall be handled by a professional handler only.

iii. Staff shall be sensitive to those residents who may have negative reactions when they are around dogs.

iv. Staff and residents shall be instructed about proper ways to interact with the dog, such as no petting or feeding.

5. Visitors

a. All visitors shall be informed that LHH strives to be a safe, drug-free healing environment, and that all contraband and illegal activities are prohibited. All items brought for residents may be subject to search by staff. If contraband, paraphernalia, and/or illicit substances are found, they shall be disposed of per facility policy. If a visitor is suspected of bringing in contraband, staff may implement interventions, including but not limited to: inspection of packages the visitor brings to the unit, restricting or prohibiting visits, and/or calling a member of the Behavioral Response Team, BRT, to support the behavioral health of the visitor and to prevent escalating behavior during the search. Additional support will be provided by the contract-security-provider to assistance as a deterrent to moderate or prevent any escalating behavior.

b. A SFSO Deputy should be called when there is reasonable cause to believe that the visitor presents a danger to themselves and others.

ATTACHMENT:
None.
~~Attachment A: Standard Work for Contraband Item Handling, Storage and Disposal~~
~~Attachment B: Standard Work for Clinical Safety Search~~

REFERENCE:
LHHPP 20-06 Leave of Absence (Out on Pass)
LHHPP 22-03 Resident Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 22-10 Management of Resident Aggression

LHHPP 75-05 Illicit or Prohibited Drugs or Paraphernalia Possession/Use by Residents or Visitors
LHHPP 75-10 Security Services Standard Operating Procedures
LHHPP 76-02 Smoke and Tobacco Free Environment
Check-In Form – Resident Returning from an Out on Pass
Standard Work for Contraband Item Handling, Storage and Disposal
Standard Work for Clinical Safety Search

Revised: 19/09/10, 22/07/14, 22/12/13, 23/05/09, 25/04/14 (Year/Month/Day)
Original adoption: 19/03/12

COMPLETION OF RESIDENT ASSESSMENT INSTRUMENT/MINIMUM DATA SET (RAI/MDS)

POLICY:

1. The assessments of the Resident Care Team (RCT) members are the primary data sources used by the RAI/MDS coordinator to complete the RAI/MDS assessments.

2. Respective members of the RCT are responsible for the timely completion of MDS assessments i.e. Admission, Quarterly, Annual, Significant Changes, Medicare and other required assessments.

3. The RCT shall utilize the RAI/MDS assessments to develop, review and revise each resident's comprehensive plan of care.

PURPOSE:

1. To successfully use the RAI/MDS process to enhance resident care, increase resident's active participation in care, and to promote the quality of life of the resident(s).

2. To utilize the RAI/MDS during care planning process.

3. To ensure accurate and timely completion of the Resident Assessment Instrument/ Minimum Data Set.

BACKGROUND:

The RAI/MDS is a tool used to identify resident problems, strengths, weaknesses, and preferences and provides information for the development of an individualized plan of care.

DEFINITION:

1. Independent: if the resident completes the activity by themself with no assistance from a helper.

2. Setup or clean-up assistance: if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container or requires setup of hygiene item(s) or assistive device(s).

3. Supervision or touching assistance: if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.

4. Partial/moderate assistance: if the helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

5. Substantial/maximal assistance: if the helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

6. Dependent: if the helper does all of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.

PROCEDURE:

1. RAI/MDS Accuracy and Completion

a. The MDS Coordinator notifies Resident Care Team members by the end of each month identifying those residents who are scheduled for assessments the following month. The MDS Coordinators may send an updated list after the initial notification to reflect schedule revisions and additions.

b. The RAI/MDS Coordinator shall approve changes to the individual resident's schedule of RAI/MDS completion.

c. The Resident Care Team and the Department of Admissions and Eligibility are responsible for completing respective MDS sections as specified in Attachment C.

d. The team member whose area of assessment is triggered shall complete the Care Area Assessments (CAA). CAA that are triggered during completion of the comprehensive MDS shall be evaluated and discussed during RCC whether or not a comprehensive care plan needs to be developed for the triggered care areas (See LHHPP 23- 01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC).

e. The MDS Coordinator shall access the MDS in the electronic health record (EHR) during the scheduled Resident Care Conference for final review.

f. The MDS Coordinator shall facilitate discussion of the MDS, care areas (CAA) triggered and prompt the care planning process during the RCC and/or individual RCT members prior to the scheduled RCC.

g. All staff who complete any portion of the MDS shall enter their signatures, titles, sections, or portion(s) of section(s) they completed, and the completion date in the

EHR.

2. The RAI/MDS Assessments

A RAI/MDS assessment (CAA process and utilization guidelines) shall be completed for all residents at LHH.

Assessment Types:

a. Tracking Records

i. Entry- completion of an Entry tracking Record during admission and reentry.

ii. Death in facility- refers to when a resident dies in the facility or dies while on leave of absence (LOA).

b. OBRA Assessments

i. Admission- comprehensive assessment for a new resident or a returning resident.

ii. Annual- comprehensive assessment completed on an annual basis (at least every 366 days).

~~iii.~~ Significant Change in Status Assessment- comprehensive assessment is completed if RCT determined that a resident meets the significant change guidelines for either improvement or decline ~~(see Standard Work for Significant Change in Status Assessment)~~

~~iv.~~iii. ~~v.~~iv. Quarterly- an OBRA non-comprehensive assessment completed every 92 days following the previous OBRA and is used to track resident's status between comprehensive assessments.

~~vi.~~v. Significant Correction to Prior Comprehensive Assessment- completed when the RCT determines that a resident's prior Comprehensive assessment contains a significant error.

~~vii.~~vi. Significant Correction to Prior Quarterly Assessment- completed when the RCT determines that a resident's prior Quarterly assessment contains a significant error.

~~viii.~~vii. Discharge return not anticipated or return anticipated)- must be completed within 30 days when resident is discharged from the facility either return anticipated or return not anticipated.

c. Medicare Assessment- assessment of clinical condition of the resident receiving Part A SNF- level care.

3. Submission of required data to Centers for Medicare and Medicaid Services (CMS)

a. The facility must report data to meet the SNF Quality Reporting Program (QRP). The MDS 3.0 is transmitted to CMS through the Assessment Submission and Processing (ASAP) system to the Quality Improvement Evaluation System (QIES).

b. The MDS 3.0 data is generated for the Certification and Survey Provider Enhanced Reporting system (CASPER) which provides the quality measures indicating the facility's star rating.

i. List of Quality Measures

- High-Risk/Unstageable Pressure Ulcers (L*)
- Physical Restraints (L*)
- Falls (L*)
- Falls with Major Injury (L*) Residents Who Newly Received an Antipsychotic Medication (S*)
- Residents Who Received an Antipsychotic Medication (L*)
- Prevalence of Antianxiety/Hypnotic Medication Use (L*)
- Antianxiety/Hypnotic Medication Use % (L*)
- Behavior Symptoms Affecting Others (L*)
- Depressive Symptoms (L*)
- Urinary Tract Infection (L*)
- Catheter Inserted and Left in Bladder (L*)
- Low-Risk Residents Who Lose Bowel/Bladder Control (L*)
- Excessive Weight Loss (L)
- Need for Help with ADLs Has Increased (L)

- Percent of Residents Whose Ability to Move Independently Worsened (L)*
- Percent of Residents Who Made Improvements in Function (S)*
- Changes in Skin Integrity Post-Acute Care Pressure Ulcer/Injury* (SNF Only)

c. The facility is required to submit staffing information through the Payroll Based Journal (PBJ) on a quarterly basis.

*L-Long Stay
*S-Short Stay

ATTACHMENT:
Attachment A: Required OBRA Assessment Schedule for the MDS
Attachment B: Medicare MDS Assessment Schedule
Attachment C: MDS 3.0 Section by Section

REFERENCE:
LHHPP 23-01 Resident Care Plan, Resident Care Team & Resident Care Conference
MDS 3.0 User's Manual, MED-Pass
Standard Work for Timely Submission and Accuracy of MDS
Standard Work for Significant Change in Status Assessment RCC

Revised: 10/01/20, 12/05/22, 19/05/14, 19/07/09, 22/12/13, 23/03/14, 24/02/13, 25/04/14 (Year/Month/Day)

Original adoption: 10/01/20

Attachment A: Required OBRA Assessment Schedule for the MDS

ADMISSION	Refer to RAI Manual page 2 - 8
ANNUAL	Refer to RAI Manual page 2 - 19
SIGNIFICANT CHANGE IN STATUS	Refer to RAI Manual page 2 - 22 to 2- 27
SIGNIFICANT CORRECTION OF A PRIOR FULL ASSESSMENT	Refer to RAI Manual page 2 - 30
QUARTERLY	Refer to RAI Manual page 2 - 31 to 2- 33
SIGNIFICANT CORRECTION OF A PRIOR QUARTERLY ASSESSMENT	Refer to RAI Manual page 2 - 34
ENTRY	Refer to RAI Manual page 2 - 34 to 2 - 35
DEATH IN FACILITY	Refer to RAI Manual page 2 - 36
DISCHARGE	Refer to RAI Manual page 2 - 36 to 2 - 37

Attachment B: MEDICARE MDS Assessment Schedule

5 Day NPE (Medicare Last Covered Day) IPA (Interim Payment Assessment) Interrupted Stay	Refer to RAI Manual

Attachment C: MDS 3.0 Section by Section

SECTION	RESPONSIBLE DISCIPLINE(S)
A	
A0050	MDS
A0100 - A0200	IS
A0200	MDS
A0300 – A0410	MDS
A0500 – A0900	A&E - autoflow
A1000	MDS - SS autoflow
A1100 - A1300	SOCIAL SERVICES -
A1200 – A1550	SOCIAL SERVICES and MDS
A1600 – A1700	MDS
A1800 – A2400	MDS
B	
B0100 – B1200	MDS
C	
C0100 – C0500	MDS
C0600 – C1000	MDS
C1310	MDS
D	
D0100 – D0350	MDS
D0500 – D0600	MDS
E	
E0100 – E600	MDS
E800 – E1100	
F	
F0300 – F0400	ACTIVITIES
F0500 – F0700	ACTIVITIES
F0800	ACTIVITIES
G	
G0110 – G0120A	MDS
G0300 – G0900	MDS
GG GG0100-GG0170	MDS
H	
H0100 – H0600	MDS
I	
I 0100 – I 8000	MDS
J	
J0120 – J2000	MDS
J2100 - J500	MDS
K	
K0100 – K0710	DIETITIAN (RD)

L	
L0200	MDS
M	
M0100 – M1200	MDS
N	
N0300 – N2005 0450	MDS
O	
O 0100 - O 0300	MDS
O 0400 - O0430	MDS (in collaboration with Rehab)
O 0400 D & E	MDS
O 0400 F	ACTIVITIES
O 0500 – O 0700	MDS
P	
P0100- P0200	MDS
S	
S9040A- S9040H	MDS
Q	
Q0100	MDS
Q0300 – Q0600	SOCIAL SERVICES
V	
V0100	MDS
V0200	RCT
V0200 B&C	MDS
X	
X0100 – X1100	RAI
Z0100	SOFTWARE CALCULATION
Z0400	RCT
Z0500 A&B	MDS COORDINATOR

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. Trained, licensed staff and providers (nurses and social workers) conduct a suicide risk screen using a validated stratified risk screen tool.

    b. Notifying 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:

1. **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 ___."

