

March 31, 2023

A Secondary Analysis of LHH's "Root Cause" Problems

Pre-Mortem of a Hospital: One-Year Anniversary

Preliminary Analysis of Quantitative Root Factors Is Scary and Refute Claims Diminishing Severity of LHH's Violations

by Patrick Monette-Shaw

[Note: I ask for readers' indulgence with this necessarily long article meant to help preserve the historical record of LHH's mismanagement.]

April 14, 2023 is the one-year anniversary of LHH's decertification.

It's taken two months to wade through reading, digesting, and reflecting on the two root causes analysis reports Laguna Honda Hospital (LHH) commissioned to uncover the underlying factors that led to LHH's decertification from the Medicare Program, along with other documents released on February 8. Background material for this article total 669 pages, hence this in-depth article.

LHH's residents deserve to have this history told. And read. And preserved. They deserve to be cared for safely.

It was shocking to learn the 63 detailed root causes uncovered now requiring 454 corrective actions to resolve 138 citations LHH has received. LHH had violated 78 separate patient care-related "F-Tags" — many multiple times each — plus an additional 20 "K-Tag" violations of facility "physical plant" deficiencies across the three years and four months since the sexual abuse of patients scandal at LHH surfaced in 2019. The 98 various types of "Tag" deficiencies led to the 138 citations.

The sheer volume of the 138 citations involving the 78 F-Tag violations was even more shocking to the cadre of dedicated current employees and alumni who served at LHH over the years. They are mostly not responsible for the current sad situation at LHH and will suffer from the negative publicity. They are people who feel proud of their work providing LHH's residents with high levels of care.

The hospital's alumni don't have to be present at LHH today to surmise origins of these citations. Most of them remain shocked because citations before had never been so severe, with so many violations of basic patient care regulations.

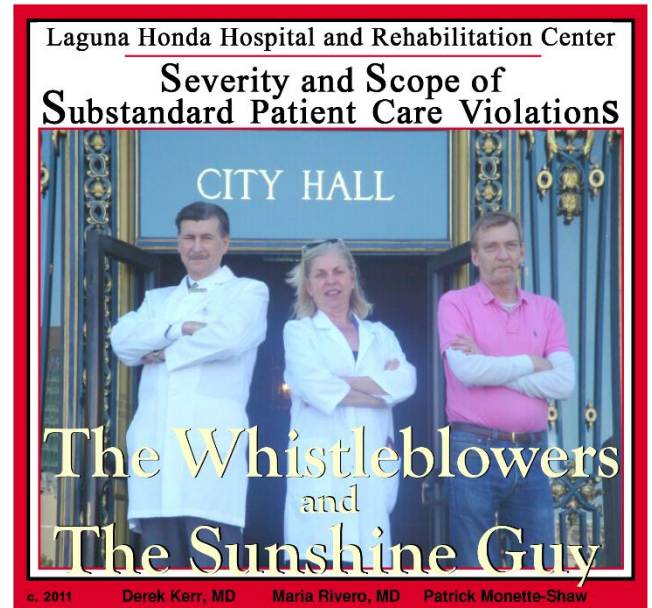
It was only when interloping managers from SFGH and the San Francisco Health Network (SFHN) began running LHH in the past three years like it was an acute care hospital instead of as a skilled nursing facility that the citations mushroomed. The inept managers are principally responsible for the current mess at LHH, not LHH's caring and dedicated staff.

Even more shocking are attempts by San Francisco City officials, including the Board of Supervisors, who have baldly tried desperately to diminish the scope and severity of the 138 deficiencies and citations, and the causal factors that led to them.

To dispel attempts to falsely diminish the severity of LHH's patient care violations, consider a few numbers.

One-hundred and thirty-eight. One-hundred and twenty-three. Two-hundred and sixty-one.

Those may not sound like very large numbers, but 138 is the shocking number of actual substandard patient care violations plus facility physical plant citations Laguna Honda Hospital (LHH) has racked up as a result of State survey inspectors during



A Dozen Years Ago Doctors Derek Kerr and Maria Rivero bravely exposed wrongdoing at Laguna Honda Hospital and SFDPH as whistleblowers. Kerr faced wrongful termination. I became **The Sunshine Guy** by placing hundreds of public records requests. LHH's wrongdoing continues through today.

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the three-year, four-month period following the patient sexual abuse scandal that first rocked the hospital in July 2019. That's a lot of violations over a short period.

Add in another 123 substandard care violations uncovered during an unofficial inspection conducted by LHH's in-house consultant, Health Management Associates (HMA), during LHH's first "mock survey" done in June 2022 to prepare LHH for an official re-certification survey by the California Department of Public Health (CDPH). A planned second "Mock Survey" was never held, without explanation.

LHH tried to minimize the 123 "Mock Survey" findings by claiming here were only 101 unduplicated F-Tag violations, creatively excluding 22 repeated F-Tags.

That totals 261 patient care, and facility, violations of Federal regulations, suggesting severe problems with regulatory compliance to provide quality of care safely to LHH's vulnerable residents. All along and at every opportunity LHH, the Board of Supervisors, and City officials have minimized the severity and scope of the violations.

But there's no escaping the fact that 261 problems — requiring up to 454 corrective actions identified as necessary — can't simply be brushed off as outliers, or "minimal," as the "minimizers" have asserted. The problems occurred primarily due to inept management brought in to LHH who had no experience whatsoever managing a skilled nursing facility.

This isn't about LHH's ability to walk and chew gum at the same time, as Supervisor Myrna Melgar cavalierly asserted, along with her pal, Supervisor Hillary Ronen.

LHH has been in the throes of potential closure for now a full year following its decertification on April 14, 2022 as a participating provider in the Federal government's Centers for Medicare and Medicaid (known as Medi-Cal in California) Services (CMS) participation program for skilled nursing facilities (SNF's).

To receive reimbursement from CMS, SNF's must remain in substantial compliance with approximately 211 "F-Tags" required by various Federal regulations designed to protect nursing home residents, along with other regulations. LHH was found to have extensively violated those regulations during the past three years.

It wasn't always this way. LHH was typically in substantial compliance with CMS' regulations and routinely passed State inspections with few, if any, regulatory violations. What is new is the recent massive mismanagement of LHH.

When a trove of records were released belatedly on February 8, we began learning the severity and scope of just how serious LHH's violations have been. The records released read like a pre-mortem of a hospital's potential death spiral.

Doctors Derek Kerr and Maria Rivero published a terrific [article](#) on February 23 in the *Westside Observer* summarizing a portion of the root causes that led to LHH's decertification in a report San Francisco's Department of Public Health had succeeded at keeping secret for nine weeks. Their article is a must read for anyone interested in the fate of LHH and its dwindling resident population.

Kerr and Rivero have been an investigative whistleblower and watchdog team for the *Observer* for approaching 20 years.

