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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

TOMMY O. JOHNSON, by and through his Attorney-in-Fact REV. DORIS WHITE and JOHN DOE on behalf of themselves and all others similarly situated, Plaintiffs, v. CITY AND COUNTY OF SAN FRANCISCO, Defendant. AND CONSOLIDATED CASE.	Case No. CPF-20-517064 CLASS ACTION **DECLARATION OF CHRISTOPHER CHERNEY IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION** Date: May 24, 2024 Time: 9:30 am Dept.: 613 Judge: **Assigned for All Purposes to Hon. Andrew Y.S. Cheng, Dept. 613** Action Filed: March 24, 2020 Trial Date: Unassigned

DECLARATION OF CHRISTOPHER CHERNEY

1. I, Christopher Cherney, declare as follows:

2. I am familiar with the matters stated in this declaration. Unless otherwise stated, the matters contained herein are based upon my personal knowledge, which is derived from my review of the materials identified within this declaration and my education, experience, and training discussed below. If called and sworn as a witness, I can and will testify competently thereto.

3. This declaration describes my opinions and conclusions to date based on the documents and information presently available in connection with the above-referenced lawsuit asserted against the City and County of San Francisco and Laguna Honda Hospital (LHH) and in the public domain.

4. My understanding is that Plaintiffs are asserting claims with respect to the general and systemic violation of patients' rights allowed to occur at LHH since at least 2019. I offer the instant declaration in support of Plaintiffs' Motion for Class Certification to address how LHH's systemwide violations of statutorily protected patients' rights reflected an overall failure of governance at the hospital that prevented its Governing Body and executives from implementing policies and procedures designed to prevent those same patients' rights violations, in violation of federal and state regulations.

I. QUALIFICATIONS

5. **Education:** In 1988, I received my Bachelor of Arts in Biochemical Sciences from Harvard University. I received my Masters in Gerontology, with an emphasis on the social policy of aging, from San Francisco State University in 2012.

6. **Nursing Home Experience:** I have been a California-licensed nursing home administrator for 27 years, since 1997. My license never has been encumbered. As an administration professional I have worked for seven health care organizations and I have been the licensed administrator of skilled nursing facilities with 59, 70, 74, 99, 122, and 180 beds. My experience includes working for two non-profit

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organizations (Kaiser, ElderCare Alliance) and five for-profit nursing home chains (Employee Equity Administration, Mariner Post-Acute Network, Independent Quality Care, Kindred Healthcare, Cambridge Healthcare).

Table 1. Christopher Cherney Employers 1996 - 2019

Cherney Employer	Dates	Multi-facility chain?	Number of facilities
Employee Equity Administration	Dec 1996 - Apr 1999	Yes	10 skilled nursing facilities
Mariner Post-Acute Network	May 1999 - Jul 1999	Yes	~200 skilled nursing facilities
Independent Quality Care	Aug 1999 - Sep 2000	Yes	10 skilled nursing facilities
Kaiser Foundation Hospitals, Inc.	Feb 2001 - Jul 2015	Yes	21 hospitals 1 skilled nursing facility 1 acute rehab facility
Kindred Healthcare	Aug 2015 - Aug 2017	Yes	97 skilled nursing facilities
Cambridge Healthcare	Oct 2018 - Dec 2018	Yes	~15 skilled nursing facilities
Elder Care Alliance	Jul 2019 - Sep 2019	Yes	4 assisted living facilities 1 skilled nursing facility

7. I was the first employee of Kaiser Permanente Post-Acute Care Center (KPPACC), Kaiser's first-ever, and only-ever freestanding skilled nursing facility. I served on all 12 committees convened to coordinate the facility's opening. I remained at KPPACC for 14 years. KPPACC admitted patients from 21 Kaiser-operated acute care hospitals in Northern California. In my 14 years, the facility admitted more than 30,000 residents.

8. **Consulting Experience:** Since 2017, I have provided administration consulting services to several clients regarding regulatory issues, operations, and compliance. A current client includes a consortium of California District Attorneys, for whom I have served as a subject matter expert since September 2017 regarding nursing home administration. I also provide advice and consultation on operational, regulatory, and clinical risk mitigation to a for-profit chain of approximately 40 skilled nursing facilities. Since 2023, this client has granted me access to clinical records, policies and procedures, line staff, facility leaders, and regional leaders.

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9. **Testifying Expert Witness:** Since September 1, 2017, as a testifying expert witness regarding health care administration, I have reviewed more than 300 cases in 22 states.

10. **CMS Expert:** Effective July 2023, I became a contracted expert for the Centers for Medicare and Medicaid Services (CMS).