2. **C-SSRS:** Columbia Suicide Severity Rating Scale, a validated screening instrument to assess risk for suicidality to guide next steps by a clinician.

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

4. **Passive suicidal ideation**: An individual ~~no longer has the motivation to live~~ expresses thoughts regarding death 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 from using the C-SSRS as performed by trained, licensed staff.

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 use the MDS Assessment under section D-0200 and/or D-0500 (PHQ-9) to assess the resident's mood 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 who have triggered as 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 and therapeutic environment such as desired noise level, lighting and visitors.

         - Staff shall assess the environment for potentially dangerous items for self-harm that may need to be removed or for which risk may need to be mitigated.

         - Consider AeroSs~~s~~cout (an electronic patient location tag).

      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 the resident within 2 hours and determines the appropriate next step as described in section 8.

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

v. Notify the Nursing Operations Supervisor within 2 hours.

b. Medium and High Risk (per C-SSRS screening)

i. Create a safe and therapeutic environment such as desired noise level, lighting and visitors.

- Staff shall assess the environment for potentially dangerous items for self-harm that may need to be removed or for which risk may need to be mitigated.

- 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, including the need for and urgency of psychiatry consultation if indicated.

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

iv. Immediately notify the Nursing Operations Supervisor.

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

7. **If the Resident Declines C-SSRS Screening**

a. Create a safe and therapeutic environment such as desired noise level, lighting and visitors.

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

ii. Consider AeroSs~~s~~cout.

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 Physician 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 any need for and urgency of psychiatric consultation.

i. The attending physician or on-call physician will evaluate the reasons for the C-SSRS 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 Primary Care Physician (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 Psychiatric Emergency facility (directly or via an Acute medical facility.

- If the resident or patient does not meet 5150 criteria for danger to self, per LHH Psychiatry provider assessment, but the clinical team identifies that LHH 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 LHH can manage the patient with appropriate behavioral interventions, the resident or patient shall not be transferred from LHH.

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.

c. The RCT will conduct a Resident Care Conference (RCC) as indicated within the next business day, 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 within the next business day (as described in c) to address safety related to suicidal ideation risk.

10. **Returning from Psychiatric Emergency**

a. The consulting ~~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 consulting ~~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/patient may return, and if so, will provide the order. (The physician shall only accept the resident for return after clearance by the consulting ~~psychiatry clinician~~ or on-call psychiatrist.)

11. **If the resident is cleared to return to LHH**

a. Maintain a safe environment;

   i. Staff shall assess the environment for potentially dangerous items for self-harm that may need to be removed or for which risk may need to be mitigated.

      - Refer to the Patient Safety and Ligature Identification Checklist.

   ii. Consider AeroS~~s~~cout.

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 suicide ~~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 develop a comprehensive care plan to address safety related to suicidal ideation risk.

12. **Psychiatry Communication with RCT**

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 (EHR).

b. Document the resident/patient's behavior(s) in the EHR~~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:
Attachment A - Columbia-Suicide Severity Rating Scale
Attachment 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 24-28~~3~~ Behavioral Health Service Care and Services
NPP C04.0 Notification and Documentation of Change in Resident Status
MSPP ~~(Medical Staff Policies and Procedures)~~ D08-03 Access to LHH Psychiatry Services
Standard Work: Suicide Screening
Standard Work: Referral to Psychiatry
Standard Work: Communication between Psychiatry and RCT

Revised: 24/03/12 (Year/Month/Day)
Original adoption: 23/06/13

SUPPORT SURFACES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) residents shall be assessed for specialized support surfaces needs upon admission and/or when there is a clinical need.

2. The Wound Care Clinical Nurse Specialist (CNS) shall evaluate all requests for specialized support surfaces.

3. Purchase and/or rental of support surfaces shall be co-managed by ~~Central Processing Department (CPD)~~Materials Management (MM) and the Wound Care CNS.

4. Delivery, set-up, pick-up, and/or storage of LHH owned support surfaces shall be managed by Environmental Services.

5. Maintenance and repair of LHH owned support surfaces shall be maintained by Facility Services.

PURPOSE:

To provide guidelines in determining appropriate support surfaces to prevent pressure ulcers for residents who are identified at risk for pressure ulcers and/or aid in optimal wound healing.

DEFINITION

The National Pressure Ulcer Advisory Panel (NPUAP) describes support surfaces as “specialized devices for pressure redistribution designed for management of tissue loads, microclimate, and/or other therapeutic functions.” These devices include specialized mattresses, mattress overlays, chair cushions, and pads used on transport stretchers, operating room (OR) tables, examination or procedure tables, and gurneys. Some support surfaces are part of an integrated bed system, which combines the bed frame and support surface into a single unit.

PROCEDURE:

Equipment:

	Delivery, Set-up, Pick-up, Storage for LHH Owned Surfaces	**Maintenance and Repair for LHH Owned Surfaces**	**Delivery, Set-up, Storage, Maintenance, Repair for Purchased/Rented Surfaces**

Responsible Department	EVS	Facility Services	~~Central Processing Department (CPD~~ Materials Management (MM)

1. Support Surfaces

a. Pressure Ulcer Prevention and/or Wound Management:

i. Low Air Loss Mattress

ii. Air Fluidized

iii. Mattress overlay

~~i.~~iv. Foam mattresses

b. Bariatric Beds

c. Seat cushions

i. Waffle seat or gel cushion

~~i.~~ii. Roho Cushion

2. Referred Pre-admits

a. Patient Flow ~~Nurse~~ shall screen the potential resident who may need support surface for wound management and/or accommodate bariatric needs.

b. Patient Flow ~~Nurse~~ shall coordinate with wound care CNS and attending physician the most appropriate support surface.

3. In-house Residents

a. The primary care physician and/or licensed nurse shall consult with wound care CNS to evaluate resident's needs for support surface.

4. Documentation on Resident Care Plan (RCP)

a. Document the type and purpose of support surface in the electronic health record.

5. Discontinuing Support Surface

a. Once the resident's pressure ulcer has healed, discuss in resident care team and continue pressure ulcer prevention interventions.

b. Notify wound care CNS or designee

c. Submit ~~EVS~~ an Environmental Services (EVS) request to pick up LHH owned support surface

d. Notify ~~CPD~~ MM via email for rental support surface pick up

ATTACHMENT:
Attachment A: Support Surface Guidelines

REFERENCE:
NPP K1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury
Hill-Rom Bariatric Manual; Sizewise Bariatric Manual
LHHPP 96-04 Special Surface Requisition Form
Laguna Honda Form MR 118 (10/91) Summary of Informed Consent Guidelines
Laguna Honda Form MR 812 Consent for Physical Restraints
Medical Staff PP: C02-01 Patient's Informed Consent for Treatment and Operation

Revised: 00/10/05, 13/01/29, 19/05/14, 25/04/14 (Year/Month/Day)
Original adoption: 98/04/01

RESIDENT/PATIENT AND VISITOR COMPLAINTS/GRIEVANCES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) strives to create an environment that is responsive to residents/patients/visitors' complaints/grievances and addresses residents/patients/visitors' concerns.

2. LHH encourages residents to raise concerns for resolution with their Resident Care Team (RCT), at Community meetings, or at Residents' Council without discrimination or fear of reprisal.

3. LHH encourages patients on the acute medical unit to raise concerns for resolution with the care providers on the acute unit without discrimination or fear of reprisal.

4. LHH shall make prompt efforts to resolve grievances residents/patients/visitors may have by actively working toward a resolution.

5. Individual resident/patient concerns that are addressed by the RCT or acute medical care team shall be documented in the medical record. Concerns raised during Residents Council and Community meetings shall be reflected in meeting minutes and or notes of those meetings respectively.

6. When methods for resolving concerns have not been successful and residents/patients/visitors choose not to use any of the above methods, LHH has a Complaint/Grievance form that can be submitted to the Administration Department (Administration) to address unresolved complaints/grievances in equitable and inclusive manner via unit-based grievance boxes and suggestion boxes throughout the facility.

7. The neighborhood bulletin board shall display necessary information, consistent with federal requirements on the residents/patients/visitors right to file complaints/grievances orally and in writing, including anonymously, and the process for submitting complaints/grievances, including how to contact the Ombudsman.

8. The Assistant Nursing Home Administrator for Care Experience (ANHA- CEX) shall act as the Grievance Official and is responsible for managing the grievance process; receiving and tracking grievances through to their conclusions; leading/directing any necessary investigations; maintaining confidentiality of information compiled; issuing written grievance decisions on behalf of department/unit managers; and coordinating with state and federal agencies as necessary.

PURPOSE:

1. To ensure that ~~t~~ complaints are addressed, and appropriate follow-up actions are taken to resolve the issue to the fullest extent possible.

2. To optimize the experience and satisfaction of the residents/patients/visitors with the care and services in a timely manner.

DEFINITION:

Complaint/Grievance: A verbal or written communication about a problem and/or concern signed or anonymous, presented via resident drop boxes, included in resident satisfaction surveys, or given directly to staff. Examples of complaints/grievances may include those about treatment, care, management of funds, lost clothing, or violation of rights.

PROCEDURE:

1. On admission, each resident receives the Resident Guidebook and the social worker orients him/her to the Resident Complaints/Grievance policy.

    a. If admitted to the acute medical unit at Laguna Honda, the admitting nurse will remind the patient of their right to file a grievance.

2. The Resident/Patient/Visitor Complaint/Grievance policy will be reviewed in Hospital-wide orientation for new employees and will be included in Resident's Rights annual in-services.

3. Resident/Patient/Visitor Complaint/Grievance forms shall be kept on each unit, in the Social Services Office, in the Nursing Office, and in the Administration Office to be available for residents or families as requested.

4. Grievance forms and submission boxes shall be located near the elevators of each neighborhood so that residents, families, and visitors may submit grievances without the assistance of LHH staff.

5. The RCT in the Skilled Nursing Facility, and/or the care team on the medical acute unit, shall encourage a resident/patient to complete the Resident/Patient/Visitor Complaint/Grievance form when methods for resolving concerns are not successful despite attempted interventions and the resident's concerns continue to be unresolved.

6. Should the grievance be concerning property loss, the resident/patient may file a claim for loss of property, by completing a claim form entitled "Claim Against the City and County of San Francisco". The filing of a claim form does not guarantee

reimbursement for the lost or stolen property. The Medical Social Worker or any member of the RCT may assist the resident/patient in completing claims form.

a. LHH is liable for damage or loss of the personal property of a resident/patient, but only if negligence or willful wrongdoing on the part of LHH or its employee is shown. LHH may also deny liability when reasonable efforts to safeguard the resident's personal property has been provided and the resident chooses to take other actions, or the property is not listed on the resident's IRP. Liability is subject to the amounts provided by law, including Civil Code sections 1840, 1859.

7. If the resident/patient/visitor is unable to or does not wish to complete the grievance form, staff may document the resident/patient's complaint/grievance on behalf of the resident/patient/visitor. The Resident/Patient Complaint/Grievance form may be submitted via the Grievances boxes near the elevators on the neighborhoods, to staff in Nursing, Social Service, or Administration. Any staff that receives a complaint/grievance form is responsible for submitting the completed form to Administration.

