Exhibit 14

LHH Recertification KPI Dashboard - 11.12 to 11.18

Weekly Recertification Progress Update for Staff

Issue #14 - Week of November 12 - 18, 2022

Overview

The first step in preparing for CMS recertification was an extensive facility assessment. Now, we are tracking our progress, monitoring survey-readiness and quickly identifying gaps through the **CMS Recertification Key Performance Indicators (KPIs)**. The KPIs can help us celebrate and sustain successes, direct resources towards areas of non-compliance, and know when to submit our CMS recertification application.

Immediate Actions Needed to Support Compliance

See a light, make it right. Call lights are an important way for residents to initiate communication. Answering call lights and responding to resident requests in a timely manner improves resident satisfaction and safety.

Locate your unit safety data sheets (SDS). SDS provide information on the hazards of working with a chemical and procedures to ensure safety. It is important to know the location of the SDS in the event of an emergency.

Ensure linen carts are covered. Following proper protocols ensures that clean linen is kept clean until it reaches a resident's room. Proper linen handling prevents dirty linen from contaminating residents, staff, the environment, or other linen.

Check inside the lids of pharmaceutical waste bins. Pills continue to be found lodged in the lid compartments of the pharmaceutical waste bins on medication carts. It's vital these are removed to reduce the risk that a resident could access these pills.

Severe Findings

Severe findings can be the difference between passing and failing a survey. There were 7 severe findings last week. These include:

- Multiple instances of staff without proper PPE (eye protection & N95s in resident care areas)
- Medication cart not completely closed and accessible
- Soiled linen being handled without gloves
- Tube feeding in resident room with outdated label
- Resident room closed with isolation cart next to the room yet no sign on door indicating isolation precautions.
- Front doors to the locked unit not operating properly (not closing/locking) yet no staff assigned to monitor the door.

Accomplishments

Rowena Patel, Director of Nursing for the North Tower, has shown remarkable leadership, meeting each challenge head on. For the past two weeks, she covered both towers. She is ensuring all Plans of Correction (POCs) are followed, following-up on audits, rounding on units, and working with departments to make sure that changes are communicated. Rowena has been representing nursing at the Executive POC rounds and has demonstrated a great understanding of the work, data and action that needs to come from it. Thank you, Rowena, for being the type of leader we need for successful CMS recertification.

Team Success Story

This week, Laguna Honda's new survey command center held its first dry run to prepare staff for CMS surveys. This strategy included having mock surveyors at the unit level and staff available for support. This was a team effort that included the following departments: Quality Management, Nursing, Medicine, and Administration as well as the Infection Prevention and Control team. Thank you to everyone who participated in this effort to help make LHH survey ready!

Together We Can Recertify

Thank you for your continued engagement and dedication on behalf of the residents, families, and communities of Laguna Honda.

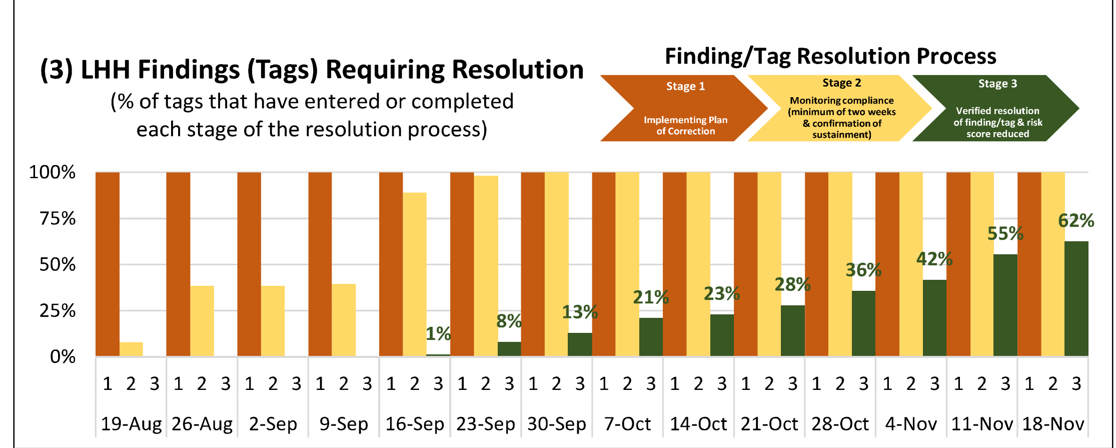
Laguna Honda Hospital: CMS Recertification Key Performance Indicators (KPIs)

