San Francisco Department of Public Health
Grant Colfax, MD, Director of Health

San Francisco Health Network
Roland Pickens, MHA, FACHE, Director

City and County of San Francisco
London N. Breed
Mayor

Laguna Honda Hospital and Rehabilitation Center
Michael T. Phillips, MHA, FACHE
Chief Executive Officer

Via facsimile 415-330-6350

December 27, 2021

Diana Marana, R.N.
District Manager
California Department of Public Health
Licensing & Certification Program
San Francisco District Office
150 North Hill Drive, Suite 22
Brisbane, CA 94005

Re: Request for Informal Dispute Resolution (IDR);
Facility Reported Incident nos. CA00675386, CA00744774, CA00745390, CA00747134, CA00746900 and CA00747220, Survey Completion 10/14/2021;
Laguna Honda Hospital & Rehabilitation Center D/P SNF;
Provider Number: 555020.

Dear Ms. Marana:

This letter serves to notify the California Department of Public Health (CDPH) that Laguna Honda Hospital and Rehabilitation Center D/P SNF (Laguna Honda) requests an informal dispute resolution process on the above-referenced incidents and requests that the deficiency stated in the Statement of Deficiencies dated December 16, 2021, further identified and described below and the resulting determination that the alleged noncompliance constitutes substandard quality of care as defined at 4 CFR §488.301 be rescinded, or in the alternative that CDPH reconsider its determination that these incidents constitute a substandard quality of care based on the evaluator's conclusion these incidents are a pattern of deficiencies that comprise a scope of severity of H, to a determination that these incidents are isolated deficiencies that comprise a scope and severity of G or widespread deficiencies with no actual harm that comprise a scope and severity of F, which do not constitute a substandard quality of care.

Disputed Deficiency

F689; SS=H. 42 CFR 483.25(d)(1) and (2). The resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.

State Surveyor's Findings

The state surveyor found that the requirement is not met because Laguna Honda did not implement policies and procedures for the following practices:

a. Prohibiting use and possession of illicit drugs; where 13 of 37 sampled residents tested positive for non-prescribed substances; use of which resulted in the following outcomes:
   i. Residents 1 and 3 experienced a life-threatening emergency and were hospitalized;
   ii. Residents 4 and 27 experienced a change of level of consciousness;
   iii. Residents 2 and 32 fell;
   iv. Residents 11, 18, 24, and 29 experienced behavior changes.

b. Possession of contrabands, trading illicit substances, and consuming marijuana and alcohol inside the facility; where 23 of 37 sampled residents (Residents 14, 3, 4, 5, 2, 27, 11, 17, 13, 15, 16, 23, 20, 26, 21, 19, 25, 32, 12, 18, 33, 10, and 24) were found in possession of marijuana, syringes, pocket-knife, scissors, smoking paraphernalia, and bottles of alcohol, access to which posed a safety hazard that jeopardize the health and safety of residents, staff, and visitors.
c. Monitoring and implementing care plan for 11 of 37 sampled residents who were identified as safe and

unsafe smokers (Residents 2, 27, 17, 34, 18, 20, 26, 14, 25, 24, and 19), for which unsafe possession of ignitable items had the potential to cause burn injuries and significant harm to residents, staff, and visitors.

d. Storing lighters, combustibles in specific secure place according to policy to prevent misuse and control access.
e. Tracking and disposition of confiscated contrabands for 16 of 37 sampled residents (Residents 17, 35, 36, 37, 13, 15, 23, 19, 11, 25, 12, 4, 10, 21, 34, and 2) had the potential for diversion, misuse or uncontrolled redistribution of confiscated contrabands and further harm to residents, staff, and visitors;

which placed residents in an unsafe living environment and negative health outcomes.