8. Residents/Patients/Visitors who wish to file their grievances anonymously may submit their Complaint/Grievance form into drop boxes labelled "Suggestion box" located at near the elevators on the neighborhoods, at the Pavilion lobby entrance (ground floor), Out-patient clinic lobby (first floor Pavilion) and the Administration lobby.

9. Contents from Suggestion Boxes shall be picked up Monday through Friday, excluding holidays by the Resident/Patient Safety Advocate or designee. Complaint/Grievance forms and Suggestion forms sent via email to the main Laguna Honda email address, laguna.honda@sfdph.org, and then shall be routed to the AHNA-CEX or their designee and members of the Executive Leadership team.

10. The Resident/Patient Safety Advocate, with guidance from the ANHA-CEX as needed, shall triage the complaint/grievance. The grievance shall be logged into the grievance log and assigned to the appropriate departments for timely follow up.

11. The appropriate department/unit manager shall acknowledge the complaint/grievance and or make contact the resident/patient in within the same day of receipt of the grievance. The resident/patient's right to confidentiality and privacy will be respected at all times.

12. If the complaint/grievance is anonymous, follow up with the complainant is not possible. However, the appropriate department head is still responsible for acknowledging receipt of the complaint/grievance, investigate the complaint/grievance, and address the general concerns of the complaint if the matter can be confirmed to the Grievance Official.

13. The Grievance Official shall respond to the complaint/grievance with a final resolution in 10 business days. In the event that the grievance cannot be resolved within 10

business days, the Grievance Official will inform the resident/patient of the plan to resolve the grievance and the estimated time frame to resolution. The Grievance Official will continue to monitor the progress until the grievance has been resolved, and ~~will~~ communicate with the resident/patient ~~nt about any changes to the timeline and upon resolution~~regarding the progress to resolving the grievance.

14. Appropriate corrective action(s) shall be implemented by the facility if an alleged violation of resident's rights is confirmed.

15. Documentation consistent with federal requirements related to resident grievances shall be maintained for a period of 3 years from the issuance of the grievance decision.

16. Complaints/grievances shall be evaluated and analyzed by the Grievance Official with respect to type, timely follow-up, trends, identification of problems/process gaps and the prevention of similar future problems. Data will be reported out in the following committees and meetings:

    a. Weekly at the Executive Committee meeting to ensure leadership have the opportunity to address complaints during leadership rounding. Discussion of the data shall be documented in the minutes.

    b. Monthly at Resident Council and during Community Meetings. Discussion of the data shall be documented in the respective groups' meeting minutes.

    c. Quarterly at the Quality Assurance Performance Improvement/Performance Improvement and Patient Safety (PIPS) meeting.

ATTACHMENT:
Attachment A: Grievance Information Flyer
Attachment B: Grievance Form
Attachment C: Grievance Acknowledgment
Attachment D: Grievance Response Form

REFERENCE:
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response
LHHPP 22-03 Residents' Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 75-07 Theft and Lost Property
Appendix PP/Guidance to Surveyors for Long Term Care Facilities F585/Sections 483.10(j) (1) – (4)

Revised: 09/10/01, 10/04/27, 16/01/12, 17/09/12, 19/03/12, 20/01/14, 22/08/17, 22/08/30, 22/12/13, 23/05/09, 23/07/18, 23/11/14, 2025/04/14 (Year/Month/Day)

Original adoption: 92/03/01

RESIDENT/PATIENT VISITATION

POLICY:

1. Residents'/Patients' visitors at Laguna Honda Hospital and Rehabilitation Center (LHH) shall be accommodated, without compromising the safety of the facility, residents/patients, and staff, or the care or the well-being of residents/patients at the facility.

2. Every resident/patient has the right to receive visitors of their choosing at the time of their choosing, subject to the resident's/patient's right to deny visitation when applicable and in a manner that does not impose on the rights of another resident/patient.

3. LHH shall provide access to a resident/patient by individual(s) that provides health, social, legal, or other services to the resident/patient, subject to reasonable clinical and safety restrictions and the resident's/patient's right to deny or withdraw consent at any time. This includes the following individuals:

    a. Treating physician(s);

    b. Immediate family, other relatives and friends of the resident/patient;

    c. Resident/patient representative;

    d. Representative(s) of the Health and Human Services Secretary;

    e. Representative(s) of the State;

    f. Representative(s) of the Office of the State long term care ombudsman,

        i. Any representative of the protection and advocacy systems, as designated by the state; and any representative of the agency responsible for the protection and advocacy system for the developmentally disabled individuals;

        ii. Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder as established under the Protection and Advocacy for the Mentally Ill Individuals Act of 2000. Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder.

4. Residents/patients, and or their representative, ~~(or the resident/patient representative, where appropriate)~~ shall be informed of their visitation rights through review of the Resident Handbook on admission and periodically thereafter as necessary.

5. LHH will inform each resident/patient and/or resident/patient representative of their visitation rights and related facility policies and procedures, including any clinical or safety restriction or limitation of such rights, in a manner they understand.

6. LHH will inform each resident/patient of the right, subject to his or her consent, to receive the visitors whom he or she designates as well as deny visitation, including but not limited to:

   a. A spouse, including a same-sex spouse

   b. A domestic partner, including a same-sex domestic partner

   c. Another family member

   d. Adoptive/foster family members

   e. A friend

7. Visitation privileges shall not be denied based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

PURPOSE:

To encourage visitation of residents/patients while protecting resident/patient rights and health needs.

PROCEDURE:

1. LHH will provide immediate access to a resident/patient by immediate family and other relatives of the resident/patient, subject to the resident's/patient's right to deny or withdraw consent at the time. ~~-~~Resident's/patient's family members are not subject to visiting hour limitations or other restrictions not imposed by the resident/patient except for reasonable clinical and safety restrictions, placed by the facility based on recommendations of the federal, state, and or ~~CMS, CDC, or the~~ local health department~~s~~.

   a. Recommended visiting hours for LHH are daily, from 10:00 a.m. to 9:00 p.m. Visits outside of the recommended visiting hours can be arranged with the Resident Care Team.

2. LHH will provide immediate access to a resident/patient by others who are visiting with the consent of the resident/patient, subject to reasonable clinical and safety restrictions and the resident's/patient's right to deny or withdraw consent at any time.

3. LHH will provide reasonable access to a resident/patient by any entity or individual that provides health, social, legal, or other services to the resident/patient, subject to

the resident's/patient's right to deny or withdraw consent at any time. LHH staff will provide space and privacy for these visits. All visitors must check in and sign in at the Pavilion Lobby and the unit upon arrival. (Cross Reference: LHHPP 75-02 Public Access and Night Security).

4. Visitors are not allowed personal items. Visitors may have a phone or wallet but cannot enter with a bag, purse, or any other personal item. Visitors are advised to leave personal belongings in their vehicles. If the visitor does not have a vehicle, staff will provide a secure locker for their belongings.

    a. If a visitor has personal medications that must be on their person, (such as blood pressure medication, allergy medication, seizure medication, etc.), they are permitted to carry this on their person.

5. All items and packages brought for residents/patients are subject to search. Searches shall be conducted by trained staff and follow standard protocol. If inappropriate items are found, they will be disposed of per facility policy.

6. If a resident's/patient's physician has determined that having visitors would not be in a resident's/patient's best interest on a given day, this shall be explained to the family. When only family visits are permitted (as determined/requested by the resident/patient), friends shall be so advised and not given entrance. (Cross Reference: LHHPP 75-03 Disorderly or Disruptive Visitors and LHHPP 75-10 Security Services Standard Operating Procedures Appendix H)

7. If isolation precautions are required in a resident's/patient's room or the care unit, visitors shall be advised of this by the unit's nursing personnel and instructed as to the necessary precautions. (Cross Reference: LHHPP 72-01 Infection Control Manual, B14 Visitors Guidelines for Infection Prevention)

8. If visitors object to any general restrictions or specific ones imposed on the resident's/patient's behalf, they should be referred to the Nursing Office for special consideration.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 Infection Control Manual, B14 Visitors Guidelines For Infection Prevention
LHHPP 75-02 Public Access and Night Security
LHHPP 75-03 Disorderly or Disruptive Visitors
LHHPP 75-10 Security Services Standard Operating Procedures Appendix H
Appendix PP/Guidance to Surveyors for Long Term Care Facilities, F172 Section 483.10 (f) (4) (vii) – (xi)
Cal. Code Regs. Tit. 22, § 70707 - Patients' Rights 70707 (b)(17)

Revised: 92/05/20, 12/09/25, 16/11/08, 17/09/12, 22/06/14, 22/12/13, 24/01/09, 25/04/14 (Year/Month/Day)

Original adoption: 88/01/22

CREMATION ASSISTANCE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) provides funding assistance to the families of LHH residents who do not have the means to pay for cremation arrangements.

2. The amount expended for cremation assistance to families shall not exceed the budgeted amount within the LHH~~Laguna Honda~~ Gift Fund (Gift Fund) for a given fiscal year.

PURPOSE:

To establish guidelines for the request and expenditure of funding from the Gift Fund for assistance to families of LHH residents for cremation.

CHARACTERISTIC:

1. The Gift Fund shall be the funding source for cremation assistance. ~~–~~A budget for cremation assistance shall be established on an annual basis as part of the Gift Fund budget and approved by the Health Commission.

2. The Gift Fund is a limited resource, and all efforts are made to find alternatives~~,~~ or to use the funds to supplement other sources.

PROCEDURE:

1. The Resident Care Team (RCT) shall identify candidates for burial assistance who meet the following criteria.

    a. The resident is nearing end-of-life and is expected to pass away as a resident at LHH.

    b. The resident has no funds or inadequate funds in their trust account to pay for cremation.

    c. The family of the resident has no funds or inadequate funds to pay for the resident's cremation.

2. Without financial assistance, a referral would need to be made to the Public Administrator for disposition of the body.

3. The Social Worker shall contact the Gift Fund Program Manager or designee to confirm that there are sufficient funds remaining in the burial assistance budget for the fiscal year.

4. The Social Worker shall evaluate the need for cremation assistance.

    a. The Social Worker shall contact the Accounting Department to ascertain the resident's balances in the Trust Account.

    b. The Social Worker shall consult with the resident's family if available to determine if they are able to pay the cost of cremation.

    c. The Social Worker shall document the information in the resident's medical record.

5. If the need is established, the Social Worker shall contact a city-approved mortuary for a written quote for cremation.

6. The Social Worker shall facilitate the completion of a Cremation Assistance Request Form and submit to the Director of Social Services.

7. Upon approval from the Director of Social Services, the Social Worker shall consult with the resident and/or the family to establish funeral plans.

8. Copies of all documents related to the Creation Assistance Request shall be forwarded to the Program Monitor overseeing the Rols 1000325 Gift Fund project code.

9. Upon the passing of the resident, the Director of Social Services or designee shall facilitate payment to the mortuary via the PeopleSoft eProcurement process using the following chart fields.

    a. Fund: 22150

    b. Department: 207690

    c. Project Code: 10000325

    d. Authority: 10001

10. The Program Monitor shall approve the requisition within PeopleSoft.

11. Copies of all documents related to the Creation Assistance Request and service procurement shall be forwarded to the Gift Fund program Coordinator to be filed.