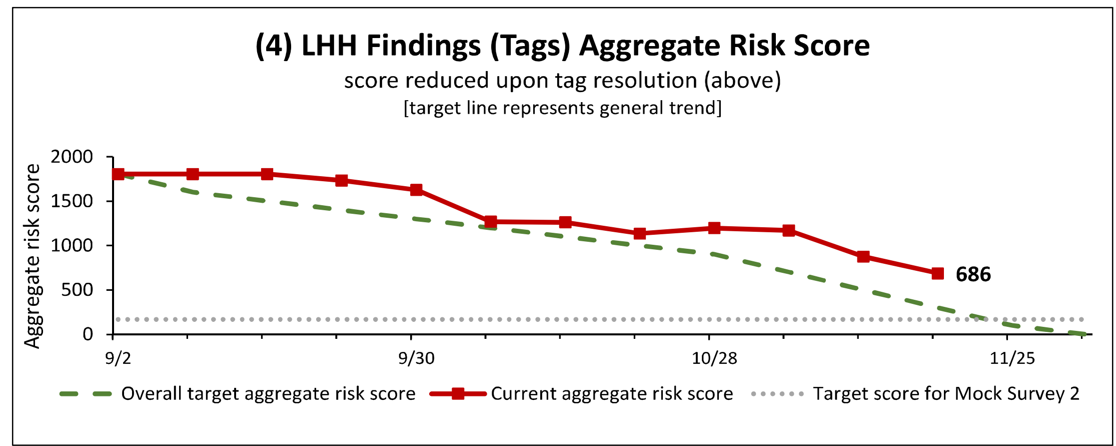
Weekly Data for Unit/Neighborhood Huddle Boards

Data as of Friday: 11/18/22

Due to the Thanksgiving holiday, there will not be an updated issue of the dashboard published on Monday, 11/28/22. The next issue of the dashboard will be published on Monday, 12/5/22.

(1) Unit Compliance for Survey	10/15 - 10/21 Target:				10/22 - 10/28 Target:				10/29 - 11/4 Target:				11/5 - 11/11 Target:				11/12 - 11/18 Target:			
	EOC	HH	IPC	*	EOC	HH	IPC	*	EOC	HH	IPC	*	EOC	HH	IPC	*	EOC	HH	IPC	*
North Mezz.	98%	100%	92%	1	97%	99%	92%	0	95%	100%	93%	0	99%	98%	89%	0	98%	99%	91%	1
North 1	98%	100%	92%	2	96%	100%	94%	1	95%	99%	90%	1	98%	100%	91%	2	99%	100%	91%	0
North 2	97%	100%	93%	0	97%	97%	94%	1	94%	97%	93%	2	99%	98%	90%	0	98%	98%	92%	0
North 3	98%	100%	94%	1	96%	100%	96%	2	96%	99%	95%	2	98%	100%	95%	0	97%	97%	96%	0
North 4	97%	99%	88%	1	96%	100%	93%	2	94%	100%	95%	1	99%	100%	95%	1	99%	97%	95%	0
North 5	98%	99%	96%	1	94%	100%	94%	1	96%	100%	96%	3	99%	100%	97%	0	98%	100%	98%	1
North 6	99%	100%	95%	0	99%	100%	97%	1	99%	97%	94%	0	98%	99%	96%	0	97%	99%	97%	0*
Pavilions Mezz.	98%	100%	92%	0	97%	99%	89%	4	99%	99%	86%	1	97%	100%	87%	1	97%	98%	89%	2
South 2	98%	100%	86%	0	96%	100%	88%	1	98%	98%	86%	2	98%	98%	90%	0	96%	99%	94%	1
South 3	98%	100%	94%	1	98%	100%	93%	2	99%	100%	91%	1	97%	100%	93%	1	99%	99%	96%	1
South 4	97%	100%	93%	1	98%	100%	95%	2	98%	100%	96%	1	95%	100%	91%	1	98%	99%	93%	0
South 5	98%	100%	94%	1	98%	100%	95%	0	98%	100%	96%	1	94%	100%	97%	2	99%	99%	96%	0
South 6	97%	100%	86%	0	97%	100%	95%	0	98%	98%	91%	1	97%	100%	90%	2	98%	99%	97%	0
Percent survey ready:	23% 3 of 13 units				23% 3 of 13 units				15% 2 of 13 units				38% 5 of 13 units				62% 8 of 13 units			