11. **Court Appointed Facility Monitor:** Effective May 2020, I have been a Court Appointed Monitor of a 144-bed skilled nursing facility in Santa Cruz County, California, under a court injunction. I have court-ordered access to the facility's electronic medical record. Between December 2020 and August 2022, I was the Court Appointed Performance Monitor of a 99-bed skilled nursing facility in Los Angeles, California under a Final Judgment. Effective March 2022, I have been the Court Appointed Quality Compliance Specialist of a 120-bed skilled nursing facility in Bakersfield, California under a Final Judgement. I have court-ordered access to the facility's electronic medical record.

12. **Stipulated Monitor:** Between October 2022 and April 2023, as part of a confidential settlement agreement in a civil action, I served as the stipulated Monitor of a small chain of skilled nursing facilities.

13. **Contracts with the California Department of Justice:** I have contracted with the California Department of Justice as a health care administration expert as follows:

a. January 2021: I became a contracted member of Operation Guardian, which inspects California skilled nursing facilities.

b. February 2021: I was contracted to assist with a criminal investigation of a long-term care facility's response to the COVID-19 pandemic.

c. December 2021: I was contracted to inspect records and evaluate the clinical quality of care in seven California skilled nursing facilities.

d. December 2021: I was contracted by the Healthcare Rights and

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Access Section to conduct a fitness review of an entity planning to purchase a non-profit continuing care retirement community for $20 million.

e. May 2021: I was contracted by the Healthcare Rights and Access Section to conduct another fitness review of an entity planning to purchase two non-profit continuing care retirement communities for $30 million.

14. **Contracts with Other State Attorneys General:** Effective March 2022, I was contracted with a confidential State Attorney General as a subject matter expert on skilled nursing facility staffing and operations. Effective August 2022, I was contracted with the Massachusetts Attorney General and the New York Attorney General as a subject matter expert in long term care administration.

15. **Contracts with California District Attorneys:** I am contracted with Alameda County as a subject matter expert on skilled nursing facility administration. I have analyzed civil and criminal cases. For several years, I have been contracted with Kern County and Santa Cruz County as a subject matter expert who advises on issues related to long term care administration and service quality.

16. A copy of my Curriculum Vitae, setting forth my education and professional experience and which, at least partially, comprises my qualifications to express the opinions set forth in this declaration, is attached hereto as Appendix A. In addition, Appendix B expands on my qualifications as an expert regarding skilled nursing facility standards. I am familiar with federal and State of California statutes and regulations regarding skilled nursing facilities.

17. This declaration is based on my review of documents, deposition testimony, public media reports, state and federal statutes and regulations governing skilled nursing facility operation, as well as my experience as a licensed nursing home administrator, knowledge, background, and training. Appendix C consists of a listing of documents received prior to preparation of this declaration, in addition to

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documents and information separately mentioned in the body of this declaration.

II. Overview: The Basis for Findings and Opinions

18. In addition to my education and professional experience, the findings and opinions expressed herein are based upon the following categories of records:

a. Laguna Honda Hospital (LHH) policy and procedure documents;

b. LHH deposition testimony;

c. Documents produced by LHH in discovery, including Root Cause Analysis and Monitoring reports prepared by the Quality Improvement Expert (QIE) appointed in connection with the 2022 settlement between the City and County of San Francisco and the Centers for Medicare & Medicaid Services (CMS);

d. Publicly available databases regarding nursing home deficiencies, including those issued to LHH;

e. Public media reports.

III. LHH Is Required to Develop and Implement Policies and Procedures for the Protection of Resident Rights, Their Confidential Information, and to Prevent Patient Abuse and Neglect

19. Pursuant to 42 C.F.R. 438.12(b) and 22 CCR § 72527(a), LHH is required to "develop and implement" written policies and procedures protecting statutorily prescribed resident rights, confidential resident information, and to prevent patient abuse and neglect at LHH.

20. As stated in 42 C.F.R. 438.12, to protect all residents from "abuse, neglect, misappropriation of resident property, and exploitation … [t]he facility must develop and implement written policies and procedures that" meet specific requirements.

21. Protecting a panoply of patients' rights, including the rights to be free from mental and physical abuse, to be assured confidential treatment of financial and health records, to be treated with consideration and respect, to be free from the use of

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psychotherapeutic drugs and physical restraints for non-medical purposes, 22 CCR 72527(a) similarly requires "[t]he facility," to "establish and implement written policies and procedures" to "ensure that these rights are not violated."

22. LHH Policy 22-03 is titled "Resident Rights." CCSF-TJOHNSON_034538.[1] The various rights set forth in Appendix A to Policy 22-03 apply to all LHH residents and include, *inter alia*, the right to "receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment." CCSF-TJOHNSON_034543.