ATTACHMENT:
Attachment A: Cremation Assistance Request Form
Attachment B: List of City-Approved Mortuaries

REFERENCE:
Admissions and Eligibility Department Policy 07-02 Procedure for Disposition of Expired
LHHPP 29-06 Caring for the Deceased, Use of Morgue, and Provision of Death Certificates
LHHPP 45-01 Gift Fund Management
NPP D8.0 Post-Mortem Care
MSPP C01-01 Patient Expiration
Social Services Departmental Policy 7.19 Burial and End of Life Care Arrangements Resident and Distribution of Funds

Original Adoption: 19/03/12 (Year/Month/Day)

Reviewed: 25/01/17

Revised: 23/03/14 (Year/Month/Day)

CARING FOR THE DECEASED, USE OF MORGUE, AND PROVISION OF DEATH CERTIFICATES

POLICY:

LHH Hospital and Rehabilitation Center (LHH) maintains decedents in the morgue when necessary until transfer to a mortuary, the Medical Examiner morgue or the Zuckerberg San Francisco General Hospital (ZSFG) Morgue. Admitting & Eligibility (A&E) and Nursing Departments shall collaborate to release and transfer decedents in a timely manner.

PURPOSE:

To assist the family or legal representative with the decedent's final arrangements while maintaining respect for the decedent.

PROCEDURE:

1. Guidelines for the Notification of Families / Guardians of a Resident's Death

a. Notification of Death	Responsible Party
Family / Guardian	Physician who pronounced death
Mortuary	Family or Legal Guardian, Nurse, or Admissions & Eligibility (A&E) staff

b. Funeral Arrangements	Responsible Party
Routine or Legal Guardian	Family
Public Administrator / Medical Examiner	A&E

2. Guidelines for the Completion of the Required Forms

a. Documentation	Responsible Party
Death Registry	Medical Records
Death Certificate	Medical Staff
Release Form	Completed by Mortician/ Public Administrator
Deceased Resident's Morgue Data Base Deceased Registry	Nursing Office/A&E

Documentation	Responsible Party (continued)
Transfer Authorization Form Application/ Permit for Human Remains through Electronic Death Registry System (EDRS) (If decedent is still in the morgue after 8 days)	Mortician A&E Staff

3. Death Certificate

a. Health Information Services (HIS) transfers the death certificate into the EDRS to the mortuary or vice versa. HIS contacts the physician to obtain the signature on the death certificate and retains a copy of the death certificate on file.

b. If the resident expires ~~over the a~~a ~~weekend,~~ in the evening hours ~~or~~, on a legal holiday~~s~~, or during the weekend (between the hours of 5 p.m. Friday and 8 a.m. Monday):

i. ~~Signing the Death Certificate shall wait until the care unit attending physician/designee is available.~~The death certificate shall be signed by the primary attending physician or designee by the next business day

ii. Under exceptional circumstances, if the family of the deceased, their ~~or~~ legal representative or mortician requires immediate completion of ~~insists on immediately receiving~~ the ~~D~~death ~~C~~certificate, the ~~on call~~on-call ~~house~~ night/weekend physician may sign the ~~D~~death ~~C~~certificate as the "certifier" using his/her own signature and printed name and California Medical License #. The name and address of the primary attending physician will be entered into block 118: Attending Physician's Name. ~~, but the on call the house night/weekend physician shall print or type the care unit attending physician's name in the appropriate signature block.~~

4. Morgue Monitoring: Laguna Honda Nursing and A&E department uses the Morgue Data Base (MDB) to document final disposition of the deceased and to monitor the morgue capacity.

a. Laguna Honda Hospital and Rehabilitation Center (LHH) maintains decedents in the morgue when necessary until transfer to a mortuary, the Medical Examiner morgue or the ZSFG morgue.

b. A&E and Nursing departments shall collaborate to release and transfer decedents in a timely manner.

c. Nursing Ops shall be responsible for data entry of resident information in the morgue database (MDB). A&E shall be responsible in monitoring the MDB for morgue capacity and accuracy.

d. **Guidelines for the Completion of the MDB and Required Forms:** Nursing Ops shall enter data to MDB when the resident's body is transferred to the morgue or picked up by the mortuary or examiner's office.

i. **Steps for creating MDB record:**

- Type in last name of Resident.
- Select resident from drop down box and click on select button to display record.
- To complete entry select boxes to indicate if resident was picked up from Neighborhood or transferred to LHH morgue. If picked up from Neighborhood, name of mortuary and date of pick-up from drop down menu. If transferred to LHH morgue, select drawer number locations.
  - Old Morgue drawer location numbers: Drawers O1-O12
  - New Morgue drawer location numbers: H15 – H20

e. **Forms and Responsible Staff:**

i. MDB Record printed from MDB and signed by Mortuary attendant picking up the decedent – Nursing Ops.

ii. Nursing Ops or designee shall scan MDB records to A&E. Original forms shall be placed in a designate A&E box located in the nursing office and shall be picked up by A&E staff.

f. **MDB Monitoring:**

i. The MDB shall be monitored and updated by the nursing office and A&E.

ii. A&E Census Desk shall monitor the MDB daily to check number and status of decedents remaining in the morgue.

g. Transfer to ZSFG due to overcapacity or autopsy: During normal business hours A&E Manger or designee shall arrange transport of decedents(s) to ZSFG or the Medical Examiner's office. During non-business hours, weekends and holidays, Nursing Ops shall arrange transportation to ZSFG or the Medical Examiner's office.

h. The A&E Manager or designee shall notify the Chief Nursing Officer (CNO) and Director of Social Services if the morgue is nearing capacity (16 decedents).

i. Social services shall contact families to determine which decedents can be promptly transferred to mortuaries.

j. A&E Manager or designee shall contact the PA to expedite transfer of cases. If the Medical Examiner's office has accepted jurisdiction, the A&E manager or designee shall request expedited pick-up.

k. The CNO or designee shall identify decedents to be transferred to ZSFG and contact ZSFG Morgue to arrange transfer.

l. **Transportation Arrangements due to overcapacity:**

   i. A&E contacts Green Street Mortuary for availability and quote.

   ii. A&E completes RPO to Materials Management (requires signature from Chief Financial Officer (CFO) or designee).

   iii. A&E finalizes pick-up/drop-off arrangements with Green St. and ZSFG morgue attendant.

   iv. A&E contacts CNO or designee with transfer arrangement information.

ATTACHMENT:
None.

REFERENCE:
LHHPP 24-11 Notification of Family/Surrogate Decision-Makers (SDMs) and/or Conservators of Change in Condition and/or Death
MSPP C01-01 Patient Expiration
NPP D8.0 Post Mortem Care
~~LHHPP 24-11 Notification of Family/Surrogate Decision-Makers (SDMs) and/or Conservators of Change in Condition and/or Death~~

Revised: 15/07/14, 16/09/13, 16/11/08, 25/04/14 (Year/Month/Day)

Original adoption: 03/05/08

HUMAN SUBJECT RESEARCH

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) complies with the Department of Public Health (DPH) policy, "HIPAA Compliance: Privacy and the Conduct of Research".

2. LHH supports the inherent value of research and is committed to collaboration~~s~~ which produce knowledge translatable into clinical practice.

3. The Chief Executive Officer/Nursing Home Administrator (CEO/NHA) approves all requests for human subject research at LHH and designates the Research Oversight Committee (ROC) as reviewer and monitor of such research.

4. Research conducted at LHH is consistent with ethical and legal standards, likely to benefit resident care or contribute to long-term care knowledge and ~~is~~ in alignment with the mission and goals of LHH.

5. City general fund dollars will not support research unless the City specifically authorizes such use.

6. Any grant funds obtained by LHH staff from outside resources for research at LHH will be subject to the “accept and expend” approvals of the San Francisco Health Commission and the principles for avoidance of conflict of interest in medical research funding outlined by the Institute of Medicine and the National Academies[1].

7. This policy does not apply to evaluation of waiver programs, educational grants, court mandated evaluation projects, or quality improvement projects intended for internal performance improvement only.

8. The ROC is not an Institutional Review Board as stipulated in federal regulation, often referred to as Federal Wide Assurance (FWA).

PURPOSE:

1. To establish a procedure for reviewing requests to conduct research at LHH.

2. To outline the role of ROC.

3. To establish a procedure for continued resident participation in research initiated prior to LHH admission.

[1] Campbell, E. Conflict of Interest in medical research, education and practice. Statement for the Institute of Medicine and the National Academies to the Senate Committee on Aging. July 29, 2009.

BACKGROUND:

1. Committee Scope and Membership:

a. The ROC is responsible for:

i. Serving as the primary resource for investigators seeking to conduct research at LHH.

ii. Acting as facilitators to effectively guide investigators through the process of obtaining approval for the initiation of research studies at LHH and communicating with affected department administrators or supervisors.

iii. Reviewing all human subject research projects submitted to LHH.

iv. Making recommendations to the Performance Improvement and Patient Safety (PIPS) committee and the CEO/NHA regarding requests to initiate research studies.

v. Maintaining a log of all research studies being conducted at LHH.

vi. Providing semi-annual reports to the PIPS and the CEO/NHA about the status of active research studies at LHH.

vii. Requesting and receiving reports from investigators regarding findings and results from completed projects.

viii. Assuring that the informed consent process takes into account the potentially vulnerable persons served by LHH.

2. ROC Committee Membership:

a. The Chair of the ROC will be appointed by the CEO/NHA.

b. Members of the ROC Committee include

i. Medical Services Representative

ii. Nursing Services Representative

iii. Chief Quality Officer, or designee

iv. Deputy City Attorney, or designee

v. Director of Pharmacy, or designee

vi. Compliance and Privacy Officer, or designee

PROCEDURE:

1. Review and Approval Process:

a. LHH staff will direct investigators who are interested in performing human subject research at the hospital to contact the Chair of the ROC. Investigators are not required to have an institutional review board (IRB) approved study before contacting the ROC.

b. The ROC chair ~~will provide the DPH Research Proposal Approval form for completion and submission~~ will direct investigators to the UCSF Research Protocol / Approvals at ZSFG/SFDPH: UCSF Research Protocol Approvals at ZSFG/SFDPH: https://zsfg.ucsf.edu/research-protocol-applications-zsfg

~~b.~~c. ~~(link below).~~ The research application should be completed with the appropriate signatures from LHH obtained.

~~c.~~d. In addition, the ROC request that interested investigators complete the LHH Human Subjects Research Investigator Checklist. (Attached)

i. When an IRB application is available (approved or pending approval), the investigator will attach the application to the completed Checklist.

ii. When a research protocol is available, the investigator will attach it to the completed Checklist.

~~d.~~e. The criteria for review of proposed research studies by the ROC include:

i. Acceptable risks - benefits ratio to participant LHH residents and staff.

ii. Reasonable use of LHH resources (e.g. staff time, resident health care costs, etc.).

iii. Alignment of research study to LHH's mission and goals.

iv. Absence of conflict with LHH risk management issues.

~~e.~~f. If the research proposed does not substantially meet the criteria for review identified in 1 (d), the ROC will present the study to the PIPS Committee for review with the recommendation of non-approval.

If the research study substantially meets the criteria identified in 1 (d) and involves LHH staff, the ROC Chair will:

i. Ask the investigator to obtain support from the department head / supervisor / administrator for the disciplines/services impacted by the proposed study.

ii. Forward copies of the Human Subject Research Investigator Checklist and any attachments to the department head/supervisor/administrator whose service/department impacted by the proposed study.

iii. Inform the department head/supervisor/administrator that communication with the investigator does not constitute LHH approval of the study.

iv. ~~–~~Ask the department head/supervisor/administrator to communicate with the ROC Chair about the outcome of the discussion with the investigator.

v. ~~–~~Once support is obtained from the department head / supervisor / administrator for the disciplines/services impacted by the proposed study, the ROC will forward the proposed study to the Medical Executive Committee (MEC) and Nursing Executive Committee (NEC) for review and approval.