Laguna Honda Hospital: CMS Recertification Key Performance Indicators (KPIs)

Data as of Friday: 11/18/22

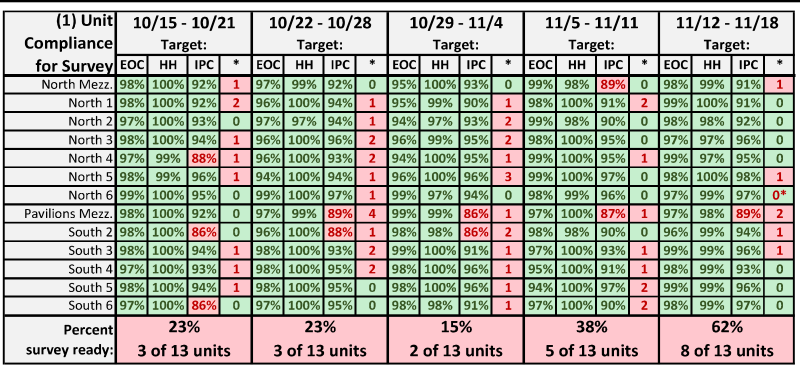
(1) LHH Unit Weekly Survey Readiness & Compliance Assessment

Systemwide improvements necessary for compliance:

- Glucometer cleaning dwell time protocols
- Linen carts left uncovered; proper management/storage
- Call light responsiveness
- PPE compliance (e.g., respirator but no eye protection)
- Staff not able to identify where SDS forms are available
- Pill crushers not being cleansed
- Sharps not disposed of completely in sharps containers
- Pills in lid compartments
- Foley catheter/privacy bag touching floor

Severe findings & weekly lessons learned:

Seven severe findings were identified through rounding this week. Examples of findings include PPE compliance and an unlocked medication cart. *Severe finding observed on N6 was the result of a centralized operations staff member that is not typically on the unit.



(1) Unit Compliance for Survey	10/15 - 10/21 Target:				10/22 - 10/28 Target:				10/29 - 11/4 Target:				11/5 - 11/11 Target:				11/12 - 11/18 Target:			
	EOC	HH	IPC	*	EOC	HH	IPC	*	EOC	HH	IPC	*	EOC	HH	IPC	*	EOC	HH	IPC	*
North Mezz.	98%	100%	92%	1	97%	99%	92%	0	95%	100%	93%	0	99%	98%	89%	0	98%	99%	91%	1
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North 5	98%	99%	96%	1	94%	100%	94%	1	96%	100%	96%	3	99%	100%	97%	0	98%	100%	98%	1
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South 5	98%	100%	94%	1	98%	100%	95%	0	98%	100%	96%	1	94%	100%	97%	2	99%	99%	96%	0
South 6	97%	100%	86%	0	97%	100%	95%	0	98%	98%	91%	1	97%	100%	90%	2	98%	99%	97%	0
Percent survey ready:	23% 3 of 13 units				23% 3 of 13 units				15% 2 of 13 units				38% 5 of 13 units				62% 8 of 13 units			

(2) Critical Element Pathway (CEP) Assessments

Weekly lessons learned and key takeaways:

As of 11/11, CEP assessments are paused to complete resolution of tags/findings by 12/2

(2) Critical Element Pathway Assessments

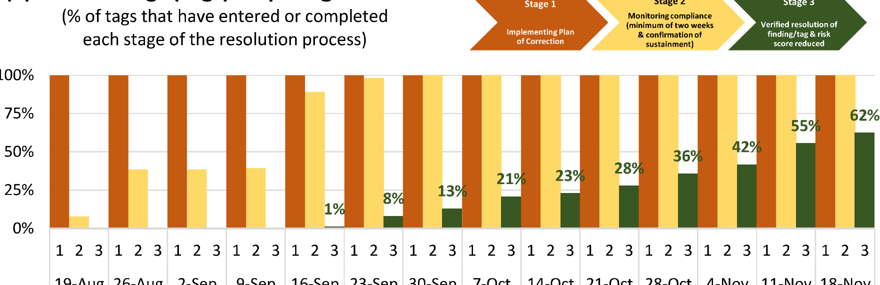
CEP Compliance % = (Total # of Compliant F-Tag Questions/Total # of Critical Element Questions)

