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U.S. Department of Health and Human Services
Departmental Appeals Board
Via DAB E-file

Re: Request for Appeal Hearing; Incident Nos. CA744774, CA745390, CA747134, CA746900, CA675386, and CA747220; Laguna Honda Hospital & Rehabilitation Center D/P SNF; Provider Number: 555020.

To DHHS Departmental Appeals Board:

Laguna Honda Hospital and Rehabilitation Center D/P SNF (Laguna Honda) hereby requests a hearing with the U.S. Dept. of Health and Human Services (DHHS), Departmental Appeals Board, to appeal the California Department of Public Health's (CDPH) findings that the incidents in the Statement of Deficiencies dated December 16, 2021, are deficiencies under the "accident" provision of the federal regulations[1] applicable to long term care facilities and that those incidents constitute "substandard quality of care" as defined at 4 CFR §488.301. As described in more detail below, Laguna Honda respectfully disagrees that any of the incidents cited are "accidents" under the stated regulation, and also disagrees that the alleged noncompliance establishes a pattern of deficiencies that constitute a substandard quality of care based on the evaluator's conclusion that these incidents are a pattern of deficiencies that resulted in actual harm. Rather, the identified deficiency tag, F 689, which coincides with the regulation that relates to "accidents" is not intended for these types of incidents that involve patients who have capacity, free will, and protected Patient Rights, and who intentionally use illicit drugs or seek and obtain impermissible contraband for these purposes, on and off campus. Whether a patient will use illicit drugs or smuggle contraband, is not a circumstance under which Laguna Honda "has control and provides supervision and assistive devices." In fact, the regulations do not even mention illicit drug use. Finally, Laguna Honda has instituted appropriate policies and procedures to avoid actual "accidents."

For the foregoing reasons, Laguna Honda requests that the Departmental Appeals Board reverse CDPH's finding that the incidents identified by CDPH are deficiencies under the stated regulation or that the alleged factual circumstances amount to a pattern that consititute 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.

[1] 42 CFR § 483.25(d). "Accidents"

CDPH Surveyor's Finding

CDPH 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.

CDPH found that Laguna Honda's failure to implement policies and procedures for these practices placed residents in an unsafe living environment and negative health outcomes.

Facility's Response

CDPH did not allege or present evidence 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 involved staff error; or that staff failed to follow the established policies and procedures), led to an avoidable accident and resulted in a pattern of deficiencies that led to actual harm to any patient. All of the incidents involved situations where a patient either chose to, or because of their addictions were compelled to, seek and use drugs or alcohol or possess paraphernalia and other contraband.

Laguna Honda treats substance use disorders very serious because staff understand that substance use can have a significant impact on the lives of individuals and their families, especially how 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 will always have the right to refuse treatment and even to refuse to adhere to any component of the goals outlined in their individual care plans that they do not want to abide by even if they agreed to their treatment care plan.

Substance use disorder/addiction treatment does not guarantee abstinence from substances. The National Institute on Drug Abuse notes that addiction is a chronic illness that cannot be cured, with a relapse (return to use of substances) rate of 40-60%, even with treatment. As noted by the National Institute on Drug Abuse "relapse doesn't mean treatment has failed." (https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery). In addition, patients do not always seek abstinence as the goal of substance use disorder treatment. The concept of patients collaborating on their own goals for substance use disorder treatment is part of the standard of care, as well as the recommended harm reduction framework for interventions for patients who do not desire to stop using substances (https://www.samhsa.gov/find-help/harm-reduction). In addition, the concept of patients collaborating on treatment goals, choosing treatment goals that differ from the "ideal", and making treatment decisions is not just supported, but required, by federal law and skilled nursing facility regulations.[2] (CMS State Operations Manual Guidance to Surveyors for Long Term Care Facilities Appendix PP -F552+F553, as well as 42 CFR §483.10)

CDPH's claim that Laguna Honda failed to implement policies and procedures to address the identified incidents is simply inaccurate. 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. In fact, the 37 patients and most of the incidents listed in CDPH's statement of deficiencies were not identified by CDPH through a random sample of patients, they were taken from a list that Laguna Honda provided to the CDPH surveyor which Laguna Honda began using to track incidents of drug and contraband use or possession in an effort to reduce such incidents.

While CDPH would like Laguna Honda staff to search every patient every time they leave the facility, and to search every piece of mail that is delivered to every patient, Laguna Honda cannot ignore a patient's CMS right to privacy, which requires that staff perform searches within legal requirements and limits. Patients who have substance use disorders and drug seeking behavior will successfully obtain drugs and contraband, 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 a reasonable expectation of privacy and where every visitor is searched and every package is opened by trained law enforcement officers, can keep drugs and other contraband out of their secured, locked facilities. CDPH expects that Laguna Honda achieve a standard that is neither reasonable nor attainable at an unlocked facility, where patients have a reasonable expectation of privacy that includes privacy in their rooms, to receive unopened mail, to freely come and go from Laguna Honda whether on a pass or against medical advice, can choose to refuse treatment or to abide by their treatment plan goals, or choose treatment plan goals outside of substance abstinence. While we understand that CDPH cannot ignore circumstances where patients are injured, this type of facility is going to have incidents that involve unwanted drug use or other unavoidable accidents.