~~f.~~g. For research studies with IRB approval: With confirmed support from the involved LHH department(s), approval by MEC and NEC, and external IRB approval, the ROC will present the research proposal to the PIPS Committee and the CEO/NHA with recommendations for approval or non-approval by the CEO/NHA.

i. If the study is approved by the CEO/NHA, the investigator must ensure that LHH is acknowledged as a research site/partner on its IRB application/approval and any subsequent publications. Evidence of this designation of LHH as research site and partner must be submitted to the ROC prior to initiation of the study.

~~i.~~ii. The appropriate signatures will need to be obtained to complete the UCSF Research at SFDPH Research Protocol Application.

~~ii.~~iii. If the study is not approved by the CEO/NHA, the ROC will inform the investigator of this decision along with any pertinent feedback.

~~g.~~h. For research studies pending IRB approval: If the research study has received support from the involved department/s, MEC and NEC, the ROC will ask the investigator to obtain IRB approval and designate LHH as a research site.

i. If requested by the investigator, LHH may generate a letter of support and/or a letter of deferment (deferring IRB approval to another institution)

ii. After the research study receives IRB approval:

- The investigator must submit the IRB approved research study to the ROC that includes the designation of LHH as a research site prior to the initiation of the study.

  ROC will review the approved IRB, and, if appropriate, recommend approval of the study to PIPS Committee. If approved, the DPH Research Proposal Approval form will be signed by the CEO/NHA and the Dataset Representative, or designee.

- If the study is not approved by the CEO/NHA, the ROC will inform the investigator of this decision along with any pertinent feedback.

~~h.~~i. Investigator's responsibilities include:

i. Providing a copy of the signed informed consent form for filing in the legal section of the medical record of participant LHH residents.

ii. Informing the Chair of the ROC of any subsequent changes to the IRB application during the course of the study, including those that impact resident care, or involvement of resident or staff.

iii. Communicating at the start and at intervals not greater than six months the status of the study by the principle investigators to the LHH ROC.

iv. For research involving the use of drugs, submitting a copy of the signed informed consent and research protocol to the LHH Director of Pharmacy to coordinate storage, labeling and dispensing (see Appendix for Department of Pharmaceutical Services Policy and Procedure 02.05.00).

v. For research involving simple blood draws or other required tests, bearing the cost, unless done as part of usual care.

vi. Immediately reporting any suspected adverse effect related to study participation to ROC.

vii. Assuming financial and legal responsibility for harm to study participants.

~~i.~~j. Termination of LHH participation:

i. Prior to the approval by the CEO/NHA, if there are conditions, such as changes in LHH resources, that preclude the research study from moving forward, the ROC Chair will inform the investigator.

ii. Even after approval by the CEO/NHA, if the study is determined to be detrimental to the safety of study participants or hospital operations, the ROC

will facilitate communications for corrective actions and/or notify the investigator of immediate termination.

2. Resident Participation in Research Studies Initiated Prior to Admission:

a. Residents or their surrogate decision makers will be asked if they wish to continue to participate in the research study after admission to LHH.

b. Off LHH Site: For a resident continuing participation in research that occurs off-site, the signed consent form will be made available for review by the resident's primary physician and scanned into the electronic health record (EHR).

c. On LHH Site: For a resident continuing participation in research that takes place on-site, the consent form and research protocol will be made available for review by the resident's primary physician and scanned into the EHR. The Protocol will be forwarded to the ROC.

d. For research studies requiring access to medical records, examination or performing procedures on LHH resident and or administration of medication, the ROC will facilitate communications in requesting approval from the Chief Medical Officer or his/her designee before proceeding.

ATTACHMENT:
Appendix A: LHH Human Subjects Research Investigation Checklist

~~UCSF Research Protocol Approvals at ZSFG/SFDPH: https://zsfg.ucsf.edu/research-protocol-applications-zsfg~~

UCSF Research Protocol / Approvals at ZSFG/SFDPH: UCSF Research Protocol Approvals at ZSFG/SFDPH: https://zsfg.ucsf.edu/research-protocol-applications-zsfg

REFERENCE:
Pharmaceutical Services Policies and Procedures 02.05.00: Investigational Drugs
DPH Policy: HIPAA Compliance-Privacy and the Conduct of Research
DPH Research Proposal Approval
~~Laguna Honda's Commitment to Service webpage: http://lagunahonda.org/MissionVisionValues~~

Revised: 10/04/27, 11/09/27, 13/05/28, 19/05/14, 20/10/13, 25/04/14 (Year/Month/Day)
Original adoption: 10/04/27

APPENDIX A:

Laguna Honda Hospital and Rehabilitation Center (LHH)
Human Subjects Research Investigator Checklist
Research Support and Oversight Committee

Study Title: _____

Principal Investigator/Discipline: _____

If student project, indicate name of supervisor: _____

Email: _____ Tel.No.: _____

Academic Affiliation (if applicable): _____

Laguna Honda liaison/co-investigators (if appropriate): _____

Has study been funded? If so, list funder[s]: _____

Review Criteria	YES	NO	Comments
1. Has the DPH Research Proposal Approval been completed and submitted to the ROC chair?			
2. Has a protocol (or IRB) application been submitted to, or approved by, a FWA- certified IRB? *If **YES**, indicate name of IRB and submit documentation of approval			
3. Has LHH been designated as a study site in the protocol?			
4. Will study include LHH staff as researchers, subjects, data collectors, or implementers of study protocol (including recruitment of residents)? If so, provide additional information.			
5. Have researchers contacted LHH staff/dept/ committee about this project? *If **YES**, indicate who was contacted.			
6. Has the department head or division chief, whose practice or staff is affected by the study, provided provisional support? (List name of LHH leader contacted)			
7. Have you reviewed LHH policies related to conduct of human subjects research? (see attached Hospital Wide Policy and Procedure 29-07 “Human Subject Research”)			
8. Will pharmacological agents or medical devices be tested?			
9. Will laboratory or radiology tests be required as part of this protocol? *If **YES**, how are these expenses being covered?			

Review Criteria	YES	NO	Comments
10. Will medical record information be accessed, if so are ~~HIPPA~~HIPAA provisions outlined in the protocol?			
11. If review of LHH medical records is needed, is this stipulated in the study?			
12. Do you agree that study-related adverse event(s) be reported to LHH immediately?			
13. Do researchers agree to provide at least annual reports to LHH about ongoing studies?			
14. Do researchers agree to provide findings upon study completion?			
15. Is the research consistent with ethical and legal standards, likely to benefit resident care or contribute to long-term care knowledge, and is in alignment with the mission and goals of LHH?			

Deletion Hospital-wide Policies and Procedures

ACCOMMODATION OF THE FAMILY AFTER PATIENT'S DEATH

POLICY:

The acute care unit of Laguna Honda Hospital and Rehabilitation Center (LHH)'s acute care units shall provide a "reasonably brief period of time" for family or next of kin to gather at the patient's bedside after a patient is pronounced dead as described in the Health and Safety Code Section 1254.4.

PURPOSE:

To comply with the Health and Safety Code Section 1254.4.

PROCEDURE:

1. Ventilator support is not available at Laguna Honda HospitalLHH. Consequently, LHH is not equipped to manage patients who are declared brain dead, due to as such patients require continuous ventilatory assistance required to maintain organ perfusion. Therefore, the accommodation for family or next of kin related to declaration of brain death, as described in Health and Safety Code Section 1254.4, is not applicable.

2. This policy shall be provided to the family or next of kin upon request.

ATTACHMENT:

None

REFERENCE:

Health and Safety Code Section 1254.4
http://www.weblaws.org/california/codes/ca_health_and_safety_section_1254.4

Revised: 15/07/14 (Year/Month/Day)
Original adoption: 12/03/27

Revised Food and Nutrition Policies and Procedures

1.143 Food Supply/Food Storage

~~Established and~~ Revised: 7/2024~~3/81, 1/89, 1/92, 9/94, 5/97, 9/06, 7/09, 1/10~~
~~Reviewed: 8/13, 8/14~~

Policy: All foods and supplies will be stored properly under HACCP guidelines.

Purpose: To ensure safety of the food supply while in storage. To comply to Federal, State, and Local regulations.

Procedure:

1. Upon delivery, perishable foods are placed in a freezer or refrigerator which is maintained at appropriate temperature.
2. All staple supplies are stored on ~~n metal~~ shelves in a ventilated storeroom. The temperature for dry storage will be between 40*F to 70*F. Temperatures will be checked daily to assure that recommended temperatures are maintained.
3. All food and supplies are rotated into storage with the older units in front or on top, as appropriate. (First in/First out)
4. Food is stored away from potentially hazardous substances such as cleaning supplies.
5. Temperatures of refrigerators/freezers are checked daily to ~~a~~assure that recommended temperatures are maintained. A~~a~~. Dairy: 40º~~36 – 38*~~ F or below~~.~~ B~~b~~. Produce: 40º F or below ~~36 – 38* F.~~ C~~c~~. Meat: 40º F or below ~~30 – 38* F.~~ D~~d~~. Freezer: 0º~~10 – 20*~~ F or below.
6. Food that is outdated, spoiled, or contaminated will be properly identified with a sign and removed from the general stores area. The storeroom clerk will promptly notify the Chef, supervisor or designee ~~and/or Assistant Food Service Director~~. If the product needs to be returned to the vendor for credit, the food item will be stored in a designated area for returned items and a sign will be placed on the items.
    i. The maximum time products will be retained on hand in the designated storage locations e.g. storeroom and freezers will be one (1) year~~s~~ or per manufacturer's recommendation.
    ii. The maximum of period ~~of time non~~ nonperishable products will be retained after being put into use e.g. spices etc. will be six (6) months.
    iii. The maximums period ~~of time~~ perishable products will be retained under refrigeration will be seventy~~-~~-two (72) hours. Unless in cr~~a~~yovac packaging left unopened, one month, or per manufacturer recommendation.~~-~~
7. HACCP (Hazard Analysis Critical Control Point) methods will be used and maintained during the food storage process.
8. The Chef ~~Operations~~ is accountable for designated storage locations e.g. storeroom and freezers.
9. The ~~Production~~ Chef is accountable for designated locations in the kitchen and adjacent areas associated with Production.

1.59 Authorized Personnel Only

~~Established and~~ Revised: 7/2024 ~~3/81, 1/89, 5/97, 9/06, 7/09~~
~~Reviewed: 8/13, 8/14~~

Policy: All ~~non food~~nonfood service personnel or visitors will not be allowed in the production area except when authorized by Management. Authorized personnel or visitors must adhere to safe food safety practices and safety precautions to prevent injury.

Purpose: For safety and sanitation purposes and to comply with health regulations.

Procedure:

- All ~~non food~~nonfood service personnel and visitors will not be allowed in the production area except those that are authorized by Management ~~to do so~~.
- Shoes must cover the entire foot (no open toe, high heel and/or slippery shoes or sandals).
- Hospital Staff members, contractors, and visitors should check with Management prior to entering~~going to~~ the production area. They may be required to wash their hands and wear the proper personal protective equipment (PPE), prior entering the department ~~hair covering~~.