23. LHH Policy 22-01 is titled "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response." CCSF-JOHNDOE1_023583.[2] Pursuant to the policy, "LHH employees and volunteers shall provide a safe environment and protect residents from abuse, neglect, misappropriation of property, exploitation, and use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's condition." LHH is required to train all employees and volunteers on abuse prevention and timely reporting; all LHH employees are required to immediately respond to and report suspected instances of abuse pursuant to a detailed reporting and investigation protocol. CCSF-JOHNDOE1_023591-95. LHH Department Managers are responsible for monitoring staff compliance with the policy, with process oversight from LHH Quality Management (QM) and Human Resources (HR). CCSF-TJOHNSON_023583.

24. LHH Policy 21-04 is titled "HIPAA Compliance." CCSF-JOHNDOE1_023494.[3] Policy 21-04 purports to "implement procedures that comply with the San Francisco Department of Public Health's (DPH) 'HIPAA Compliance:

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[1] Attached to the Declaration of Brian S. Umpierre in Support of Plaintiffs' Motion for Class Certification ("Umpierre Decl."), filed contemporaneously herewith, as Exhibit U (Depo Ex. 8).

[2] *See* Umpierre Decl., Ex. X (Depo Ex. 11).

[3] *See* Umpierre Decl., Ex. AA (Depo Ex. 13).

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Privacy Policy,'" which in turn adopts the Privacy Rules set forth in HIPAA itself and related federal and state confidentiality laws. *Id.* In general, Policy 21-04 prohibits LHH employees from disclosing a resident's protected health information (PHI) without first the resident's authorization, unless such disclosure is made for treatment, payment, or health care operations or other limited public interest exceptions. *Id.*

IV. Summary of Opinions

25. Expert Opinion 1: The hundreds of substantiated regulatory violations committed by LHH between 2019 and 2023 reflect a colossal failure of governance and management by the LHH Governing Body and LHH managers.

a. The root cause analyses conducted by the QIE shows that LHH's regulatory noncompliance and decertification resulted from systemwide failures due to an absence of leadership and oversight – in other words a failure of governance.

26. Expert Opinion 2: The failure of governance at LHH from 2019 through at least the time of its MediCal recertification in August 2023 prevented LHH from complying with its statutory obligation to implement nursing home policies and procedures, including LHH policies for the protection of resident rights and their confidential information, and to prevent resident abuse and neglect.

a. The regulatory deficiencies issued to LHH after public disclosure of the patient abuse scandal in 2019 were rare in their scope and severity for a U.S. nursing home and led to its decertification. A primary governance failure was LHH's reliance for almost two decades on hospital professionals, not nursing home professionals, to lead LHH. Despite a 2019 commitment to hire a permanent CEO, the LHH's Governing Body did not hire a qualified Executive Administrator until June 2023. This critical failure facilitated LHH's consistent pattern of regulatory non-compliance for at least the last

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four years.

27. **Expert Opinion 3:** The governance and management failures at LHH were not pre-ordained. The LHH Governing Body and executive leaders had the capacity to govern and manage competently, but with respect to protecting residents' rights they did not.

a. When LHH successfully managed its COVID response between March – July 2020, it managed that crisis from the top: London Breed, Mayor of San Francisco, and Grant Colfax, Public Health Director, immediately requested State and Federal help for LHH, and soon got it. On the other hand, even four years after LHH became aware of an abuse scandal under its own roof, LHH's Governing Body and executives failed to marshal the same focus, the same competence, and the same reliance on subject matter experts (including experienced nursing home administrators) in responding to a crisis of a different sort.

28. **Expert Opinion 4:** If LHH does not continue to engage skilled nursing facility subject matter experts (SMEs), LHH will slip back into its yearslong pattern and practice of non-compliance with regulatory and professional standards.

a. In keeping with a yearslong pattern of noncompliance with regulatory requirements, LHH leaders failed to decisively address its governance and management failures until as late as Spring 2023 (shortly before a mandated Action Plan deadline of May 13, 2023) and only with strict scrutiny by subject matter experts (SMEs) who were mandated by the federal government. Even after struggling to meet the Action Plan deadline, LHH continued to fail to comply with its policies and procedures and regulatory requirements.

V. The Unique Gravity of the Failure of Governance at LHH

29. I have been a licensed nursing home administrator for 27 years. As a

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testifying expert witness I have reviewed approximately 350 nursing home cases in 22 states. In my long experience as a licensed nursing home administrator, Court Appointed Monitor, and testifying expert witness, the failure of governance at LHH was unprecedented.