[2] See CMS State Operations Manual Guidance to Surveyors for Long Term Care Facilities Appendices PP -F552+F553, as well as 42 CFR §483.10

The Alleged Incidents are not Accidents and CDPH's Reliance on F 689 is Misplaced

The identified deficiency tag, F 689, which coincides with the regulation that relates to "accidents"[3] is not intended for these types of incidents that involve patients who have capacity, free will, and protected Patient Rights, and who intentionally use illicit drugs or seek and obtain impermissible contraband for these purposes, on and off campus. 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. In most instances, Laguna Honda is required to obtain consent to even obtain a urine toxicology test to confirm who is actively using substances. These impermissible items 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 an 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."[4] Laguna Honda does not have control over whether a patient will use illicit drugs or smuggle contraband. Laguna Honda can offer substance use disorder treatment, as it does to every patient with an identified history of substance use disorder, but every patient has a right to refuse treatment, and a right to refuse to adhere to their treatment plan goals. Laguna Honda has implemented 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. CDPH's findings show that staff have been successful in identifying and confiscating drugs and other paraphernalia, but they cannot completely eliminate incidents that are unavoidable among a population where 20% (160 residents) have a history of substance use disorder, not all will accept treatment, and not all will choose abstinence as a treatment goal. Even among the most successful substance use treatment programs, relapse among participants is still a significant reality that is built into the treatment programs.

With the possible 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 CDPH which involve the use or possession of drugs or contraband, 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."[5] 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. CDPH did not allege that the resulting harm, including the hospitalizations, the fall, or that change in consciousness were the accidents, instead, CDPH alleged that the acts of using

[3] 42 CFR § 483.25(d). "Accidents"
[4] CMS State Operations Manual, Appendix PP. Guidance to Surveyors for Long Term Care Facilities. (Rev. 173, 11-22-17) at p. 284
[5] CMS State Operations Manual, Appendix PP. Guidance to Surveyors for Long Term Care Facilities. (Rev. 173, 11-22-17) at p. 284

and possessing drugs and related paraphernalia and contraband were the hazards that Laguna Honda failed to address.

Additionally, with respect to the environment that Laguna Honda is responsible for keeping as free as possible from avoidable accidents under this regulation and coinciding F tag, the state operations manual defines the key applicable terms in the following manner:

> - Environment as "any environment or area in the facility that is frequented by or accessible to residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas."
>
> - Hazards as "elements of the resident environment that have the potential to cause injury or illness.
>
> - "Hazards over which the facility has control" as those hazards in the resident environment where reasonable efforts by the facility could influence the risk for resulting injury or illness.
>
> - "Free of accident hazards as is possible" refers to being free of accident hazards over which the facility has control.

The only mention of "drugs" under this F tag in the state operations manual is as an example of a material that may pose a safety hazard for patients as part of a facilities responsibility over physical plant hazards. This section in the manual, however, refers CDPH surveyors to the guidance related to a facility's responsibilities regarding the facility's physical environment, or F tag F-838 (42 CFR §483.70(e)), which indicates that this provision is intended to apply to the components of the facility that Laguna Honda can reasonably control. In addition, the examples in this section of the manual focus on materials and chemicals that you would expect to find for the facility's normal course of business and operations, such as cleaning supplies, or plants or other natural materials that may be found in the facility that can cause injury or illness, such as poison ivy. Even drugs are mentioned in line with "therapeutic agents," signifying that that intent is to ensure that facilities have policies and procedures to ensure the safe handling and storage of the prescription drugs for patients at Laguna Honda. This regulation and coinciding F tag is not intended to be applied to a patient's voluntary use and possession of illicit substances or medication that is not prescribed to them, because they are not accidents as defined under this regulation. Laguna Honda staff has implemented policies and procedures to ensure that their substance use treatment services comply with the applicable substance use treatment program, which are the standards that Laguna Honda should be held accountable to in this instance with respect to the majority of the incidents listed by CDPH.