[Disclosure: When Dr. Rivero served as LHH's Medical Director, she extended my job offer when I was hired at LHH in 1999. A decade later, I helped proofread and format their seminal "[Critical Analysis of the Ja Report](#)" in 2009 about a behavioral health program proposed for LHH.]

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LHH's Institutional Comorbidities

Kerr's and Rivero's article in February covered the initial 48-page *Root Cause Analysis (RCA) Report* prepared by Health Services Advisory Group (HAG), a consultant that has been paid \$17.3 million to date to assist LHH obtain re-certification from CMS. That report was released on February 8 following drawn out public records requests to obtain it.

I only take slight issue with an editor's caption to an illustration accompanying their article that suggests the initial *RCA* report dated December 1, 2022 finally gives us a *complete* picture of LHH's problems and the path to recovery. A *complete* picture is premature, given there was a second 36-page *RCA report* describing LHH's first "90-Day Monitoring Survey" dated January 31, 2023 and a 49-page "Action Plan" *report* listing 454 corrective actions needed to fix LHH's mismanagement.

A second *90-Day Monitoring Survey* that began on March 13 planned to take a week that concluded in March 17 will be followed by a third *RCA* report and a potential additional "Action Plan." I'm hesitant to conclude we've seen a *complete* picture of LHH's problems decades long in the making.

Just as individual patients often have multiple, co-existing, long-term medical conditions — known as comorbidities that may develop independently of one other but may not directly cause each other — hospitals, institutions, and skilled nursing facilities can also develop multiple long-term, systemic, and chronic conditions that threaten their survival.

Kerr and Rivero's February *Westside Observer* article explored five of the first eight problem areas in the first *RCA* report exploring the causal root factors leading to LHH's decertification, including:

1. Quality Assurance & Performance Improvement (QAPI),
2. Infection Prevention and Control,
3. Behavioral Health and Substance Abuse,
4. Comprehensive Care Plans and Quality of Care, NS
5. Competent Staff, Training, and Quality of Care


But following the *Fire Life Safety* inspection resulting in four "Immediate Jeopardy" citations over a fire alarm debacle during the first *90-Day Monitoring Survey* CMS and the California Department of Public Health (CDPH) conducted at LHH in December, the list of eight problem areas grew to 11, including the last three:

6. Medication Management and Administration
7. Resident Rights and Freedom from Harm
8. Emergency Preparedness Program
9. Fire and Life Safety
10. Resident Quality of Care
11. Food and Nutrition Services

The additional three problem categories outline significant problems State inspectors uncovered between December 1 and December 16 after the first *90-Day Monitoring survey* wrapped up.

The final two categories, *Resident Quality of Care* and *Food and Nutrition Services*, were among the most damning, which will be reviewed in detail in an upcoming article.

Back in May 2015, Drs. Kerr and Rivero's *Westside Observer* [article](#), "Laguna Honda's Falling Star," documented LHH's CMS five-star rating plummeted to just two stars. Four years following their 2015 article, LHH's patient sexual abuse scandal surfaced in June 2019. That was when LHH was slapped with CMS' then new, red stop-hand warning icon for consumers. Since then, LHH sank to its current pathetic one-star CMS rating. The warning icon remains next to LHH's name to this day on CMS' *Nursing Home Compare* [website](#).



On October 23, 2019, CMS added a new abuse icon to its **Nursing Home Compare** website to alert the public about nursing homes cited for abuse violations.

The icon will appear next to the names of facilities given a citation for abuse that led to the harm of a resident within the past year, or was cited for abuse that could have potentially led to resident harm in each of the previous two years.

LHH was promptly slapped with the new icon on CMS' on-line web site before November 30, 2019.

Three years later, LHH's listing on the *Nursing Home Compare* website still sports the icon as a warning of continuing abuse.

“That was when LHH was slapped with CMS' then new, red stop-hand warning icon for consumers.”

The 261 Citations

In the three years and four months since news reports surfaced reporting LHH’s sexual abuse scandal in July 2019, the hospital racked up 261 citations across 12 State survey inspections, shown in Chart 1, below.

LHH Inspection Surveys by California Department of Public Health (CDPH) and Consultant to LHH (Health Management Associates)

CMS Severity and Scope (S/S =) Ratings

		Level 1			Level 2			Level 3			Level 4						
		No Actual Harm			No Actual Harm, Potential for More than Minimal Harm			Actual Harm That Is Not Immediate Jeopardy			Immediate Jeopardy to Resident Health and Safety						
Patient Care "F-Tags"		Isolated	Pattern	Widespread	Isolated	Pattern	Widespread	Isolated	Pattern	Widespread	Isolated	Pattern	Widespread				
Event	Date	A	B	C	D	E	F	G	H	I	J	K	L	Total			
Sex Abuse Scandal	7/12/2019				3	2			1			3	1	10	3.8%		
Facility Survey	11/19/2019				5	9	2	1						17	6.5%		
Facility Survey	4/19/2021				7	4	2							13	5.0%		
CDPH Eight Surveys *	10/14/2021				12	4	2	2	1			1		22	8.4%		
90-Day Monitoring Survey **	11/28/2022				18	20	9	5					4	56	21.5%		
Sub-Total Patient "S/S" Rated Findings:					45	39	15	8	2		4	5	118				
Facility's Physical Plant "K-Tags"																	
90-Day Monitoring Survey **	11/28/2022				9	8	3							20	7.7%		
Patient Care + Facility's Physical Plant Total "S/S" Rated Findings:					138												
First Mock Survey	6/22/2022	22	6	5	9	18	16	1	2	4	2	3	8	96	36.8%		
Total (Actual Plus Mock Surveys)		22	6	5	63	65	34	9	4	4	2	7	13	234			
													"Unrated" Scope of Mock Survey Findings on LHH Medical Acute and Acute Physical Rehab Units:	27	10.3%		
													Total Actual Citations and Mock Survey Findings:	261	100.0%		

* Root Cause Analysis Report 1, dated December 1, 2022.
 ** Root Cause Analysis Report 2, dated January 31, 2023.

Sources:

- LHH "Sexual Abuse" Surveys: CDPH Form 2567 Initial Inspection Report dated 7/12/2019, and Re-Survey Report dated 9/3/2019.
- LHH Facility Survey: CDPH Form 2567 Initial Inspection Report dated 11/19/2019.
- LHH "Root Cause Analysis Report #1" Prepared by HSAG, dated 12/1/2022: Eight CDPH Form 2567 Inspection Reports (Only) dated 10/14/2021 through 4/13/2022.
- LHH "Root Cause Analysis Report #2" Prepared by HSAG, dated 1/31/2023: "90-Day monitoring Survey" started on 11/28/2022, triggering an "Extended Survey" and "Fire Life Safety Survey," due to fire alarm fiasco that went off during "90-Day Monitoring Survey."