# of CEPs Assessed: 15, 10, 5, 0
CEP Compliance % (vulnerabilities/opportunities): 100%, 75%, 50%, 25%, 0%
CEP compliance %: 93%, 91%, 91%, 92%, 92%, 91%
Weekly CEP Assessments: 10, 10, 10, 10, 10, 10
10/7, 11/4
Weekly CEP Assessments — Target CEP assessments (10) — CEP compliance % — Target CEP compliance (95%)

(3) LHH Findings (Tags) Requiring Resolution

Weekly lessons learned and key takeaways:

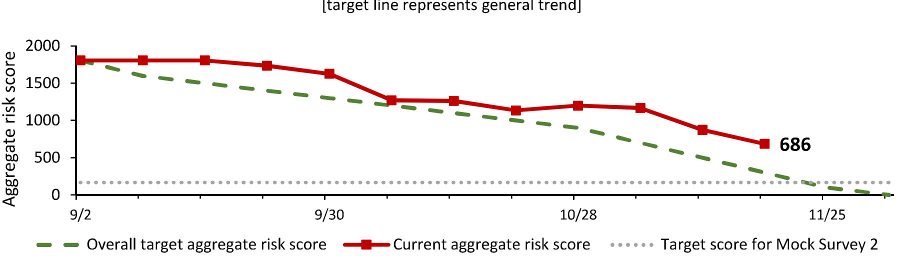
An additional 7 tags were verified as resolved by the expert regulatory compliance triad this week (11/18), making the overall total 63. This means that nearly two-thirds of the original 101 tags are resolved. Compliance will continue to be monitored for all tags via the LHH PIPS Committee.



(4) LHH Findings (Tags) Aggregate Risk Score

Weekly lessons learned and key takeaways:

The aggregate risk score was reduced an additional 188 points this week (11/18) to 686 from the original baseline of 1806 points. The aggregate risk score has now been reduced by 62% of its original value. The target remains for all tags to be resolved by the last week of November.



(5) Major Projects

Project	Target Date of Completion	Summary
Kitchen Floor Improvement – Mitigation Plan	Ongoing sustainability	Mitigation plan continues to be followed with just-in-time repairs and improvements.
Security Enhancements	On track	Security enhancements in place as of 11/16. Additional milestones to be determined pending CMS Phase 3 determinations.

Change Management/ Care Experience

Workstream	Major Milestones	Target Date of Completion
Staff Experience	Increase to 90% of all execs completing leadership rounds in assigned areas each week by 12/2	12/2/2022 (11/11: 58%; 11/18: 77%)
Resident Experience	Implement resident surveys	12/15/2022 (on track)
Resident Experience	Initiate Phase 1 of Call Light PIP	11/20/2022 (complete)

Laguna Honda Hospital: CMS Recertification Key Performance Indicators (KPIs)

Data as of Friday: 11/18/22

The **aggregate risk score** is calculated by summing the individual risk score of all 101 tags from the first Mock Survey. The risk score for an individual tag is determined based on the Scope and Severity of the finding and its corresponding letter grade (see right). The score itself is from CMS's points deficiencies used to determine Five Star ratings related to health inspection. These scores are being adapted to provide an overall picture of progress toward Recertification and to prioritize corrective actions. When a finding/tag is verified as resolved the aggregate risk score will decrease by the number of points associated with that Scope/Severity letter grade. If a previously resolved finding is found to be non-compliant in subsequent reassessments, the risk score will rise again based on the new scope of the non-compliant findings. The target score for Mock Survey 2 provides a rough estimate of the goal to achieve to advance to the next mock survey. The score assumes there are no remaining individual tags of "F" scope/severity or greater.