There are those that are authorized to be in the area on a usual business basis such as service technicians and food business vendors.

~~11/6/2015~~

1.165 General Cleaning and Sanitizing work Surfaces and Kitchen or Galley Equipment

Reviewed: 07/2024 ~~8/13, 8/14~~

Cleaning is the process in which a food service worker is removing food and other types of soil from a surface such as countertop or plate. Sanitizing is the process in which a food service worker uses a sanitizer on the same surface that was previously cleaned to reduce the number of micro-organisms to a safe level. To be effective, the food service worker must conduct a two-step process, cleaning and sanitizing. Surfaces must be first cleaned and rinsed before being sanitized.

All food-contact services must be washed, rinsed and sanitized:

- After each use
- Any time the food service worker begins working with another type of food
- Any time the food service worker is~~are~~ interrupted during a task and the tools or items that the food service worker has been working with, may been contaminated
- At four- hour intervals, if the items are in ~~constant~~constant use

~~use~~ Equipment needed for Cleaning and Sanitizing:

- Three Clean ~~Rags~~cloths
- Three color coded 3 qt size buckets – green for cleaning solution; blue for clean rinse water; and red for sanitizing solution.
- Gloves
- Apron
- May need the use of Goggles and Mask
- Warm Water
- Spray bottle of sanitizing solution if applicable for a particular equipment such as a large kettle or inside wells of the steam table.
- Cart for transporting the three buckets for cleaning and sanitizing

General Cleaning and Sanitizing Procedure:

1. On a cart, place the three--color coded 3 qt size buckets – green for cleaning solution; blue for clean rinse water; and red for sanitizing solution.
2. At the designated sink, fill the green bucket with an ounce of department approved detergent ~~Tuff Suds Detergent~~ (one pump) and fill with 3 quarts of warm water.
3. Fill the Blue bucket with clean warm water.
4. Fill the red bucket with department approved sanitizer~~Mikrolene~~ using the auto-dispenser. To properly dispense of the premix solution of department approved sanitizer~~MikroKlene~~, press the blue button and allow it to run through the clear tube for a couple of seconds then proceed to filling up the red bucket. If the dispenser does not work properly, you may mix using the vile and pump, 2 ml with 3 qt. water (75-100 degrees water)

5. Using the cleaning solution detergent~~tuff suds~~, use a clean cloth and clean the surface such as countertop or food service equipment.
6. Rinse the surface with a clean rag of warm to hot water ~~water~~.
7. Sanitize the surface by using a clean cloth with sanitizer~~Mikroklene~~. Then allow surface~~ervice~~ to air dry.
8. If the equipment has been approved to use a spray bottle filled with sanitizer~~MikroKlene~~, spray evenly onto the surface and allow to air dry. (Do not wipe down).
9. Change solution and water after each equipment has been cleaned and sanitized or within (2) two hours of usage.
10. After you have cleaned and sanitized all the countertops and food service equipment, dispose of the water into the designated sink. Rinse out each bucket~~s~~ and run them through the dish machine. Allow to air dry. Put into their proper storage location.
11. If using a spray bottle, refill with product and place back in correct storage location.
12. Take the soiled rags and dispose them into the correct container. ~~for laundry.~~
13. Keep all chemical products away from food.
14. Be familiar with the Chemical Safety Data Sheets~~'s Material Safety Data Sheets~~ on proper handling and safe use of the chemicals.
15. Never mix chemicals together.
16. It is important to follow the policy and procedure on testing the concentration of Sanitizer~~MikroKlene~~. This will be done twice daily to ensure that the chemical is being effective. It is important to follow Ecolab's recommendation on the concentration for effectiveness and consistency. ~~For our general purpose, we will be at 25 ppm.~~

Note: Using the Dish machine for cleaning and sanitizing may be appropriate to use such as a slicer that has detachable parts that can be run through the dish machine.

Spray bottles must be clearly labeled with the product sanitizer~~MikroKlene~~ and to be used for this ~~particular~~ chemical. Please do not use the spray bottle if it is not clearly labeled as such and report it to your supervisor.

Testing of correct concentration for MikroKlene

To ensure that the chemical used for sanitizing food service work equipment and surfaces are at the correct concentration for most effective use of the product sanitizer~~MikroKlene~~.

Procedure:

1. Twice a day (AM and PM) a senior food service worker or designee for Galley Service and Chef~~s~~ in the main Production Kitchen will test with an iodine litmus paper strip the concentration of the chemical sanitizer~~MikroKlene~~ to ensure that it is at the appropriate ~~25~~ppm for sanitizing the work services and food service equipment.

2. Fill 3~~-~~-quart container with sanitizer~~MikroKlene~~ using the auto-dispenser. To properly dispense of the premix solution of sanitizer~~MikroKlene~~, press the blue

button and allow it to run through the clear tube for a couple of seconds then proceed to fill the bucket~~cup~~. Take ~~an iodine litmus~~ paper test strip and dip half of it into the bucket~~cup~~ and concentration per manufacturer recommendation~~hold for one minute~~. Take the test~~litmus~~ paper out of the solution and match it to the color chart to read ~~25ppm~~.

3. If the dispenser does not work properly, you may mix one half ounce of product to 2 ½ gallons of warm water (75-100~~F.~~)F).
4. If solution is acceptable document the results ~~it reads 25 ppm, document the results~~ on the daily equipment checklist managed by the Supervisors and/or Chefs.
5. Report any concerns immediately to Ecolab for corrective action when product does not meet standard~~. of 25 ppm.~~ Ecolab's contact number: (800)-352-5326.
6. If it is not dispensing correctly, tag the dispenser do not use until repaired.
7. Instruct the food service worker to mix concentrated solution per manufacture recommendation.~~with warm water. (half ounce per 2 ½ gallons of warm water (75-100 degrees) or 2ml with 3 quarts of water.)~~

Note: Quarterly, the Ecolab Representative will test the titration of each sanitizer~~MikroKlene~~ dispensing units in Galleys and Production Kitchen. They will take correction action when product does not meet standard ~~or 25ppm~~.

1.93 Food Preparation Standards

~~Established and revised: 5/98, 9/06, 7/09, 11/10, 11/22~~

Reviewed: ~~8/13,8/14,~~ 7/24

Policy: All food items will be prepared in a manner that will ensure the best quality food product. Cooking methods will be used to conserve good nutrient value, to maintain food temperatures outside of the danger zone, and to maintain good color, texture, and flavor of the food item. Food will be cooked progressively and held for service under heated conditions for no more than 45 minutes.

Procedure:

1. All food items will be received, stored, issued and processed under the HACCP guidelines. Thawing of food products will be completed under the HACCP guidelines. Chefs will monitor this process.

2. All cold food items will be stored covered under proper refrigeration. Employees will handle the food item in batches to ensure that standards are ~~always~~ maintained at all times. Cold Food Preparation (Advance Prep) will be monitored by the Production Chef and be assigned for completion by trained staff 24-48 hours in advance of service date.

3. All hot food items, if not being heated for service, will be stored covered in the refrigerator.

4. All hot food items will be cooked in batches and will not be left in a holding cabinet for more than 45 minutes.

5. Vegetables will be stored under refrigeration until the cooking process begins. All vegetables will be batch cooked for meal service.

6. The cooks will make temperature and quality checks on all food items prior to leaving the production area for cafeteria and tray service.

7. Cooling Down Log Policy

    a. Each day the on-duty Chef or designee will check and monitor the cool down temperature of a lunch and dinner meal selection (entrée, mechanical soft = ground and puree) in addition to one other menu selection.
    b. Temperatures will be measured when the selected foods reach 140°F.
    c. All foods will be cooled in two (2") inch uncovered inserts in the blast chiller.
    d. Large cuts of meat will be cut into five (5#) pound pieces and cooled in the blast chiller.
    e. All foods must be cooled from ~~140~~ 135°F to 70°F or below within two hours (2) hours; then from 70°F – 40 F or below within four (4) hours or the food will be discarded. Chef shall take immediate corrective action if cooling is not progressing in a timely manner.
    f. All food products will be labeled, covered and stored in a refrigerator after the food reaches 40°F or lower. Food will be stored in 4" or 6" deep inserts, only after the food is at 40°F or lower.

8. When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards.

a. Thawing – approved methods for thawing frozen foods include thawing in the refrigerator, submerging under cold water, thawing in a microwave oven, or as part of a continuous cooking process. Thawing at room temperature is not acceptable.

b. Cooking – foods shall be prepared as directed until recommended temperatures for the specific foods are reached. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed.

c. Cooling – various strategies (e.g., placing foods in shallow pans, cutting roasts into smaller portions, utilizing ice water baths, and stirring periodically) shall be implemented to cool foods so that the total time for cooling does not exceed 6 hours.

d. Holding – staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed.

e. Reheating – food that is cooked and cooled must be reheated so that all parts of the food reach an internal temperature of 165°F. Ready-to-eat foods that require heating before consumptions must be heated to at least 165°F.

9. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Strategies include, but are not limited to:

a. Covering all foods when traveling a distance (i.e., down a hallway, to a different unit or floor).

b. Using tray lines, mobile food carts or portable steam tables transported to dining areas.

c. Washing hands properly before distributing trays.

d. Washing hands between contact with residents and after collecting soiled plates and food waste.

e. Use of gloves when touching and assisting with ready-to-eat foods.

f. Timely distribution of all meals/snacks.

10. All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination.

a. Staff shall follow facility procedures for dishwashing and cleaning fixed cooking equipment.

b. Clean dishes shall be kept separate from dirty dishes.

c. Staff shall wash hands prior to handling clean dishes and shall handle them by outside surfaces or touch only the handles of utensils.

11. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects.

a. Staff shall wash hands according to facility procedures.

b. Staff shall not touch food with bare hands, exhibiting appropriate use of gloves, tongs, deli paper, and spatulas.

c. Staff who exhibit a communicable or infectious disease shall be restricted from working in accordance with the facility's work restrictions/infectious diseases policy.

d. Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food.

e. Hairnets should be worn when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad. However, staff do not need to wear hairnets when distributing foods to residents at the dining table(s) or when assisting residents to dine.

f. Staff should maintain nails that are clean and neat, and wearing intact disposable gloves in good condition that are changed appropriately to reduce the spread of infection.

g. Staff shall keep jewelry to a minimum and cover hand or wrist jewelry with gloves when handling food.

h. Gloves will be worn when directly touching ready-to-eat foods and when serving residents who are on transmission-based precautions. However, staff do not need to wear gloves when distributing foods to residents at the dining table(s) or when assisting residents to dine unless touching ready-to-eat food.

12. Additional strategies to prevent foodborne illness include, but are not limited to:

a. Preventing cross-contamination of foods.

b. Washing fresh fruits and vegetables prior to use.

c. Keeping cut and raw fruits and vegetables refrigerated.

d. Proper refrigeration of meat, poultry, and pasteurized dairy products.
e. Cleaning and sanitizing the internal components of the ice machine according to manufacturer's guidelines.

Deletion Hospital-wide Policies and Procedures

ENTERAL TUBE FEEDING MANAGEMENT

POLICY:

1. Enteral nutrition is instituted after careful resident assessment and if clinically indicated for:
   a. Short-term intervention for acute management of nutritional support.
   b. Last resort treatment for insufficient oral nutrition if consistent with the resident's goal of care.