- LHH received only 10 citations in the July 2019 inspection survey of LHH’s sexual abuse scandal, including four separate “Immediate Jeopardy” citations.
- Then LHH received 17 more citations four months later in November 2019.
- When the near-fatal patient fentanyl overdoses happened in July 2021, it triggered a succession of eight separate State survey inspections beginning on October 14, 2021 and running through April 13, 2022, during which LHH ignored successive CMS and CDPH warnings that it faced potential decertification for worsening violations. Across those eight successive survey’s, LHH racked up a total of 22 citations, including another citation alleging a pattern of “Immediate Jeopardy” violations, until CMS finally resorted to decertifying LHH on April 13, 2022. It is thought CMS had the option of placing LHH in receivership, but didn’t.

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“ Then, across those eight successive survey’s, LHH racked up a total of 22 citations, until CMS finally resorted to decertifying LHH on April 13, 2022.”

- Fast forward to LHH’s first *90-Day Monitoring Survey* that began on November 28, seven months after being decertified. At that point, LHH received a whopping 56 patient-care related citation violations, plus 20 “*physical plant*” (facility) violations, for a total of 76 violations — representing a combined 28.8% of the 261 total citations across the actual *official* survey inspections and the *unofficial* “*Mock Survey*” citations.

[**Note:** The 261 citations excludes an additional 23 (if not higher) deficiencies LHH just received following its second “*90-Day Monitoring Survey*” that just concluded, described below.]

- The jump from 22 citations in the eight survey inspections between October 2021 and April 2022 to receiving 76 citations during the first “*90-Day Monitoring Survey*” in December — more than three times higher than the 22 that led to LHH’s decertification in April 2022 — is particularly disturbing, since LHH’s three external consultants were brought on board in *May* 2022 to fix LHH and stop receiving further citations.
- Assuming the 23 new deficiencies identified in the second “*90-Day Monitoring Survey*” — that just concluded on March 17 all involve patient care, not facility, “F-Tag” violations (but aren’t included in my count of 261 violations) — they will represent a reduction of just under half of the 56 patient care violations received during the first “*90-Day Monitoring Survey*” in November and December. While that represents some progress, it remains worrisome LHH continues racking up citations nine months after the three consultants were brought in to fix the substandard care.

In total, LHH racked up 118 patient care citations in those intervening three years and four months. Chart 1 shows LHH also racked up 20 citations related to “*physical plant*” deficiencies uncovered during the first *90-Day Monitoring Survey* for a total of 138 citations across the 12 formal State survey inspections.

Toss in another 123 rated and un-rated citations uncovered during an unofficial “*Mock Survey*” conducted by LHH’s consultant Health Management Associates (HMA) which has been paid \$5.8 million to date to assist LHH gain CMS re-certification. That brings total citations for various known LHH deficiencies to 261 — which is clearly a symptom of mismanagement of the hospital in this LHH pre-mortem.

A full-page version of [Chart 1](#) is available on-line.

Spoiler Alert

Unfortunately, just before publication of this secondary analysis article, news surfaced that numbers presented here may be under-reported.

On March 21, LHH’s acting CEO, Roland Pickens, announced during a full Health Commission meeting that LHH’s second CMS/CDPH “*90-Day Monitoring Survey*” had concluded, apparently on Friday, March 17. He gushed that LHH had *only* been slapped with an additional 23 new deficiencies that he didn’t describe or summarize, and which haven’t been released to the public yet. It’s worrisome the 23 new deficiencies — a bucket of ice-cold water — may push recertification further on back, which is already way behind schedule.

Another records request has been placed to obtain CDPH’s new Form 2567 report rapidly, rather than having to wait for HSAG to write a third “*Root Cause Analysis*” report and another follow-up supplementary “*Action Plan*” for CMS.

The potential 23 new citations will push LHH’s total citations since July 2019 to a new total of 284 citations, up from 261. Hopefully, LHH hasn’t received another “*Immediate Jeopardy*,” which it had been warned not to by CMS.

During the March 21 Commission meeting, Pickens claimed LHH had received 124 deficiencies during its first “*90-Day Monitoring Survey*.” He appears to have been confused, or mis-spoke, because the second “*Root Cause Analysis*” report documented 76 citations (50 related to patient care plus 20 “*facility*” citations).

“ The jump from 22 citations in the eight survey inspections between October 2021 and April 2022 to receiving 76 citations during the first ‘90-Day Monitoring Survey’ last December is particularly disturbing. ”

“ That brings total citations for various known LHH deficiencies to 261 — which is clearly a symptom of mismanagement of LHH presented in this pre-mortem. ”

“ The potential 23 new citations will push LHH’s total citations since July 2019 to a new total of 284 citations. ”

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Pickens may have been trying to compare and contrast the new 23 deficiencies to the 76 deficiencies (but wrongly claimed 124) in an effort to claim LHH has been making progress on implementing reforms and reducing the number of citations.

But there's no escaping the fact that if LHH just received 23 additional patient-care related deficiencies, that would still be **more** than the 22 citations which led to LHH's decertification across the 8 separate inspection forms. While a reduction from 76 to 23 between two surveys is progress, 23 more citations suggests LHH still isn't ready yet to pass an actual recertification survey!

It's not yet known how many additional "*milestone*" corrective actions will be needed in another "*Action Plan*" to fix the 23 new citations. It's also not known if the new corrective *milestones* will also have to be corrected by May 13 along with the other 454 milestones. This portends LHH will definitely have to undergo a third "*90-Day Monitoring Survey*," which probably won't start until mid-June.

Attaining actual CMS recertification looks farther and farther away to the detriment of LHH's current residents and San Franciscans needing admission to LHH but can't get in given the continuing ban on any new admissions.

By the time LHH received the new 23 deficiencies on March 21, LHH had not updated the Health Commission about whether between November 18 and December 16 (or after) all 123 deficiencies identified in the "*Mock Survey*" conducted in June (that Pickens had tried to pretend were only 101 deficiencies) had been cured, since only 63 had been fully resolved with the remaining 38 unresolved by November 18. Following LHH's dashboard report for the week ending November 18, LHH stopped presenting publicly weekly dashboard reports in December, so it's unclear whether those 38 remaining deficiencies were ever fully resolved.

A reasonable person would assume the 38 outstanding deficiencies would have been resolved in the five months between June and November, but the status of their resolution vanished into thin air before LHH was hit with the 23 new citations.

Scope of the Citations

Across the 12 survey's between June 2019 and April 2022 another perspective is the sheer numbers within each "scope" category. An alternative [Chart 2](#) available on-line helpful in visualizing the severity and scope of the 261 violations reveals:

- 22 — a significant 8.4% — of the 261 citations involved the Level 4 "*Immediate Jeopardy*" severity, including 13 "L" citations, representing the number of patients who had faced immediate jeopardy.
- 17 of the citations involved "*Actual Harm*" that had **not** risen to the level of posing immediate jeopardy to patient's health and safety, ranging from "*Isolated*" to "*Widespread*."
- The 22 "*Immediate Jeopardy*" and 17 "*Actual Harm*" citations combined comprise 14.9% of the 261 violations.
- 162 of the citations had involved "*No Actual Harm*," but had the potential for *more than* minimal harm, including 67 during the first "*90-Day Monitoring Survey*" alone that began at the end of last November.
- Another 33 citations had "*No Actual Harm*," but had the potential *for* minimal harm.