Facility's Response

First and foremost, as explained in more detail below, with the exception of the patients who were hospitalized (Residents 1 and 3) and the patient who fell (Resident 32) this stated F tag, F 689, is not applicable to the alleged findings for any of the other incidents listed on this statement of deficiencies because none involved an "accident". All of the other incidents involved situations where a patient either chose to, or because of their addictions were compelled to, use or possess drugs or alcohol or possess contraband. There is no allegation or evidence presented by the surveyor that any of the incidents, including the incidents where the patients were hospitalized or fell, that the substances, alcohol, or contraband were obtained in a manner that implicates staff error or where the established policies and procedures were not followed by the staff that led to an avoidable accident and resulted in a pattern of deficiencies that led to actual harm to any patient.

Laguna Honda treats substance use disorders very seriously because we understand that it can have a significant impact on the lives of individuals and their families, especially when it affects patients who are undergoing medical and rehabilitative treatment at a skilled nursing facility. Nevertheless, as a skilled nursing facility that is required to afford its patients all of the rights required under the Patient's Bill of Rights, Laguna Honda cannot mandate substance use treatment, it can only offer treatment and resources to those patients who have an identified history of substance use or who show evidence of substance use while they are patients at Laguna Honda. Patients still have the right to refuse treatment and even to refuse to adhere to any part of their care plan goals that they do not want to abide by even if they have agreed to their treatment care plan. Laguna Honda staff have taken extraordinary measures to identify and confiscate illicit drugs, drug paraphernalia, and related contraband, within legal restrictions that they cannot just ignore. As much as the surveyor would like staff to search everyone and every package and mail, Laguna Honda cannot ignore a patient's privacy rights, so staff must perform searches within the limits of the law.

This means that patients will successfully smuggle drugs and contraband into Laguna Honda, no matter how well staff perform their duties and follow the established policies and procedures that are aimed at reducing drug use and possession of contraband. As a point of reference, not even jails and prisons, where individuals do not have any sort of reasonable expectation of privacy and where every visitor is searched and every package is opened by trained law enforcement, can keep drugs and other contraband out of their locked facilities. The surveyor in this instance is expecting that Laguna Honda attain a standard that is not reasonable or attainable at an unlocked facility, where patients have a level of an expectation of privacy in their rooms and to receive unopened mail, can freely leave and return whether on a pass or against medical advice, and can choose to refuse treatment or to abide by their treatment plan goals. While we understand that the State cannot just ignore circumstances where patients are injured, unless there are situations where Laguna Honda does not have a policy or procedure in place to address the alleged hazard, or staff failed to comply with their duties or follow an established policy and procedure that led to an avoidable accident, this type of facility is going to have unavoidable accidents.

Alleged Incidents of Actual Harm do not Rise to the Level of Avoidable Accidents

Assuming that this F tag applies to the incidents listed in this statement of deficiencies, Laguna Honda is in compliance with the federal participation requirements with regard to implementing policies and procedures to establish an environment that remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents in relation to the use and possession of illicit drugs and possession of impermissible contraband. With respect to 42 CFR § 483.25 (F 689), a skilled nursing facility is required to implement policies and procedures to ensure the facility provides an environment that is free

from accident hazards over which the facility has control and provide supervision and assistive devices to each resident to prevent avoidable accidents, not to ensure a safe environment free of all possible accidents for all residents. Accidents are a part of everyday life, and they will happen in our facility, every day. It is important to note that not all accidents are avoidable, and our responsibility as a skilled nursing facility is to ensure the safest environment possible for patients. We have to do that in a manner that respects a patients' right to privacy, dignity, self-determination, and their right to make choices about significant aspects of their life while they are in our facility.

Laguna Honda has met this requirement by identifying the hazards, evaluating the hazards and reducing them as much as possible, implementing interventions systemwide and consistent with each resident's needs, goals, care plan, and current professional standards of practice in order to reduce the risk of potential accidents, and monitoring the effectiveness of the interventions and having systems in place to modify the interventions as necessary, in accordance with current professional standards of practice, and the patients' right to privacy, dignity, and self-determination, including to make choices about their life in the facility.