Table 1
Health Inspection Score: Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	**Pattern**	**Widespread**
Immediate jeopardy to resident health or safety	J 50 points	K 100 points	L 150 points
Actual harm that is not immediate jeopardy	G 20 points	H 35 points	I 45 points
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D 4 points	E 8 points	F 16 points
No actual harm with potential for minimal harm	A 0 point	B 0 points	C 0 points

Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care. See the Electronic Code of Federal Regulations (https://www.ecfr.gov/cgi-bin/text-idx?SID=9c4d022241818fef427dc79565aba4b5&mc=true&node=pt42.5.488&rgn=div5#se42.5.488_1301) for a definition of substandard quality of care.

*Adapted from source file from Centers for Medicare & Medicaid Services

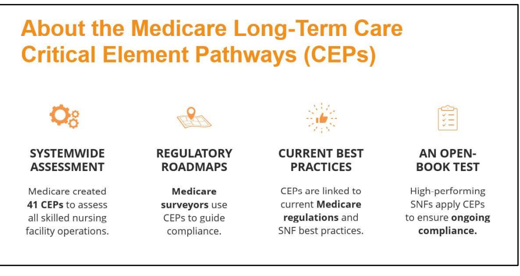
Source: Centers for Medicare & Medicaid Services

Unit Compliance Determination Methodology: All LHH units are observed using a tool based on the Association for Professionals in Infection Control and Epidemiology (APIC) environmental rounding worksheet. Unit compliance is a Yes/No determination based on quantitative and qualitative findings. A unit is non-compliant if it is below a 90% threshold (quantitative metric = compliant observations/total observations). A non-compliant observation is based on direct observation of staff and/or something in the environment of care. A unit is survey ready if it is above the 90% quantitative threshold across three key areas (below) and a qualitative review of the findings reveals no major issues that could place the unit at regulatory risk (denoted as * for severe finding in the dashboard). A severe finding (*) is defined as any individual finding that could jeopardize recertification independent of the rate of compliance in environment of care (EOC), hand hygiene (HH), and infection prevention and control (IPC). Severe findings can also be cited for failure to correct a previous significant finding over multiple weeks, as it would also be done in a real survey. All LHH units are observed during multiple rounds 24/7 across all shifts, with different teams focused on Hand Hygiene (HH), Infection Prevention and Control (IPC), or Environment of Care (EOC), as well as for severe non-regulatory compliance (*). Underlined compliance rates indicate a significant week-to-week increase in compliance defined as an increase of 10 or more absolute percentage points. The target unit compliance rate is 90% to reflect the Infection Prevention (IP) policy of Laguna Honda Hospital, which is based on the latest best practice research and input from Health Services Advisory Group. System-level severe findings are called out separately from unit-specific severe findings. The severe finding count for each unit in the dashboard will now reflect only the isolated/unique severe findings on that unit.

The **Critical Element Pathways (CEPs)** represent the purposeful rounding that is intended to increase regulatory competencies while proactively uncovering regulatory non-compliance [F-tag vulnerabilities]. **Critical Element Questions** are the final assessment questions located at the end of each Critical Element Pathway (CEP). These questions are attached to specific F-tags. Each week, CEPs are assessed to determine F-Tag vulnerabilities using these questions. Weekly CEP compliance is defined as the total number of compliant F-Tag questions divided by the total number of CEP questions.

Number of CEP assessments completed last week: this represents how many CEPs were assessed on the week they were assigned. This metric shows the level of weekly effort to apply CEPs and proactively identify F-tag vulnerabilities. During one assessment, teams observe up to six units, review up to six charts, and perform up to six staff/resident interviews using the CEP as guidance.
Critical Element Pathways (CEPs) are the guidelines Medicare surveyors use to assess deficiencies and assign F-Tag citations. High-performing nursing homes regularly assess their practices against CEPs to monitor ongoing regulatory compliance. CEPs are not implemented and assessed just once; they are continuously assessed to create an environment of ongoing survey readiness and improved regulatory knowledge.

CEPs are the exact same guidelines that surveyors use to determine whether or not there is regulatory non-compliance and what type of tag to issue in the instance that there is. By building CEPs into daily routines, LHH is able to prepare for surveys as an "open book test." At LHH, CEPs are continuously assessed monthly, which is the best practice of high performing institutions.