It was beyond the resources of this article to tally the number of individual residents identified anonymously across the 12 survey inspections reports that had earned the 261 citations. But given LHH's typical resident census was 710 people, and given the scope ranged from isolated to widespread incidents, it's not a stretch to imagine that the aggregate number of patients affected may have neared or exceeded the 710 residents.

“ Attaining actual CMS recertification looks farther and farther away to the detriment of LHH’s current residents and San Franciscans needing admission to LHH but can’t get in.”

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“ The 39 ‘Immediate Jeopardy’ plus ‘Actual Harm’ citations combined comprise 14.9% of the 261 violations.”

For instance, just one inspection — on July 12, 2019 involving the sexual abuse allegations that had earned four “*Immediate Jeopardy*” scope ratings of “pattern” or “widespread” — had found 21 residents had been harmed by physical, mental, verbal, and sexual abuse, and chemical and physical restraints; and 5 residents had endured life-threatening complications as a result of receiving purloined medications from LHH staff that had not been prescribed by their LHH physicians.

About the “F-Tags”

For those who may want to get into the weeds, [Table 1](#) available on-line lists the titles of each of 78 separate “F-Tag” (patient care) violations. CMS’s is thought to have 211 separate “F-Tag” criteria all skilled nursing facilities nationwide are required to comply with; 48 of the 211 — 22.7% — involve sub-standard care, by definition.

So, the 78 F-Tags LHH violated — accounting for 118 actual survey patient care citations and an additional 57 “*Mock Survey*” patient care F-Tags findings in the 261 citations — represents 37% of all 211 F-Tags. That suggests LHH’s widespread and potentially willful disregard of the “F-Tag” CMS standards.

“ The 78 F-Tags LHH violated represents 37% of all 211 F-Tags. That suggests LHH’s widespread and potentially willful disregard of the ‘F-Tag’ CMS standards.”

This bears repeating: The sheer volume of citations during the three years was being mismanaged as if it were an acute care hospital, not as a skilled nursing facility (SNF), is a symptom of, and result of, LHH having been run by managers having no experience in running SNF’s.

Add in 38 “K-Tag” (physical plant) violations across LHH’s actual inspection report citations plus the “*Mock Survey*” findings, out of an unknown number of total “K-Tags.” Again, that suggests LHH’s willful neglect to keep its “*physical plant*” in safe operating condition to house its vulnerable residents.

About the “Federal Regulatory Groups”

As for “*Federal Regulatory Group*” categories, [Table 2](#) also available on-line illustrates that the 118 citations LHH received for “F-Tag” patient care violations across the 12 inspections spanned 17 of 21 *Regulatory Groups*. Of the 118, fully 40 — 34% — involved quality of patient care and resident-centered care plans.

- Three of the 17 groups shown in Table 2 exclusively involve sub-standard patient care (*Freedom From Abuse and Harm*, *Quality of Care*, and *Quality of Life*). They accounted for 37 — 31.3% — of the 118 citations.
- Two other *Regulatory Groups* that don’t exclusively involve sub-standard patient care — “*Comprehensive Resident-Centered Care Plans*” and “*Resident Rights*” — also racked up 37 (31.3%) of the 118 citations involving patient care.

“ The 118 citations LHH received for ‘F-Tag’ patient care violations across the 12 inspections spanned 17 of 21 Regulatory Groups.”

The “*Regulatory Groups*” are analogous to organs and parts of the body, such as the brain (Hospital Administration), heart (Nursing Department), liver (Quality Management Department), lungs (Medical Services Department), stomach, kidneys, and skin (encompassing the “*physical plant*”), and eyes, arms and legs, etc. Given the scope and severity of LHH’s diseased citations, it necessitated this pre-mortem, if you will. LHH’s prognosis from the 261 citations, is poor.

If you agree the sheer quantitative numbers in this preliminary analysis of root causes leading to LHH’s decertification and its subsequent inspections are scary, the qualitative narrative in a planned next installment are even scarier.

About the Causal “Root Factors”

The consultants hired to root out the causal factors that led to LHH’s decertification did yeoman’s work, but stopped short of holding anybody accountable. Had LHH corrected its “*culture of silence*” — which the consultants themselves admitted they uncovered and had actually occurred — back in 2019 when LHH had claimed it would develop a “*culture of [patient] safety*” with a “*60-Day Reform Plan*” it would roll out (discussed further, below), perhaps CMS wouldn’t have decertified LHH in April 2022.

Never mentioned was the need for LHH to implement a “*culture of managers*” qualified to run SNF’s.

[Table 3](#) is a detailed list of the 63 underlying root causes grouped by each of the 11 major problem categories across the first two *RCA* reports exploring the causal root factors leading to LHH’s decertification. A sampling of some of the more shocking root causes includes:

- *Quality Assurance and Performance Improvement (QAPI) program not aligned to skilled nursing facility (SNF) setting*
- *Lack of nursing involvement [in infection prevention and control]*
- *Inadequate electronic healthcare record [system] (EHR)*
- *Insufficient hand hygiene and personal protective equipment (PPE) audits*
- *Non-compliance with safe medication management practices*
- *Lack of proactive interventions to prevent [resident] abuse*
- *Lack of formalized restorative [care] nursing program*
- *Ineffective [patient] care planning by interdisciplinary [care] team*
- ***Lack of leadership with SNF [skilled nursing facility] experience, regulatory knowledge***
- *Lack of fire and life safety awareness*
- *Use of outdated clinical nutrition standards of practice*

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There are other equally alarming root causes contained in Table 3 on-line.

As Kerr and Rivero rightly noted in their February 23 article that although HSAG bravely exposed many of the underlying root causes that led to LHH’s decertification, HSAG omitted mentioning in its two *Root Cause Analysis* reports that the disastrous “*Flow Project*” of SFGH patients routed to LHH beginning in 2004 as having been the start of LHH’s decline. Kerr and Rivero noted:

“*The Root Cause Analysis [reports] omits [that] foundational history, but covers its grim outcome*” and also observed the “[root cause analysis reports] *exposes the ignorance and mismanagement that befell the hospital.*”

Sadly, none of the managers who allowed these root causes to first germinate and then flourish have been held accountable. None have been terminated to date, except LHH’s recent CEO, Michael Phillips, who served for just two years, long before the problems had begun. He was let go, but nobody else has been.

A Word on Methodology

Data presented in the two charts and four tables in this pre-mortem include a divergence in reporting. The first “*Root Cause Analysis*” HSAG had been contracted to produce under its \$2.6 million contract to be LHH’s *Quality Improvement Expert (QIE)* — and its additional \$14.7 million in consulting contracts to steer LHH toward recertification — was supposed to have been based on analyzing the “*root causal factors*” behind the 22 citations contained in the eight CDPH on-site inspection Form 2567 reports CDPH conducted between October 14, 2021 and April 13, 2022.