<u>Laguna Honda has Policies and Procedures in Place to Address the Alleged Deficiencies</u>
Laguna Honda has various policies and procedures that have been implemented to address each of these specific alleged deficiencies related to use and possession of substance use and related possession of contraband, including all of the following:

a. LHHPP 20-04 Discharge Planning
    i. Attachment A: Residential Substance Use Treatment and Dual Diagnosis Treatment Placement for LHH Residents
    ii. Attachment B: LHH Referral Protocol for Opiate Replacement Treatment
b. LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response
c. LHHPP 22-02 Resident Alcohol Consumption
d. LHHPP 22-03 Resident Rights
e. LHHPP 22-12 Clinical/Safety Search Protocol
f. LHHPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)
g. LHHPP 24-12 Laguna Premier Club: A Neurobehavioral Day Program
h. LHHPP 25-12 Drug Diversion Reporting and Response
i. LHHPP 75-05 Illicit or Diverted Drugs and/or Paraphernalia Possession/Use Residents or Visitors
j. LHHPP 75-10 Appendix K: Enforcement of the Smoking Policy
k. LHHPP 75-12 Firearms, Dangerous Weapons and Contraband
l. LHHPP 76-02 Smoke and Tobacco Free Environment
m. MSPP D08-03 Access to LHH Psychiatry Services
n. MSPP D08-07 LHH Substance Treatment and Recovery Services
o. MSPP D08-09 Mental Health Services
p. MSPP D08-10 Behavioral Management Services by LHH Psychiatry

In fact, the only reason that the State surveyor had such detailed information about the 37 "sampled" residents is because Laguna Honda staff has been so successful in following the established policies and procedures to identify and confiscate drugs and other contraband, monitoring and tracking our established interventions, and implementing and updating care plans where substance use is identified. The surveyor is using Laguna Honda's own monitoring of its success in identifying and confiscating drugs and related contraband, to lump them all together into a single file to try to claim that just the sheer number of alleged deficiencies led to the hospitalization of two residents and the fall of one other resident and allegedly shows a pattern of deficiencies, without actually focusing on the evidence for each of the three isolated and unique incidents to establish the facts needed to conclude that any of those three incidents involved "avoidable accidents" as defined in Appendix PP of the Centers for Medicare and Medicaid (CMS) State Operations Manual.

An avoidable accident is defined as an accident that

> "occurred because the facility failed to identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or evaluate/analyze the hazards and risks and eliminate them, if possible, or if not possible, identify and implement measures to reduce the hazards/risks as much as possible; and/or implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident; and/or monitor the

effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice."[1]

Regarding the incidents that involved actual harm:

- with respect to Resident 1 who had to be hospitalized, the only finding related to the hospitalization was that a urine toxicology screen indicated presence of fentanyl, amphetamine, marijuana, and benzodiazepine. Nowhere in the entire 64 pages of the statement of deficiencies, does the surveyor allege or present evidence that Resident 1's hospitalization was an accident that occurred because Laguna Honda failed to identify hazards and/or assess the resident's risk of an accident, evaluate and analyze those hazards and risks and eliminate them if applicable or implement measures to reduce their likelihood, implement interventions including adequate supervision, assistive devices or the like that are consistent with the resident's needs, their care plan or the current professional standards of practice to reduce that risk, or monitor the effectiveness of those interventions and modify the care plan as necessary.
- with respect to Resident 3 who had to be hospitalized, the only findings were that a urine toxicology screen indicated presence of amphetamines, methamphetamines, and fentanyl and a care plan that did not include intervention or planning to address history of illicit drug use. The patient's chart did include a notation that the patient was referred to behavioral medicine for assessment related to their history of substance use. In addition, the patient was receiving Medication Assisted Therapy, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.
- with respect to Resident 4 who had a change of consciousness, the only findings related to the change of consciousness, were that a urine toxicology screen indicated presence of marijuana and methamphetamines. The surveyor points to nursing notes or interviews with staff about prior incidents where Resident 4 was witnessed by assigned staff smoking marijuana, or where drugs or other contraband were confiscated. In fact, the notes and interviews indicate that staff was implementing various interventions and modifying as needed, including assigning a coach, conducting regular clinical searches, confiscating drugs and other contraband, and disposing of the drugs and contraband or providing it to the Sheriff's Department for destruction.
- with respect to Resident 27 who had a change of consciousness, the only findings related to the change of consciousness, were that a urine toxicology screen indicated presence methamphetamines. The surveyor points to nursing notes about prior incidents where Resident 27's drugs, smoking paraphernalia or other contraband were identified and confiscated. In fact, the notes indicate that staff was implementing various interventions, including conducting regular clinical searches, confiscating drugs and other contraband, and disposing of the drugs and contraband or providing it to the Sheriff's Department for destruction.
- with respect to Resident 2 who allegedly fell, there is no evidence that the resident actually fell, so we believe that was a mistake in the statement of deficiencies. The surveyor points to nursing notes or interviews about prior incidents where Resident 2's drugs, smoking paraphernalia or other contraband were identified and confiscated. In fact, the notes indicate that staff was implementing various interventions and modifying as necessary, including conducting regular clinical searches, identifying and confiscating drugs and other contraband, and disposing of the drugs and contraband or providing it to the Sheriff's Department for destruction.
- with respect to Resident 32 who fell, the only findings related to the fall were the possession of alcohol, suspected alcohol use, and a urine toxicology screen that indicated presence of methadone. The surveyor did not allege or present evidence that Resident 32's fall was an accident that occurred because Laguna Honda failed to identify hazards and/or assess the resident's risk of an accident, evaluate and analyze those hazards and risks and eliminate them if applicable or implement measures to reduce their likelihood, implement interventions including adequate supervision, assistive devices or the like that are consistent with the resident's needs, their care plan or the current professional standards of practice to reduce that risk, or monitor the effectiveness of those interventions and modify the care plan as necessary.

Instead of presenting evidence that ties the incidents to facts that establish that these incidents were avoidable accidents that the facility failed to identify, evaluate, implement measures to reduce, monitor, or modify, the surveyor attempts to find a nexus simply by listing lumping together all of the incidents listed in Laguna Honda's monitoring and tracking of their successful interventions to identify and confiscate illicit drugs and contraband as the evidence that Laguna Honda has failed to prevent avoidable accidents. Simply listing a wide range of unrelated

[1] CMS State Operations Manual, Appendix PP. Guidance to Surveyors for Long Term Care Facilities. (Rev. 173, 11-22-17) at p. 284

incidents that involve some form of drug use, alcohol use, or possession of drugs or other contraband over a period of two years, does not establish that Laguna Honda failed to prevent avoidable accidents to constitute a substandard quality of care determination.

The Majority of Alleged Deficiencies did not Constitute "Actual Harm" and Fail to Show a "Pattern"

Most Incidents did not Constitute Actual Harm

Even if we include the four incidents that involved behavior changes as actual harm, the majority of the findings in the listed deficiencies did not constitute actual harm. The surveyor herself acknowledged that the findings listed in sections "b-d" only posed the "potential" for harm.

Related to the incidents identified here:

- the alleged deficiencies under section "b" involved possession and access to a variety of contraband that "posed a safety" hazard, but none resulted in actual harm to the patients.
- the alleged deficiencies under section "c" involved possession of smoking paraphernalia and ignitable items that had the potential to cause burns or other harm, but the surveyor did not allege that any of the incidents involved actual harm to the patients. The surveyor stated that Laguna Honda failed to monitor and implement a care plan for 11 residents who were identified as safe or unsafe smokers, but her own discussion about her review of the patient care plans reveal that residents had smoking care plans and that staff was adhering to Laguna Honda's policies and procedures to identify and confiscate drugs and contraband and provide patients intervention options when they were identified with unauthorized items.
- the alleged deficiencies under section "d" involved storing lighters and combustibles in specific secure places to prevent misuse and control access, but the surveyor did allege that any of the incidents involved actual harm to the patients.
- the alleged deficiencies under section "e" involved an allegation that Laguna Honda failed to track and dispose of confiscated contraband that had the potential for diversion, misuse, or redistribution and the potential for harm to patients, but no allegation or evidence that any of these incidents resulted in actual harm to patients.