2. Position is confirmed by gastrografin for any tube placement or replacement prior to initial use.

3. Routine enteral tube placement is checked by measuring external tube length and inspecting the mouth for Nasogastric Tubes:
   - upon admission and relocation
   - after placement or replacement
   - each shift and as needed
   - prior to accessing

4. The Licensed Nurse (LN) checks the feeding pump at the beginning of the shift to verify that the pump is functional and programmed per the order.

5. For simple balloon gastrostomy tubes (no PEG or internal bumper) that are older than 6 weeks, a trained Registered Nurse (RN) replaces the tube at least every 3 months due to the balloon failure risk and as needed (i.e., worn, dislodged or clogged), unless ordered otherwise. A foley or gastrostomy tube may be placed in the stoma to keep tract open until tube can be replaced.

~~6.~~ Gastrostomy tubes less than 6 weeks old are re-inserted by Interventional Radiology (IR) or Gastroenterologist. No attempts should be made by LHH staff to replace tubes less than 6 weeks old ~~(Refer to LHHPP File # 26-03).~~

6. **Jejunostomy Tube** (J-tubes) are replaced by IR, although a foley or gastrostomy tube may be placed in the stoma to keep tract open until the resident is seen by surgery or IR
.
7. If there is question about placement of the gastrostomy tube, or if the registered nurse is unable to replace the gastrostomy tube, the physician shall order the transfer of the resident to Interventional Radiology or the Emergency Room for gastrostomy tube re-insertion. There shall be direct communication between the Laguna Honda physician and the radiologist or the Emergency Room physician confirming correct placement of the tube before resuming orders for ETN

8. A trained RN or LVN may place and remove a nasogastric tube (NGT) as ordered. Nasointestinal tubes (weighted tubes) are not inserted at LHH.

9. Tap water is used for medication dilution and access device flushes.

10. Reverse Luer lock (ENfit) devices or temporary transition adapters will be used for all enteral nutrition tubes.

PURPOSE:

To ensure safe practice associated with enteral feeding tube use, including the insertion, initial placement verification, ongoing placement verification, maintenance, and discontinuation.

DEFINITIONS:

- **Enteral feeding** ("enteral nutrition" or "tube feeding") is the system of providing nutrition or medication directly into the gastrointestinal tract (stomach, duodenum, or jejunum).
- **Nasogastric Tube** ("NGT" or "NG tube") is a tube that is passed through the nose and down through the nasopharynx and esophagus into the stomach. NGTs are placed in residents who require enteral nutrition for up to approximately 4-6 weeks.
- **Gastrostomy Tube** ("G-tube" or "GT") is a tube that is initially placed by surgeons, interventional radiologists (IR), or gastroenterologists through the skin of the abdomen and secured in the stomach. G-tubes include balloon-type G tubes, percutaneous endoscopic gastrostomy (PEG) tubes, pigtails, mushroom tubes, and MIC tubes.
- **Jejunostomy Tube** ("J-tube") is a specialized feeding tube inserted into the jejunum of the small intestine by surgeons or interventional radiologists (IR), or gastroenterologists.
- **Transgastric jejunal feeding tube** ("G-J tube" or "GJT") is a feeding tube that is placed through the stomach into the jejunum by surgeons or IR, and that has dual ports to access both the stomach and the small intestine.
- **External bolster** ("bumper" or "disks") prevents inward migration of percutaneous enteral access device.

PROCEDURES:

A. Insertion of NGT

A licensed nurse replaces dislodged NGTs unless ordered otherwise.

Procedure for Insertion and Removal of NGT:

Refer to "Feeding Tube: Small-bore Insertion, Care and Removal" on Elsevier for detailed information (see references for link).

B. Replacement of GT, JT and GJT

1. Insertion tract < 7-10 days old: immediately notify the physician of dislodgement. This may be a medical emergency if stomach contents leak into the peritoneum. Do not attempt tube replacement because it may be accidently positioned into the peritoneum.

2. Insertion tract < 6 weeks old: tubes shall be re-inserted by Interventional Radiology or the gastroenterologist. No attempts shall be made to replace these newly placed tubes by Laguna Honda staff.

3. Insertion tract > 6 weeks old: only simple balloon GT may be replaced at the bedside. For GTs with internal bumper, inform the physician to request for removal alternative (e.g., removal at Gastroenterology Clinic).
    a. The RN replaces simple balloon GTs that are dislodged or cannot be unclogged unless ordered otherwise.
    b. For expulsion, the RN will immediately insert a balloon type gastrostomy tube of the same size or smaller to prevent stoma closure and inform the physician.
    c. All gastrostomy tubes reinserted or replaced at LHH will have radiologic confirmation of tube placement (e.g., gastrografin) prior to use.
    d. The LHH physician will check the radiology reading prior to use of a reinserted tube and inform nurses when GT may be used. If there is a question about tube placement, or the licensed nurse is unable to reinsert/replace the GT, the tube will be reinserted in the emergency department (ED) or interventional radiology (IR). Refer to 26-03 Enteral Tube Nutrition.

e. If the resident can tolerate NGT placement, and NGT may be placed temporarily per physician order until an IR appointment is available. If an NGT cannot be placed and there is a delay in resuming enteral nutrition and medications, intravenous fluids and medications may be required.
f. Keep a replacement gastrostomy tube of the same size as resident's existing tube available in the neighborhood for emergency replacement. Gastrostomy tubes are available from Central Supply.
g. Consider tube replacement sooner than routine every 3 months, if any of the following are identified:
    i. Deterioration and dysfunction of the G-tube
    ii. A ruptured internal balloon
    iii. Stomal tract disruption
    iv. Peristomal infection that persists despite appropriate antimicrobial treatment
    v. Skin excoriation
    vi. Non-healing ulcer formation that will not heal despite good wound care technique
h. Complete an ~~Unusual Occurrence (UO)~~Incident ~~r~~Report if the tube replacement was not scheduled (Refer to LHHPPP File 26-03 Enteral Tube Nutrition).

Procedure for Replacement of the Gastrostomy Tube

Refer to “Long Shaft Gastrostomy Tube Replacement or Removal” on Elsevier for detailed information (see references for link).

~~1.~~ Measure the initial external tube length from insertion site at the stoma to the distal end of tube port(s). Do not include a Lopez Valve, if present, in the measurement. ~~Reusable~~Disposable ~~-~~rulers are single ~~patient/~~resident use ~~and should be disinfected before and after use.~~
~~2.~~1. Slide the GT external bumper approximately 0.5 cm from the stoma to prevent tube migration. If GT does not have an external bumper, use tape or stabilization device to position the balloon against the internal abdominal wall, and prevent migration, dislodgement or excessive traction.

C. Administration of Formula Feeding

~~**1. Types of Enteral Nutritional Support:**~~

~~a.~~ **Closed System:** formula comes in pre-filled closed containers. ~~Closed systems are preferred due to reduced opportunity for contamination.~~
    i. Label the container with the resident name, rate, date and time container is hung. The label on the container also applies to the tubing since both are one closed system.
    ii. Only spike containers once with a new tubing set. Tubing sets are never re-used and are discarded with the used container.
    iii. Shake enteral containers well prior to spiking and occasionally during hanging if settling is noticed.
    iv. Containers and tubing are discarded when the container is empty, OR within 24 hours after closed enteral container is hung.

~~b. **Open System**: nutritional products are transferred from a can or bottle to a feeding bag. Open enteral nutritional bags come with attached tubing.~~
    ~~i. Labeled the enteral bag with the resident’s name, formula, rate, date and time the bag is hung. The label on the bag also apply to the tubing as both are one system.~~
    ~~ii. Open enteral bags used for formula must be discarded after each use.~~

~~iii. Open enteral bags used solely for water must be discarded within 24 hours after they are initially hung.~~

~~Refer to Appendix 1 for Preparation for Enteral Nutritional Support – Closed and Open System.~~

~~2.~~1. ~~**Enteral tube care protocol: Refer to Appendix 2**~~

~~3.~~

D. STOMA CARE

a. Daily stoma care and as needed.
   i. Observe if GT external bumper approximately 0.5 cm from the stoma to prevent external pressure (i.e., buried bumper) or inward tube migration, which can cause leaking of gastric contents through the stoma.
   ii. Fit of the simple balloon GT should allow for easy rotation of the tube and permit cleaning under the bumper. **JT and GJT should not be rotated**.
   iii. For insertion tract < 7-10 days old, stabilize tube with one hand while cleaning skin for the first 7-10 days after initial insertion.
   iv. If ~~GT~~ enteral tube ~~-~~without a bumper, use a stabilization device (i.e., Statlock or M Fixx) to secure/anchor the tube and prevent excessive tension to the exterior portion of the tube.

b. Dressing changes
   i. A 4x4 split drain sponge may be over the external bumper as needed (e.g., drainage present) and changed daily.
   ii. If the skin is irritated, a moisture barrier cream or a hydrocolloid dressing may be applied under the external bumper to protect the skin and changed as ordered.
   iii. Refer to "Feeding Tubes: PEG, Gastrostomy, and Jejunostomy Care" on Elsevier for detailed information (see references for link).

c. Skin assessments every shift skin for redness, tenderness, swelling, irritation, or presence of purulent drainage or gastric leakage. If obscured by dressing, observe if dressing is secure every shift and assess skin with dressing change (ex: daily for split drain sponge dressing, weekly for hydrocolloid dressing or securement device, such as M Fixx). Notify physician for any signs of skin breakdown.

d. Enteral tube length measurements every shift, prior to accessing, after admission or relocation, and as needed. For NGT, inspect the back of the mouth for coiling of tube.

e. Check gastric residual volume (GRV) every shift unless specified by order. Schedule the GRV checks prior to initiating intermittent formula or evenly spaced for continuous formula.

f. Flush enteral tube with a minimum of 30 mL of water using a 60 mL syringe at a minimum of once per shift, before and after intermittent feedings, before a paused feeding is resumed, after GRV measurements, and as needed. Obtain a flush order for patients/residents with fluid restrictions. For medication administration flush protocol, refer to HWPP 25-15 Medication Administration.

g. Notify the physician for compromised feeding tube integrity or patency issues.

h. Change the storage container and enteral syringes daily on AM shift. Label syringe (name and date), rinse with water after use, and store syringe at the bedside in clean, labeled (name and date), dry container or storage bag.

~~i.~~ Change all closed system tube feeding containers and bags/tubing daily on AM shift using clean technique, even if bottle is not empty or expired. ~~Change open system bags used solely for water on AM shift. Discard open system formula bags after each use.~~

~~j.~~i. Change Lopez valve weekly if used

~~k.~~j. Simple balloon GT replacements every 3 months, as needed for dysfunction, as ordered

~~l.~~k. NGT replacement every 6 weeks, as needed for dysfunction, or as ordered

~~m.~~l. Relocate NGT position within same nostril weekly to prevent pressure on the same site in the nostril and skin breakdown
~~n.~~m. Trace tubes back to their origins to prevent misconnections and ensure lines are secure prior to connections.
~~o.~~n. Notify the Nutrition Services diet office for any new enteral diet orders or changes in formula or calories.