“ Sadly, none of the managers who allowed these root causes to first germinate and then flourish have been held accountable. None have been terminated to date.”

But when the first *Root Cause Analysis* (RCA) report delivered to CMS by HSAG as LHH's QIE on December 1 was finally released to members of the public on February 8 due, in part, to the *Westside Observer* "Sunshine Guy's" persistence, there were odd discrepancies.

As shown in [Table 4](#) also available on-line, of the 22 F-Tag citations CDPH had issued across the eight inspection survey Form 2567's (that were to comprise the first RCA report), HSAG excluded reporting 6 of the F-Tags, and added 10 other F-Tag titles, including two involving Pharmacy Services deficiencies not listed in the initial eight Form 2567 reports. RCA #1 also asserted there had only been 21 citations, not the 22 listed on the original eight Form 2567 inspection reports. (Weirdly, the RCA reported actually listed 24 separate F-Tag deficiencies by name, not 21 and not 22.)

The first RCA report specifically stated:

"The RCA specifically addressed deficiencies identified during surveys between October 14, 2021, and April 13, 2022, and all deficiencies that were discovered and disclosed to LHH by the California Department of Public Health (CDPH), CMS, or a contract surveyor after those surveys."

"Data presented in the two charts and four tables in this pre-mortem include a divergence in reporting."

SFDPH refused the *Westside Observer's* specific records request to ask the author of the first RCA report about their methodology and sources of data, and refused to provide their e-mail address. One issue was that there appeared to have been a typo in the second RCA Report dated January 31, 2023.

HSAG had claimed that during the first *90-Day Monitoring Survey* that had triggered an "Extended Survey" and a "Fire Life Safety" survey all conducted in December, State inspection surveyors had identified only 66 deficiencies. In actuality, the surveyors had identified 76, not 66, citations. The *Westside Observer* wanted to learn what the discrepancy of 10 deficiencies might have involved.

Another question of interest to the *Observer* had been what other sources of deficiencies had been identified and disclosed to LHH by other contract surveyors in addition to the eight Form 2567 reports conducted by CDPH surveyors between October 2021 and April 2022. If HSAG had indeed obtained other survey reports, those sources have not yet been disclosed to members of the press or members of the public, and weren't listed in HSAG's first "Root Cause Analysis" report.

As well, HSAG had claimed only 62 of the 66 (or 76) deficiencies had been rated as a scope and severity of "D" or higher. In actuality, all 76 had received ratings of "D" or higher.

On closer examination, it turned out 76 separate deficiencies *had* in fact had been cited, but 13 of the individual patient care "F-Tags" had been cited as having multiple, duplicated instances, including one F-Tag cited three separate times, for a total of 14 duplicated F-Tags. That artificially reduced the 76 deficiencies, allowing HSAG to wrongly assert only 62 unduplicated deficiency F-Tag titles.

It was a bald attempt by HSAG to try its own propaganda spin control of "minimizing" the severity of problems at LHH by confounding 76 as being only 62.

A generic records request to HSAG's headquarters for the author's e-mail address to pose questions went unanswered. So much for SFDPH's and HSAG's transparency and accountability.

The Tome of Documents

Here's some more numbers to digest:

Three-hundred and forty-seven. One-hundred and seventy-seven. Six-hundred and sixty-nine.

These numbers refer to the cookie-crum trail of the problems described in government public records leading up to, and following, LHH's decertification in April 2022.

The 347 number refers to the total pages in California Department of Public Health (CDPH) survey inspection Form 2567 reports following 11 separate LHH inspections between July 12, 2019 and April 13, 2022 resulting in LHH's decertification. I've read all 347 pages.

The 177 number refers to the total pages across the two *Root Cause Analysis* reports prepared by Health Services Advisory Group (HSAG) prepared as LHH's contracted "*Quality Improvement Expert*," Health Management Associates (HMA) initial "*Preliminary Assessment*" of LHH, LHH's "*Action Plan*" also prepared by HSAG, and the two-phase "*Mock Survey*" reports HMA produced. A planned second *Mock Survey* was scuttled, without an explanation of why.

Add in 84 pages of CDPH penalty reports involving the 12 patient deaths post-discharge, and another 61 pages between the *LHH Settlement Agreement* and the initial *LHH Closure Plan*, and you arrive at the 669 pages of background materials. I've read all 669 pages.

Incomplete "60-Day Reform Plan": LHH's Quality Management Problem

Following the 2019 sex abuse scandal, SFDPH released a "[60-day Laguna Honda Reform Plan](#)," claiming that as part of its *Plan of Correction* to CMS and CDPH, it would appoint a permanent CEO to replace LHH's then CEO, Mivic Hirose. A year passed before an interim CEO, Maggie Rykowski, was replaced by Michael Phillips, who was hired, in part, due to his experience running an acute-care hospital and a behavioral health facility, not a skilled nursing facility. He lasted just two years and was let go in June 2022 just after LHH was LHH was decertified. So much for a "permanent" CEO.

As a reminder, because LHH had failed to report the sexual abuse incidents in a timely manner — or at all — to the California Department of Public Health (CDPH), LHH received four "*Immediate Jeopardy*" citations. The scandal has cost at least \$1,829,212 to date in fines, penalties, and lawsuit settlements. Costs of that scandal continue to rise.

As an overarching goal, the *Reform Plan* claimed:

"There is more to reform LHH than just coming into compliance with regulatory findings. The goal for LHH is to build a best-in-class long-term care residential facility worthy of the patients and the people of San Francisco."

Unfortunately, SFDPH and SFHN kept operating LHH under Phillips as if it were an acute-care hospital, not as a skilled nursing facility, despite the claim "*reform*" in 2019 would get LHH to a best-in-class skilled nursing facility "place" and restore a "*culture of [patient] safety*" at LHH that Hirose had wantonly abandoned.

After the patient sexual abuse scandal rocked LHH in 2019 at a cost of \$1.83 million, had the *60-Day Reform Plan* actually been implemented, it may have prevented LHH's decertification in 2022 that has already racked up \$27.4 million in expenses (and continue growing) to try to get LHH back into some semblance of being a best-in-class skilled nursing facility.

The *60-Day Reform Plan* written in August 2019 by the San Francisco Health Network's (SFHN) Chief of Quality Officer, Troy Williams, asserted SFDPH was re-organizing LHH's Quality Management Department, and would appoint a

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Illustration: Patrick Monette-Shaw

What Was Hirose Thinking? On June 19, 2019 Mivic opened her mouth and inserted her foot in front of a City Attorney, admitting to a State patient safety inspection team that under her watch as LHH's CEO she'd forgotten to institute a *culture of safety*, despite having celebrated *Patient Safety Awareness Week* in March 2018!