Finally, the state operations manual explains that "Supervision/Adequate Supervision" refers to an intervention and means of mitigating the risk of an accident, and facilities are obligated to provide adequate supervision to prevent accidents.[6] Under this F tag, adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. In the statement of deficiencies and communications with CDPH staff, CDPH seems to suggest that Laguna Honda should search every patient every time they leave the facility and have 24/7 oversight over patients that have a history of substance use or drug seeking behavior. Laguna Honda has about 800 patients,

[6] CMS State Operations Manual, Appendix PP. Guidance to Surveyors for Long Term Care Facilities. (Rev. 173, 11-22-17) at p. 286.

and 20% (about 160) have a history of substance use disorder. The amount of resources that would be required to provide the kind of oversight that CDPH expects under this F tag to completely eliminate the incidents listed in this statement of deficiencies is unreasonable and contrary to a Patient's Bill of Rights and to CMS Conditions of Participation. This is the wrong standard to expect for skilled nursing facilities that provide substance use disorder treatement services to patients that are in need of medical and rehabilitation services.

The use and possession of drugs, alcohol, and related paraphernalia are related to behaviors and disorders that Laguna Honda is committed to address, but which Laguna Honda should not be expected to treat as "accidents," for which it must create interventions that will eliminate these problems in the same way that Laguna Honda is required to address a true avoidable accident, such as falls or accidentally leaving prescription medications accessible to patients. Relapse on substances (which by nature requires the possession and use of a substance) is not an accident, but rather part of the expected disease course of substance use disorder/addiction. Recurrent substance use in situations in which it is physically hazardous is not an accident, but rather one of the 11 diagnostic criteria/symptoms of a substance use disorder.[7]

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

Even if it is assumed that this regulation applies to the incidents listed in this statement of deficiencies, Laguna Honda is in compliance with the federal participation requirements because Laguna Honda implemented policies and procedures to establish an environment that remains as free of accident hazards as is possible and each patient 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 patient to prevent avoidable accidents, not to ensure a safe environment free of all possible accidents for all patients. 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 patient'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 (attached as Exhibit A):

[7] Diagnostic and Statistics Manual of Mental Health Disorders, Fifth Edition.

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 24-25 Harm Reduction
i. LHHPP 25-12 Drug Diversion Reporting and Response
j. LHHPP 75-05 Illicit or Diverted Drugs and/or Paraphernalia Possession/Use Residents or Visitors
k. LHHPP 75-10 Appendix K: Enforcement of the Smoking Policy
l. LHHPP 75-12 Firearms, Dangerous Weapons and Contraband
m. LHHPP 76-02 Smoke and Tobacco Free Environment
n. MSPP D08-03 Access to LHH Psychiatry Services
o. MSPP D08-07 LHH Substance Treatment and Recovery Services
p. MSPP D08-09 Mental Health Services
q. MSPP D08-10 Behavioral Management Services by LHH Psychiatry

As discussed above, the only reason that CDPH had such detailed information about the 37 "sampled" patients 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. CDPH 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 patients and the fall of one other patient 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."[8]

Regarding the incidents that involved actual harm:

- As 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 CDPH 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.

- As 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 (or Medications for Opioid Use Disorder), in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

- As 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. CDPH 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.

- As 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. CDPH 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.

- As to Resident 2 who allegedly fell, there is no evidence that the resident actually fell. Accordingly, we believe that was a mistake in the statement of deficiencies. CDPH references 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

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

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.

- As 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. CDPH 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 patient'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 patient'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, CDPH attempts to find a nexus simply by 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 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. Furthermore, it is inconsistent with the purpose of the regulations.

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 the four incidents that involved behavior changes are included as actual harm, the majority of the findings in the listed deficiencies did not constitute actual harm. CDPH 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 CDPH did not allege that any of the incidents involved actual harm to the patients. CDPH stated that Laguna Honda failed to monitor and implement a care plan for 11 patients who were identified as safe or unsafe smokers, but her own discussion about her review of the patient care plans reveal that patients 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 CDPH did not 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, CDPH failed to establish a nexus between the incidents that involved actual harm to patients in connection with its findings under section "a" of the statement of deficiencies, and any of the other alleged deficiencies under sections "b-d" where CDPH 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. CDPH did not make any findings to establish that the incidents were connected in any way.

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

CDPH 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 patient 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 patient, it is believed that Resident 2 received drugs from food delivery packages, Resident 32 allegedly received alcohol from another patient, it is believed that Resident 18 traded marijuana with another patient, 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 Laguna Honda nor CDPH, 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, CDPH did not find that the alleged deficiencies resulted from a pattern of conduct by Laguna Honda staff 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 patients having access and stealing these items), CDPH 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, CDPH 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."

Therefore, 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 that 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 DHHS, Departmental Appeals Board reverse CDPH's findings and rescind the deficiencies issued under Statement of Deficiencies, Incident Nos. CA744774, CA745390, CA747134, CA746900, CA675386, and CA 747220; find that the facility has met the intent of the federal regulations; and find that these incidents do not amount to a pattern of deficiencies that constitute a substandard quality of care.

If more information is needed, please contact me at (415) 554-3817 or arnulfo.medina@sfcityatty.org.

Very truly yours,

DAVID CHIU
City Attorney

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