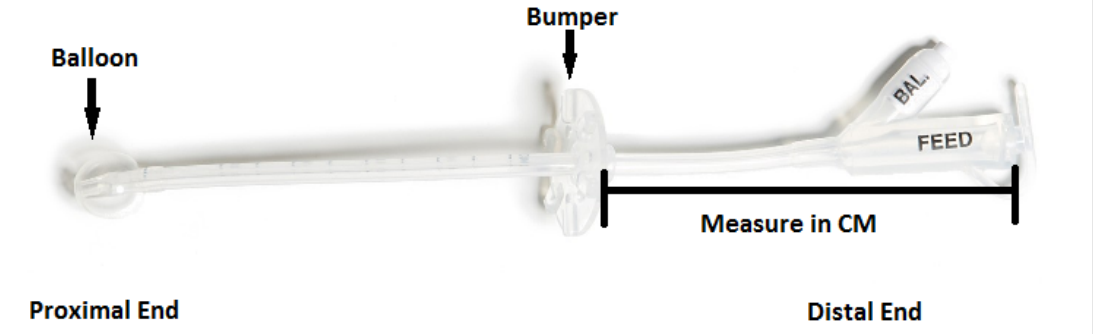
~~4.~~2. Positioning

a. Assess aspiration risk and implement appropriate interventions.
b. Elevate the resident's head of the bed (HOB) to a minimum of 30 degrees prior to, during, and for 30 minutes after feeding unless otherwise ordered. If the HOB needs to be lowered for a procedure (i.e., linen changes or incontinence care), feedings should only be stopped for the duration of the procedure and restarted with HOB re-elevated as soon as procedure is completed.
    i. If the resident has difficulty clearing secretions, it may be necessary to clear secretions (e.g., oral suctioning with order) regularly or prior to lowering of the HOB.
    ii. If on bedrest, may limit HOB elevation to 30 degrees and avoid positioning directly on a pressure ulcer/injury.

~~5.~~3. Checking Enteral Tube for Correct Placement

Enteral tube placement is checked at the bedside via external tube length. Auscultation should not be used to verify tube placement. When verifying tube placement, the nurse should use clinical judgement if concerned about migration to ensure safe patient care.

a. Measure the external tube length from insertion site at the stoma/nostril to the distal end of tube port(s). Do not include a Lopez Valve, if present, in the measurement.



b. If NGT is in place, examine the oropharynx. External tube length does not guarantee proper position, as tubes can become coiled and or/ the tube tip can become displaced into the esophagus. If there is coiled tubing, gently remove the tubing immediately to prevent airway obstruction. Inform the physician immediately if there are questions about placement.
c. If there is a question about the enteral tube placement, do not proceed with administration of medication or feeding until correct placement has been verified.
d. If a change in external tube length is observed, assess the resident for symptoms of possible dislodgement and use visualization of tube aspirate to help determine if tube has become dislocated. Do not attempt to reinsert tube if partially migrated. If in doubt of placement, notify the physician and obtain a radiograph to determine tube location. Refer to section Procedure 5 Procedure for Gastric Residual Visualization.
e. Respiratory compromise (i.e., increased respiratory rate, difficulty breathing, decreased O2 saturation, or coughing) may indicate tube feeding dislodgement or intolerance.

f. Document the procedure. Refer to section Procedure J Documentation.

~~6.~~4. Procedure for Gastric Residual Visualization and Measurement:

Refer to "Feeding Tube: Verification of Placement" on the Elsevier~~ (Mosby's)~~ Clinical Skills for detailed information (see references for link).

a. Checking gastric residual volume (GRV) may be appropriate when initiating tube feedings, if dislodgement suspected, or if the resident/patient reports or displays any signs of intolerance, such as bloating, nausea, vomiting, and complaints of fullness, abdominal distension or abdominal pain.
b. The technique of aspirating gastric juices for GRV checks can increase clogging.
c. Stop continuous feedings for several minutes before aspirating, measuring, and returning gastric residuals.
d. Measure the amount of gastric aspirate and observe for changes in the volume and appearance of the aspirate.
    i. If the gastric residual volume is > 250 ml or the GRV order parameters, hold the tube feeding and notify physician. Aspirate, measure, and return gastric residual every 2-4 hours until resident has exhibited the ability to empty his/her stomach, at which time tube feeding may be continued or re-started with an order.
e. Notify the physician if gastric secretion volume or appearance is concerning.
f. Document the procedure. Refer to section Procedure J Documentation.

~~7.~~5. If Tube Occlusion Occurs

Do not use any non-facility approved devices (i.e., tube brush), cranberry juice, soda or hot water to unclog feeding tubes at the bedside.

Use a gentle back-and-forth motion with 30- or 60-mL syringe filled with water to dislodge clog or a pancreatic enzyme solution per order to dissolve clog.

Refer to "Feeding Tube: Small-bore Insertion, Care and Removal" on Elsevier for detailed information (see references for link).

E. NGT use as Intermittent Gastric Suction

Refer to "Nasogastric or Orogastric Tube: Insertion, Flushing, and Removal" Elsevier Clinical Skills for detailed information (see references for link).

1. Large bore, double lumen NGTs, such as the sump tube, are the preferred tubes for gastric suction. The large lumen allows of suction of gastric contents and medication delivery. The smaller vent lumen allows for atmospheric air to be drawn into the tube and equalizes the vacuum pressure in the stomach once the contents have been emptied. This prevents the suction eyelets from adhering to and damaging the stomach lining.
2. If using a sump tube, do not clamp the air vent, connect the tube to suction or use it for irrigation. Keep the air vent of the sump tube above the patient's stomach level.
3. After instilling medication and/or formula and flushing with 30 ml of water, plug the NG tube for 1-1/2 hours or as ordered, before attaching to the suction machine.
4. Only use low suction unless otherwise ordered.
5. Monitor for any signs of respiratory distress and stop suction and notify physician immediately if present.
6. Document any volume of fluid instilled (intake) and suctioned (output).

F. Administration of Medication(s) Through Enteral Tube (Refer to HWPP 25-15 Medication Administration)

G. Reassessment of Enteral Feeding

1. Enteral Feeding may be held, and physician notified for possible indications listed below:
   a. Aspiration, such as vomiting, choking, coughing, frothy sputum, tachycardia, respiratory distress, or fever.
   b. Fluid and electrolyte imbalance
   c. Intolerance of feedings, using measures such as slow gastric emptying (GI motility status), assessment for abdominal distension, firmness, diarrhea and large GRV, feeling of fullness, or nausea that might lead to gastric reflux.
   d. Peritonitis, such as abdominal pain and/or bloating, constipation, fever, nausea, vomiting, diarrhea, weakness, dizziness, dyspnea, tachycardia, tachypnea, and inability to pass gas or feces, and dehydration. Feeding tubes can perforate the stomach or small intestine, and result in peritonitis.
   e. Esophageal complications, including esophagitis, ulcerations, strictures, and tracheoesophageal fistulas.
   f. Leaking around the insertion site, abdominal wall abscess, or erosion at the insertion site, including nasal areas.
   g. Clogged tube due to plugging by formula, pill fragments, or precipitation of medications incompatible with the formula.
2. Enteral feeds will be resumed by physician order, which may include radiologic evaluation or reassessment of the goals of enteral feeding
3. Notify physician and registered dietitian:
   a. If resident has unplanned significant weight gain or loss or if a reassessment of goals of nutritional support is indicated. Refer to NPP G 7.0 Obtaining, Recording and Evaluating Residents Weights.
   b. If the Intake and Output monitoring indicate the resident is consistently receiving less than the enteral nutrition goal volume.

H. Documentation

Goals of Medical Enteral Feeding

1. Nutritional and Quality of Life goals are documented in the Resident Care Conference (RCC) note.
2. Goals of enteral feeding may be documented in Advance Care Planning by the physician.

EHR Documentation by the Licensed Nurse

1. Flowsheet or Lines, Drain and Airways (LDA) and Flowsheets
   a. Admission and Tube Insertions:
      i. If the tube was inserted at a DPH facility, continue the LDA.
      ii. Document the tube properties and assessment under LDA.
      iii. Document the resident's tolerance of the procedures and any difficulty or complications encountered
   b. Removal and Replacement:
      i. Document the removal of the original tube (permanent removal or planned replacement) under the LDA, including the remove date, removal time, removal reason.
      ii. Document the replacement by initiating a new LDA.
      iii. Document the resident's tolerance of the procedures and any difficulty or complications encountered.
   c. Documentation:

i. Every shift and as needed: document the tube assessment under LDA.
ii. Intake and Flush volume: Prior to the end of EACH shift, the Licensed Nurse:
    i. Checks the feeding pump and documents the volumes for "FED" and "FLUSH" at the end of the shift.
    ii. Clears the pump of the volumes for "FED" and "FLUSH".
    iii. Documents the volume of fluid used for flushes and medications during the shift.
iii. As needed:
    i. Any other problems with enteral tube management (e.g., frequent obstruction, etc.)
    ii. Resident's tolerance or intolerance of feeding.

2. Education: Document any resident or family teaching provided and evaluation of learning
3. Care Plan:
    a. Care plan the clinical indication, as noted by the physician, which necessitates enteral tube placement and enteral nutrition.
    b. Include any related or potential problems, or resident needs. Examples of some possible adverse effects of using a feeding tube may include: diminishing socialization, and not having the opportunity to experience the taste, texture, and chewing of foods.

~~**Non-EHR Documentation by the Licensed Nurse**~~

~~Document daily enteral feeding supplies used on the Enteral Nutrition Charge Form. Refer to LHHPP 50-04 (Enteral Nutrition Charge Procedure).~~

REFERENCES:

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Nursing Reference Center Plus: https://search.ebscohost.com/Community.aspx?community=y&authtype=ip&ugt=723761666C76658727E665D662156E9261E327E33313340331633623&stsug=AkyMCIkUzWydYOr9Kbs9Ci4vDyFarVDzc-pSjff7036IJGrWUTAikjQNEKGxiffp4Wkyb7hXQ6n_9WmS7sWXAa7ddcYwaq7u9Arm-V8u7bvrm5NOT3ySErcrAwB66-l7v6sesl2KlSczixDXa6WBwK9EpYKGuVCWUjzzeHo4Yw&IsAdminMobile=N&encid=22D731163C56352737763546328 53C973113376373C374C371C376C372C376C370C331

Bryant, R. A., & Nix, D. P. (2012). *Acute & chronic wounds: Current management concepts*. Elsevier/Mosby.

CROSS REFERENCES:

Hospital-wide Policy and Procedure
File # 25-15 Medication Administration
File # 26-03 Enteral Tube Nutrition
File # 50-04 Enteral Nutrition Charge Procedure

Nursing Policy and Procedure
G 3.0 Intake and Output
G 4.0 Measuring the Resident's Height ~~and Weight~~
G 7.0 Obtaining, Recording and Evaluating Resident's Weight

ATTACHMENTS/APPENDICES:

~~Appendix 1: Preparation for Enteral Nutritional Support – Closed and Open System~~
~~Appendix 2: Enteral Pump Hang Tag provided by the manufacturer~~
Appendix ~~3:~~ Enteral Nutrition Chart

Adopted: 2002/08

NEW: 2013/05/28

Revised: 2009/08; 2011/03/10, 2011/07/12; 2015/01/13; 2016/07; 2017/11/04; 2019/05/14; 2022/07/12; 2022/11/08; 2023/04/11; 2023/08/08; 2024/05/09

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