"Unfortunately, SFDPH and SFHN kept operating LHH under Phillips as if it were an acute-care hospital, not as a skilled nursing facility, despite the claim 'reform' in 2019 would get LHH to a best-in-class skilled nursing facility 'place'."

permanent Quality Management Director to ensure resident safety at LHH. Dr. Grant Colfax, Director of Public Health in San Francisco's Department of Public Health helped develop LHH's "*Reform Plan*."

It took until June 2020 before Williams appointed Nawzaneen Talai as an interim Chief Quality Officer at LHH. She was promoted from within. Talai reports directly to Williams, not to LHH's acting CEO, Roland Pickens.

Despite the Quality Management re-organization in 2019, quality improvement problems persisted. As Kerr and Rivero [reported](#) in February, the first *Root Cause Analysis* report submitted to CMS on December 1, 2022 acknowledged in Root Cause #1 of the *Quality Assurance* category:

“[LHH’s quality improvement] structure is designed to align with LHH’s affiliated acute care hospital within the San Francisco Network and acute care processes ... [it’s] not tailored toward the SNF setting ... [increasing] the risk ... necessary care to residents related to SNF regulations is not delivered.”

Root Cause #3 found:

“Direct-care staff ... do not contribute to daily quality improvement] activities ... [resulting] in a culture of silence and indifference, increasing the likelihood that quality concerns are not raised and addressed ... [placing] residents at risk for harm.”

There's HSAG's admission of Hirose's "*culture of silence*" — a hangover from her reign of terror before being ousted — before Colfax and Williams thought up LHH's "*60-Day Reform Plan*" to replace *silence* with a "*culture of safety*" Hirose had [admitted](#) she ignored.

As Kerr and Rivero reported, the first RCA report Analysis also acknowledged:

“The four new hires in the QM Department do not have SNF or healthcare quality experience, a common hiring practice throughout LHH. This gap in nursing home knowledge and experience contributes to the staff not being properly qualified or competent.”

These root cause findings in 2022 were a damning indictment Williams and Colfax failed to reform LHH's QM problems in their *60-Day Reform Plan* in 2019. And it took until the first RCA report to get an acknowledgement of what LHH advocates have long claimed: That the mismanagement of LHH for the past 18 years was a direct result of staff and managers who lack SNF experience. That seems to be continuing despite the first RCA report, given the hiring in March 2023 of yet **another** interim LHH "*Chief Medical Officer*" who also lacks SNF experience.

“ These root cause findings in 2022 were a damning indictment Williams and Colfax failed to reform LHH’s QM problems in their ‘60-Day Reform Plan’ in 2019.”

The sex abuse citations *Plan of Correction* in 2019 claimed LHH would develop a new protocol to screen residents when returning from a pass to prevent the bringing of illicit substances into the facility. Whether that policy was developed, or implemented is doubtful, because the illicit substances proliferated and contributed to LHH's decertification in April 2022.

Troy Williams' *Reform Plan* claimed it would develop a *Request for Proposal* (RFP) to partner with healthcare consultant(s) experienced in long-term care facilities to align the care of LHH patients with the skilled nursing facility "*industry*" best practices. It's not known whether the RFP was completed or whether a consultant with experience in long-term care facilities was ever hired. It's thought the three consultants LHH eventually hired and brought on board at a current cost of \$26.7 million weren't hired until May 2022, **after** LHH was decertified in April 2022.

The *Reform Plan* asserted LHH would pursue a long-term goal of applying for *Joint Commission on Accreditation of Healthcare Organizations* (JCAHO), or another relevant accreditation body. LHH has never held, and thought doesn't need to hold, JCAHO accreditation. Skilled nursing facilities (SNF) require licensure, not accreditation. This illustrates Mr. Williams was totally unfamiliar with SNF settings. It's but one symptom illustrating SFHN and SFDPH managers were mismanaging LHH like it was an acute-care hospital, not as a SNF. Perhaps the claim was meant to portray LHH as taking a semblance of meaningful action.

No action seemed to have followed, and LHH doesn't seem to have applied for JCAHO accreditation, or we might have heard about it by now. We haven't.

The “*Minimizers*”

Because many people keep trying to minimize the severity and scope of violations at LHH — including the Health Commission, LHH CEO Roland Pickens, Director of Public Health Grant Colfax, Supervisor Myrna Melgar, Supervisor Hillary Ronen, former City Attorney Louise Renne, and others, including even some of LHH's community supporters — a large dose of skepticism is in order.

“ Because people keep trying to minimize the severity and scope of LHH’s violations, a large dose of skepticism is in order. ”

How these “*minimizers*” can collectively ignore 138 State survey inspection citations, 78 “F-Tag” and “K-Tag” specific statutory violations (many multiple times systemically), 63 causal root factors, and 454 corrective actions necessary to hopefully bring LHH back into regulatory compliance to obtain recertification — is a mystery only a spin control meister, or a mother, can appreciate and love.

After all, LHH's “*Action Plan*” released on February 8 listing 454 corrective action milestones is shockingly full describing basic problems in many departments at LHH.

Supervisor Myrna Melgar

Supervisor Melgar was interviewed for an inaugural *San Francisco Chronicle* [podcast](#) titled “*Soup With the Supes*” on February 28, 2023. The podcast series featuring additional District Supervisors is part of a *Chronicle* series titled “*SF Next: Fixing Our City*.”

The February podcast was moderated by *Chronicle* multimedia journalist Laura Wenus, who opened the segment with Melgar saying the hospital was found to be “*out of compliance*” with regulations in April 2022, and alluded to a CDPH inspection survey in October 2021 that had revealed two patients had overdosed on street drugs in July 2021 and were discharged to acute care hospitals immediately, which saved their lives. One of them had to be placed in a breathing machine. Wenus blithely said only that Federal regulators had found “*LHH was in a state of substandard quality of care.*” In truth, LHH had been routinely and repeatedly out of substantial compliance with regulations for at least three years.

It's clear Wenus hadn't read the 64-page October 14, 2021 CDPH Form 2567 inspection report. That inspection had not only revealed the two life-threatening fentanyl overdoses, but that 13 of 37 sampled residents had tested positive for illicit street drugs, two patients had been found unconscious, and two had sustained falls. Also, 23 of the 37 sampled residents were found to have contraband articles that posed a safety hazard jeopardizing the health and safety of other residents, with 11 of the 37 deemed unsafe smokers possessing ignitable items having the potential to cause burn injuries and significant harm to residents. Other serious deficiencies were also noted during the October survey, which were only the beginning of causal factors following seven subsequent inspections leading to LHH's decertification in April 2022.

The October 2021 inspection wasn't merely about two patient overdoses, as Wenus glossed over.