Additionally, the surveyor failed to establish a nexus between the incidents that involved actual harm to patients under its findings under section "a" of the statement of deficiencies, and any of the other alleged deficiencies under sections "b-d" where the surveyor herself noted that each only posed the "potential" for harm. The alleged deficiencies in sections "b-d" involve some possession of illicit drugs, but mostly involve a wide variety of possession of marijuana and other smoking paraphernalia, or other types of contraband. The surveyor did not make any findings that the incidents were connected in any way.

Surveyor Failed to Establish a "Pattern" that Constitutes Substandard Quality of Care

The surveyor concluded that the alleged deficiencies were a pattern of deficiencies that constituted actual harm and a substandard quality of care. Every alleged finding under this deficiency involves factual circumstances that were considerably different from each other failing to establish any sort of pattern that would require the same type of correction.

The incidents that led to actual harm in section "a" mainly involved patient use of fentanyl or methamphetamines, but each incident was slightly different, for example it is believed that another resident shared their drugs with Resident 1, it is believed that Resident 3's ex-husband may have provided her illicit drugs, Resident 4 admitted to buying drugs and alcohol from another resident, it is believed that Resident 2 received drugs from food delivery packages, Resident 32 allegedly received alcohol from another resident, it is believed that Resident 18 traded marijuana with another resident, but unknown with respect to other drugs, Resident 7 admitted to receiving drugs from a visitor, it is believed that Resident 31 uses drugs while they are out of the facility on a pass, and neither the facility nor the surveyor established how Residents 27, 11, 24, 29, and 28 obtained the illicit drugs that were found in their toxicology screens. Other than the similarity of the drugs that patients used, the surveyor did not find that the alleged deficiencies resulted from a pattern of conduct by Laguna Honda with respect to identifying and evaluating risks, implementing measures to reduce the risk, or monitoring and modifying the measures implemented to reduce the risks.

Additionally, between the incidents identified under section "a" which involved drug use resulted in actual harm to patients and the other incidents under sections "b" (that involved possession of a wide range of contraband, from

syringes and bottles of alcohol, to weed and smoking paraphernalia), “c” (that involved implementing and monitoring care plans for smokers and possession of ignitable contraband), “d” (that involved storing lighters and combustibles in places that may have been accessible to patients), and “e” (that involved not tracking and disposing of confiscated contraband which could have led to residents having access and stealing these items), the surveyor did not find that the alleged deficiencies resulted from a pattern of conduct by Laguna Honda with respect to identifying and evaluating risks, implementing measures to reduce the risk, or monitoring and modifying the measures implemented to reduce the risks.

Each incident was an isolated, unique incident that does not amount to a “pattern” of deficiencies to signify a scope and severity of H to constitute a substandard quality of care determination. Other than the common illicit drugs used by the patients under section “a” that resulted in actual harm, the surveyor failed to identify what the pattern of deficiencies was in relation to these incidents, or any pattern with respect to the findings under sections “b-d.”

The Alleged Incidents are not Accidents and Surveyor’s Reliance on F 689 is Misplaced

The identified deficiency tag, F 689, is not intended for these types of incidents that involve residents who have capacity, free will, and protected Patient Rights, to use illicit substances in an unlocked facility where patients have a right to leave and return to the facility with some restrictions, but where they still have a reasonable expectation of privacy, and where the illicit substances in question are not purchased, supplied, or maintained by the facility and are smuggled into the facility, despite the staff’s extraordinary efforts to search, identify, and confiscate substances and contraband from patients and their visitors before they reach the units.