Laguna Honda Hospital: CMS Recertification Key Performance Indicators (KPIs)

Data as of Friday: 11/18/22

The first LHH Mock Survey resulted in 101 regulatory **non-compliant findings (tags)** in total across two phases. These non-compliant findings (tags) require the implementation of corrective actions via a plan of correction (POC) & subsequent verification of resolution by an appropriate LHH CEP (regulatory compliance) triad, each member of which must sign off on resolution of the tag. *This resolution must be sustained during additional reassessments and compliance rounding or the finding/tag will be reevaluated as active and require additional resolution. *NOTE: graphic does not include A scope/severity tags.

Legend

~~Strikethrough text~~	Tag has been verified as resolved
Red text	Substandard care
Highlighted text	In a regulatory group cited in the decertification letter
Bold italicized text	Cited in a previous CDPH survey 2019-2022
A-Tags	Acute Care
E-Tags	Emergency Management
K-Tags	Life and Safety
F-Tags	Skilled Nursing Facility

Scope and Severity of Tags

Severity	Scope		
	ISOLATED	PATTERN	WIDESPREAD
(4) Immediate jeopardy to resident health, safety, or welfare	**J** ~~F755 Pharmacy Svcs/Procedures/ Pharmacist/Records~~	**K** ~~***F610 Investigate/Prevent/Correct Alleged Violation***~~ ~~F812 Food Procurement, Store/Prepare/Serve-Sanitary~~ ~~K921 Essential Equipment, Safe Operating Condition~~	**L** ~~A0750 Infection Control~~ ~~F689 Free of Accident Hazards/Supervision/Devices~~ ***F761 Label/Store Drugs & Biologicals*** ***F880 Infection Prevention and Control***
(3) Actual harm that is not immediate jeopardy	**G** F584 Safe/Clean/Comfortable/Homelike Environment F603 Free from Involuntary Seclusion ~~F760 Residents Are Free of Significant Med Errors~~	**H** ***F600 Free from Abuse and Neglect*** ***F697 Pain Management*** F836 License/Comply with Fed/State/Local Law/Prof Std ~~F837 Governing Body~~ ~~F886 COVID-19 Testing~~ ~~F923 Physical Environment – Ventilation~~ ~~K343 Fire Alarm – Notification~~ ~~K353 Sprinkler System – Maintenance and Testing~~ ~~K918 Electrical Systems – Essential Electrical System Maintenance and Testing~~ ~~K923 Gas Equipment – Cylinder and Container Storage~~	**I** F677 ADL Care Provided for Dependent Residents ~~K321 Hazardous Areas – Enclosure~~
(2) No actual harm with potential for more than minimal harm that is not immediate jeopardy	**D** ~~E0037 Emergency Preparedness – Training Program~~ F687 Quality of Care ~~***F688 Increase/Prevent Decrease in ROM/Mobility***~~ ~~F692 Nutrition/Hydration Status Maintenance~~ ~~***F758 Free from Unnecessary Psychotropic Meds/PRN Use***~~ ~~F809 Frequency of Meals/Snacks at Bedtime~~ F921 Safe/Functional/Sanitary/Comfortable Environment ~~K341 Fire Alarm System – Installation~~ ~~K521 HVAC~~ K711 Evacuation and Relocation Plan	**E** A0022 Administration – Hospital Licensed or Approved ~~A0023 Administration – Staff Qualifications~~ ~~F550 Resident Rights/Exercise of Rights~~ F554 Self-Administration of Drugs F645 PASARR Screening for MD & ID F684 Quality of Care ~~F740 Behavioral Health Services~~ F742 Treatment/Svc for Mental/Psychosocial Concerns ***F759 Free of Medication Error Rate of 5% or More*** ~~F804 Nutritive Value/Appear, Palatable/Prefer Temp~~ ~~F839 Staff Qualifications~~ ~~F881 Antibiotic Stewardship Program~~ ~~K293 Exit Signage~~ ~~K345 Fire Alarm System – Testing and Maintenance~~ ~~K351 Sprinkler System – Installation~~ ~~K355 Portable Fire Extinguishers~~ ~~K372 Subdivision of Building Spaces – Smoke Barrier Construction~~	**F** ***F552 Right to be Informed/Make Treatment Decisions*** F553 Right to Participate in Planning Care F557 Respect, Dignity/Right to have Personal Property ~~F585 Grievances~~ F604 Right to be Free From Chemical Restraints ***F641 Accuracy of Assessments*** ***F656 Develop/Implement Comprehensive Care Plan*** ~~F679 Activities Meet Interests/Needs of Each Resident~~ F725 Sufficient Nursing Staffing ~~F838 Facility Assessment~~ ~~F865 QAPI Program/Plan, Disclosure/Good Faith Attempt~~ ~~F867 QAPI/QAA Improvement Activities~~ F908 Essential Equipment, Safe Operating Condition ~~F925 Maintains Effective Pest Control Program~~ ~~K223 Doors with Self-Closing Devices~~ ~~K232 Aisle, Corridor or Ramp Width~~ K761 Maintenance, Inspection & Testing of Doors ~~K920 Electrical Equipment – Power Cords and Extension Cords~~
(1) No actual harm with potential for no more than minimal harm	**A**	**B** A0538 Radiology – Testing for Exposure A0546 Radiology – Personnel F776 Radiology/Other Diagnostic Services ~~F803 Menus Meet Resident Needs~~ K324 Cooking Facilities K712 Fire Drills	**C** ~~F567 Protection/Management of Personal Funds~~ F568 Accounting and Records of Personal Funds ~~F582 Medicaid/Medicare Coverage/Liability Notice~~ K225 Stairways and Smokeproof Enclosures