“ The October 2021 inspection wasn't merely about two patient overdoses, as Wenus glossed over. ”

For her part, Melgar said she had “*been working my butt off for Laguna Honda since the beginning*” [of becoming District 7 Supervisor], in part “*because the things they [CMS] were asking us to do were against our best interests, against the best interests of the residents of Laguna Honda. The Relocation Plan was a total disaster.*”

Melgar was referring specifically to LHH's initial “[Closure Plan](#)” (*LHH Closure and Patient Transfer and Relocation Plan*) that CMS required LHH to adopt and implement. Weirdly, CMS tied it to LHH's concurrent efforts to obtain re-certification.

Melgar was right the ill-conceived *Closure Plan* **was** a disaster and against the best interests of LHH's residents, because it had led to 12 patient deaths post-discharge among the first 57 involuntary transfers and discharges.

Melgar went on to recount how she helped mobilize community opposition to the *Closure Plan*. She said, “*It was indicative of our working together and use whatever assets we had to deal with the ‘political problems’ while we were also dealing with the*

‘technical issues’ with CMS.” Calling resolving the *Closure Plan* a “political” problem was strange, but alluding to the serious substandard quality of care violations as mere “technical” problems was even weirder, minimizing the severity and scope of LHH’s problems CMS had uncovered.

Melgar admittedly was instrumental in passing two resolutions at the Board of Supervisor urging Secretary of the US. Department of Health and Human Services, Xavier Becerra, to get CMS and CDPH to agree to a pause on the patient transfers.

Beyond the *Closure Plan*, which was admittedly wrong to have required, what Melgar missed or tried to minimize and gloss over was that CMS was principally asking that LHH — as DHHS Secretary Xavier Becerra subsequently rightfully noted —

“What Melgar missed or tried to minimize and gloss over was that CMS was principally asking that LHH fix all of the substandard care and 261 deficiencies that led to LHH’s decertification.”

That, ultimately, is in the best interests of LHH’s residents, as Melgar and Ronen must know. To suggest **not** doing so is what would be against residents’ best interests, and ridiculous or *Orwellian* speak.

In a *Chronicle* [article](#) ten days earlier on February 18 about a delayed affordable housing project for LHH’s campus that will include market-rate housing to help fund the affordable housing tiny studio apartments planned for the campus, Melgar was quoted as saying “*We should be able to walk and chew gum at the same time,*” saying she felt “*caught between a rock* [obtaining LHH’s recertification] *and a hard place*” [the housing project]. She was frustrated other SFDPH staff hasn’t been deployed to help shoehorn the housing in as another high priority.

“*We need to save the hospital. That’s the No. 1 priority,*” she said, not wanting to do anything to jeopardize recertification.

Considering LHH’s residents are caught between a rock and a hard place — mandatory involuntary discharges from LHH vs. not enduring transfer trauma and death — it’s difficult pondering sympathy for a City Supervisor feeling caught between a rock and a hard place.

Until LHH relearns how to walk, resumes full compliance with Federal regulations governing skilled nursing facilities, and regains its certification, the hospital — and by extension, SFDPH — shouldn’t even try to chew gum at the same time, let alone whine about rocks and hard places.

Supervisor Hillary Ronen

Somewhat shockingly, Ronen seems to be casting blame and aspersions on Secretary Becerra, rather than finding fault with the very managers transplanted from SFGH and SFHN who brought LHH’s decertification on, themselves. Ronen is misdirecting blame.

“Ronen seems to be casting blame and aspersions on Secretary Becerra, rather than finding fault with the very managers transplanted from SFGH and SFHN who brought LHH’s decertification on, themselves. Ronen is misdirecting blame.”

As the *San Francisco Standard* [reported](#) on February 10, Ronen threw a tantrum and tweeted she was boycotting attending an SFGH Foundation gala — over her annoyance Becerra had been featured at a different City Hall event. She misplaced blame on Becerra, frothing on [Twitter](#) “[because] *of his role in the deaths of 12 patients that his agency forced out of Laguna Honda Hospital & for preventing admissions* [to LHH].” Becerra had no direct, or even indirect, role in the patient’s deaths. LHH did.

Ronen doesn’t seem to get it that although CMS, under Becerra, had required LHH develop a patient relocation plan — that was eventually suspended six months ago last July — it was actually LHH’s staff who were found to have been culpable for the 12 patients’ deaths, as I [reported](#) for the *Westside Observer* in January.

The *Standard* reported Ronen’s rationale for boycotting the Foundation’s gala, which was honoring Nancy Pelosi, not Becerra, was that San Francisco “*shouldn’t be featuring this man at any event ... when he has peoples’ lives he’s playing with.*” It’s not Becerra playing with patients’ lives. That would be LHH’s own staff. More misplaced angst on Ronen’s part. Her boycott was silly. Period. It’s LHH’s managers who are playing with residents’ lives.

This suggests Ronen may not have read any of the 261 substandard patient care citations LHH has racked up over the three years and four months between July 2019 and November 2022, or facility violations, of Federal regulations documenting severe problems with regulatory compliance to provide quality and safe care of LHH's vulnerable residents.

“Becerra can't simply order CMS to stop enforcing 'F-Tag' violations, as Ronen may wish.”

It's also unclear whether Ronen understood any of the 63 root causal factors leading to LHH's decertification due to LHH's mismanagement. That's not on Becerra. He can't simply order CMS to stop enforcing “F-Tag” violations, as she may wish.

The *Standard's* article also reported Ronen asserted Becerra is:

“... gumming up our entire system. ... We've been bending over backwards to address any criticism they [CMS] have. ... He holds us hostage every minute.”

She went on to claim LHH's problems are “a direct result of Becerra's failure to lead.” Ronen clearly hasn't read my [articles](#) on LHH's own leadership failures. Ronen has her head in the sand, or clouds.

Ronen's hysteria is worrisome, as if she doesn't get it that had LHH *not* been providing substandard quality of care during the past three years, LHH would not need to bend over backwards now to fix 261 violations.

More worrisome, Ronen doesn't appear to be actively opening her ears and listening to Becerra, who accurately noted:

“We are, by law, required to make sure that patients are cared for safely and with the care that they're supposed to have. ... We have no choice by law but to say that the safety of patients must come first. We have to make sure that we're all working together to make sure ... everyone is following the rules [and] people are getting the care they need.”

“Becerra isn't holding LHH 'hostage' as Ronen wildly claimed. He's right saying: 'We are, by law, required to make sure that patients are cared for safely and with the care that they're supposed to have'.”

Not content finishing bashing Becerra, Ronen was reported in a *San Francisco Chronicle* [article](#) two weeks later as having written to the SFGH Foundation, saying:

“Instead of offering to assist the city, Becerra and his employees have done everything to threaten and punish Laguna Honda, and by extension, its patients.”

Becerra hasn't threatened or punished LHH or its patients. Instead, he's trying to get CMS to bring LHH into compliance with CMS regulations. CMS could have put LHH into receivership, which may have gotten LHH back into compliance faster than the now year-long effort LHH has struggled with trying to obtain recertification.

“Becerra hasn't threatened or punished LHH or its patients. Instead, he's trying to get CMS to bring LHH into compliance with CMS regulations.”