The intent of the requirement under F 689 is identified as ensuring that “the facility provides and environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents,” and includes “identifying hazards(s) and risk(s); evaluating and analyzing hazards and risks; implementing interventions to reduce hazards and risks; and monitoring for effectiveness and modifying interventions when necessary.”[2] Laguna Honda does not have control over whether a patient will use illicit drugs or smuggle contraband. Laguna Honda can offer substance use treatment, as it does to every patient with an identified history of substance use, but every patient has a right to refuse treatment, and a right to refuse to adhere to their treatment plan goals. Laguna Honda can implement policies and procedures to prohibit drugs and other contraband, and to identify and confiscate drugs and contraband that can impact the health and safety of patients, but Laguna Honda must also adhere to the rights of a patient’s privacy, dignity, and self-determination. The findings by the surveyor show that staff have been successful in identifying and confiscating drugs and other paraphernalia, but they are not going to completely eliminate incidents that are unavoidable among a population where 20% have a history of substance use and not all will accept treatment. Even among the most successful substance use treatment programs, relapse among participants is still significant.

As stated previously, with the exception of the actual harm that resulted to the patients who were hospitalized, the patient who fell, or the patients who experienced a change in their level of consciousness, the incidents described by the surveyor are not “accidents.” An accident is defined as “any unexpected or unintentional incident, which results or may result in injury or illness to a resident.”[3] Use and possession of drugs, drug paraphernalia, and contraband related to drug use is not an accident among the patients identified in this statement of deficiencies. These patients have a history of drug use and drug-seeking behavior that is not an accident. Laguna Honda does not have control over these drugs, drug paraphernalia, or related contraband that these patients continue to smuggle into the facility. The surveyor did not allege that the resulting harm, including the hospitalizations, the fall, or that change in consciousness were the accidents, instead, the surveyor alleged that the acts of using and possessing drugs and related paraphernalia and contraband were the hazards that Laguna Honda failed to address.

These are behaviors and disorders that Laguna Honda is committed to address, but which Laguna Honda cannot be expected to treat as accidents, that it can create interventions that will eliminate this problem in the same way that it will address falls.

---

[2] CMS State Operations Manual, Appendix PP. Guidance to Surveyors for Long Term Care Facilities. (Rev. 173, 11-22-17) at p. 284

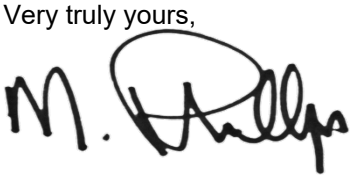
[3] CMS State Operations Manual, Appendix PP. Guidance to Surveyors for Long Term Care Facilities. (Rev. 173, 11-22-17) at p. 284

Based on the foregoing reasons, this deficiency should be dismissed or in the alternative the determination that these incidents constitute a substandard quality of care based on the evaluator's conclusion these incidents are a pattern of deficiencies that comprise a scope of severity of H should be reduced to a determination that these incidents are isolated deficiencies that comprise a scope and severity of G or widespread deficiencies with no actual harm that comprise a scope and severity of F, which do not constitute a substandard quality of care.

Summary

Laguna Honda respectfully requests that CDPH reconsider its findings, find that the facility has met the intent of the federal regulations, and rescind the deficiency issued under Statement of Deficiencies, Incident Nos. CA744774, CA745390, CA747134, CA746900, CA675386, and CA 747220, or in the alternative reconsider its determination that these incidents constitute a substandard quality of care based on the evaluator's conclusion these incidents are a pattern of deficiencies that comprise a scope of severity of H, to a determination that these incidents are isolated deficiencies that comprise a scope and severity of G or widespread deficiencies with no actual harm that comprise a scope and severity of F, which do not constitute a substandard quality of care.
If more information is needed, please contact me or Chief Quality Officer Nawzaneen Talai at (415) 759-3579.

Very truly yours,



Michael T. Phillips, MHA, FACHE
Chief Executive Officer

cc: Paula Perse, CMS
Nawzaneen Talai, MPH, CPHQ
Arnulfo Medina, DCA
Valerie Lopez, DCA