Laguna Honda Hospital: CMS Recertification Key Performance Indicators (KPIs)

Data as of Friday: 11/18/22

Mock Survey 1 Tags by Scope and Severity: 101 Total Tags

The first LHH Mock Survey included two phases and resulted in 101 total tags. In response to the findings, the facility drafted a plan of correction which resulted in 371 total corrective actions to ensure all findings are adequately addressed. The LHH Quality Management (QM) team collected proof of implementation for each corrective action and asked teams to develop plans to monitor compliance sustainability over a two week period. At the end of the two week period, teams submit their sustainability data to QM who then determine whether the data is sufficient to initiate a triad of regulatory consultant experts to comprehensively verify that the findings/issues are truly resolved. At any time during this process, if the data or triad review indicates that regulatory compliance has not been sufficiently met and/or sustained, teams are required to develop additional countermeasures, confirm their effectiveness, and again monitor for sustainability for two weeks as part of the Plan, Do, Check, and Act (PDCA) process.

The scope and severity grid breaks down the findings based on the severity. The initial focus is on the Level 4 (J, K, L) severity findings as these are an indication of an immediate jeopardy. The breakdown provided indicates the percent and number of tags Resolved and Monitoring Compliance. Resolved indicates that proof of sustained compliance has been provided to QM and a comprehensive review by a triad of regulatory consultant experts has determined that the findings/issues are verified as resolved. Monitoring Compliance indicates that the tag is still under review and/or in an additional PDCA cycle.

Phase 1 & 2 Total Findings/Tags	Resolved	Monitoring Compliance
101	63	38
Percent:	62.4%	37.6%

Mock Survey 1 Phase 1 and 2 Tags by Scope and Severity
101 Total Tags

J	K	L
1 Total Tags 1 Resolved (100%)	3 Total Tags 3 Resolved (100%)	4 Total Tags 2 Resolved (50%) 2 Monitoring Compliance (50%)
G	**H**	**I**
3 Total Tags 1 Resolved (33.3%) 2 Monitoring Compliance (66.7%)	10 Total Tags 7 Resolved (70%) 3 Monitoring Compliance (30%)	2 Total Tags 1 Resolved (50%) 1 Monitoring Compliance (50%)
D	**E**	**F**
10 Total Tags 7 Resolved (70%) 3 Monitoring Compliance (30%)	16 Total Tags 11 Resolved (68.8%) 5 Monitoring Compliance (31.3%)	18 Total Tags 9 Resolved (50%) 9 Monitoring Compliance (50%)
A	**B**	**C**
23 Total Tags 14 Resolved (60.9%) 9 Monitoring Compliance (39.1%)	6 Total Tags 5 Resolved (83.3%) 1 Monitoring Compliance (16.7%)	5 Total Tags 2 Resolved (40%) 3 Monitoring Compliance (60%)