Ronen doesn't seem to get it that had LHH's own employees *not* been found to have violated 78 of CMS's 211 separate F-Tag patient care “rules” — some several times each — LHH wouldn't have received the 118 severity-and-scope patient care citations. And Becerra and CMS would not now have to make damn sure LHH is following the rules, and the City would not have had to spend \$26.7 million hiring consultants to teach LHH staff how to follow those rules.

Had Ronen read the 454 corrective action milestones listed in LHH's 49-page “Action Plan,” she might have understood just how far out of compliance LHH had become, rather than wrongly going after Becerra.

“That's what CMS is supposed to do. CMS isn't simply punishing LHH, as Ronen wrongly presumed.”

Even more worrisome, Ronen shouldn't expect Becerra to simply order CMS to stop trying to get LHH back into substantial compliance. That's what CMS is supposed to do. CMS isn't simply punishing LHH, as Ronen wrongly presumed.

Hopefully, by the time the full Board of Supervisor's holds its next scheduled *Committee of the Whole* hearing about LHH on May 9, Ronen may have come to her senses, and realized that it's not Becerra who is at fault, it's LHH's own managers who caused LHH's decertification.

Louise Renne, Former City Attorney and Former Supervisor

Among others who continue to minimize the severity and scope of LHH's substandard patient care violations is Ms. Louise Renne. On March 9, 2023 the San Francisco Interfaith Council (SFIC) sponsored an "[Online Briefing](#)" for its community and faith partners featuring Renne, who shared a PowerPoint presentation titled "*The Story & Fate of Laguna Honda.*"

The on-line briefing was moderated by Michael Pappas, Executive Director of SFIC, who was [defrocked](#) in 2007 as an ordained priest of the Greek Orthodox Church.

Archbishop Salvatore Cordileone delivered inane remarks about saving Laguna Honda before Renne was introduced.

Renne's slide show was ludicrous, erroneously reporting LHH's current programming includes an active Adult Day Health Care (ADHC) program providing respite day care for elderly people who need close supervision. It doesn't.

Renne should have known LHH's ADHC program was shut down in 2008 even before the replacement hospital was opened in 2010 because space in the new hospital for the ADHC program wasn't included in the rebuild floor plans. Renne should also have known LHH's former COO, Gayling Gee, was [fired](#) by LHH's former CEO, Mivic Hirose, for Gee's efforts trying to save LHH's ADHC. Renne once again wrongly claimed credit during her presentation for winning the \$1 billion tobacco settlement lawsuit former Supervisor Angela Alioto had actually developed; that settlement award became part of the source of funding for the replacement hospital. As I reported in 2010, Renne had actively [tried to stop](#) Alioto's lawsuit.

Renne claimed current City Attorney David Chiu's had "won" his Federal lawsuit to rescue LHH. She was lying. As part of LHH's *Settlement Agreement* with CMS, Chiu was forced to withdraw his lawsuit, which effectively stopped a second, separate lawsuit Renne had filed that was found to be outside the Court's jurisdiction. Her appeal is unlikely to succeed. And she implied she's still representing all LHH families and patients.

Chiu **didn't** win anything. Instead, he surrendered by *withdrawing* his lawsuit. Renne must know the distinction.

Remarkably, Renne claimed LHH's decertification was caused merely by two patients using fentanyl, other patients possessing lighters and cigarettes, and a single medication error. Nothing could be further from the truth.

She basically minimized and lied about CMS's extensive findings and citations — and concluded by saying that saving LHH is a cause the religious faithful must take up for those who are not rich will have a place to go. She was merely inciting and stoking a public outcry. It was sad seeing her grandstanding using out-of-date information.

Asked by Pappas to expand on recent violations that led to LHH's decertification, Renne lamely fell back on LHH's patient sex abuse scandal in 2019. She bemoaned (like Melgar) the proposed housing project on LHH's campus has stalled.

Renne mentioned **nothing** else about more the recent and voluminous 261 State citations, or the 63 distinct root causal factors, most of which point to LHH's inept managers. By deflecting Pappas' question, Renne basically lied. Period.

Across these minimizers, I have to wonder whether any, or all, of them have read any, or all, of the 669 pages of background materials relating to LHH's decertification. If they had, why are they minimizing the seriousness of LHH's problems?

“ Renne claimed current City Attorney David Chiu's had 'won' his Federal lawsuit to rescue LHH. Instead, he surrendered by *withdrawing* his lawsuit. ”

“ The minimizers *must* be aware that if LHH's problems are 'minimal':

- **Why is it costing \$27.4 million or more in expenses to rectify the problems?**
 - **Why has it taken a full year with recertification not having happened yet and so far behind schedule?**
 - **Why has the ban on new admissions to LHH not been lifted yet? ”**
-

Of interest, the minimizers have completely avoided addressing three salient issues that they **must** be aware of:

1. If LHH's problems are "*minimal*" and not severe, why is it costing \$27.4 million or more in expenses to rectify the problems and get LHH back into being a best-in-class skilled nursing facility?
2. If LHH's problems aren't so bad, why has it taken a full year with recertification not having happened yet and so far behind schedule, and may take another six months or more to accomplish?
3. If the problems weren't so severe, why has the ban on new admissions to LHH not been lifted yet, allowing San Franciscans who need skilled nursing care to receive it in the City, instead of being dumped into out-of-county facilities?

Defrocking the "*Minimizers*"

I'm reminded of comedian and former U.S. Senator Al Franken's 2003 book, "*Lies ... and the Lying Liars Who Tell Them.*" Franken asserted God had suggested he title his book, "*Bearers of False Witness and the False Witness That They Bear.*" It was great that Franken worked with God's suggestion, updating it to modern vernacular. His book put me on alert 20 years ago for liars.

Ironically, after the *#MeToo* movement arrived, Leeann Tweeden, a conservative talk-radio host, bore *False Witness* — lying — by [alleging](#) Franken had kissed her without her consent during a USO Tour, forcing him to resign as Senator in 2018.

I became a columnist for the *Westside Observer* because the truth matters, since too many people lie to attain power and abuse people. Locally, lying to us undermines our trust in SFDPH. Public figure or private, lies impose real harm.

Me? I have to keep doing my part to give voice to LHH's voiceless.

“ LHH as we knew it may not survive it's *pre-mortem*, if lies continue leading to its *post-mortem*. ”

For those who have continued to minimize LHH's problems, deception has been the point all along: Theatrical propaganda put out by an unreliable narrators. I have to wonder if God will defrock them for bearing *False Witness*, as Pappas was defrocked.

The minimizers need to stop their deliberate misinformation.

Sadly, LHH as we knew it may not survive it's *pre-mortem*, if lies continue leading to its *post-mortem*.

Monette-Shaw is a columnist for San Francisco's Westside Observer newspaper, and a member of the California First Amendment Coalition (FAC) and the ACLU. He operates stopLHHdownsize.com. Contact him at monette-shaw@westsideobserver.com.