30. For example, for 18 years LHH never hired a licensed nursing home administrator as its Executive Administrator despite outside experts advising LHH that it lacked governance and management expertise in nursing home operations and regulations. It was not until June 26, 2023, that LHH hired a licensed nursing home administrator as its Executive Director, only after being decertified from Medicare in April 2022 (a rare occurrence, especially for a large facility like LHH). By not hiring a licensed nursing home administrator as its Executive Administrator until the 11th hour, the LHH Governing Body communicated to San Francisco taxpayers and State and Federal regulators that LHH knew better and would run its nursing home as it saw fit. But LHH didn't know better, and couldn't run its nursing home according to the rules.

31. Year after year after year, despite the drugging of 15 residents (2017-2018), despite a sex abuse scandal involving 23 residents (2019), despite rare decertification from Medicare and Medicaid, despite access to resources unimaginable to almost any other U.S. skilled nursing facility, and despite pledge after pledge after pledge that LHH would fix its problems and would comply with applicable nursing home regulations, LHH could not and did not fix its problems. LHH's inability to get its governance and management act together for four years sent a strong and clear message to the community: LHH will continue to operate without accountability to residents, regulators, or the taxpayers of San Francisco. This message and LHH's actions were the height of arrogance.

32. LHH's governance failures and corresponding lack of accountability enabled its practice of admitting residents with complex behaviors and substance abuse disorders (SUDs) whose needs LHH absolutely could not meet. In December

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2022, years after LHH had been admitting residents with complex behavioral needs and SUD, an outside expert concluded that LHH was totally incapable of caring for those residents. By admitting residents whose needs it absolutely could not meet, LHH sent these uncaring and ruthless messages: (i) We will admit whomever we want; (ii) Residents with complex behaviors and substance use disorders aren't worthy of compliant care. Again, LHH's actions epitomized the callousness of arrogance.

33. A brief chronology of the governance failures at LHH are contained in the following Table 2.

Table 2. Brief Chronology.

Date	Event(s)
Nov 2017 – Jan 2019	LHH leaders became aware of at least 15 instances of LHH residents testing positive for drugs for which there were no physician orders. No LHH employee was disciplined related to the druggings.
Feb 2019	LHH became aware that videos and pictures of about two dozen naked residents had been taken and exchanged among LHH staff members. LHH initiated an investigation.
Jun 28, 2019	Related to CCSF/LHH's investigation of the February 2019 videos and other facts, the Mayor of San Francisco and Public Health Director announced a reform plan for abuse and neglect of, and privacy violations related to, 23 LHH residents. The plan included the "critical component" of "ensuring compliance" with all regulations.
Jul 2019	Related to 6 LHH employees drugging and abusing 23 residents, government inspectors issued four deficiencies related to immediate jeopardy to resident healthy/safety, and two deficiencies for actual harm to residents.
Aug 9, 2019	The date by which LHH committed that it had implemented a plan of correction related to the July 2019 deficiencies.
Sep 6, 2019	Despite the Mayor's pledge of 06/28/19 and the 08/09/19 written plan to ensure compliance, LHH failed its recertification survey, related to the deficiencies issued in July 2019.
Jul 2021	LHH reported to regulators the non-fatal drug overdoses of two LHH residents on methamphetamine and fentanyl.
Oct 2021 – Apr 2022	Government inspectors issued 26 additional regulatory deficiencies to LHH across 11 surveys. One deficiency was for immediate jeopardy to resident health/safety, and five deficiencies were for actual harm to residents. Thirteen of 37 sampled residents tested positive for illicit drugs, and 23 residents had contraband. Margaret Rykowski testified that LHH was issued these deficiencies despite LHH's Sep 2019 promise to ensure compliance with all State and Federal regulations (Rykowski deposition transcript, 175:11-19[4]).
Apr 14, 2022	CMS notified LHH that it would be decertified from the Medicare and Medicaid programs for continuing noncompliance with regulatory requirements and directed the facility to plan for discharging residents.
Jun & Jul	LHH conducted two mock surveys, which documented 101 deficiencies including 7

[4] *See* Umpierre Decl., Ex. LL.

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2022	immediate jeopardy deficiencies. The LHH Executive Director concluded that LHH would not have passed a Medicare recertification survey in Jun or Jul.
Jul 28, 2022	Resident relocations were paused due to deaths of some transferred residents.
Aug 3, 2022	The City and County of San Francisco sued the Federal government regarding its effort to decertify LHH from Medicare.
Oct 12, 2022	CCSF and the Federal government reached a legal settlement that provided for LHH to be reimbursed through November 13, 2023.
Nov 2022	CCSF entered into a Settlement and Systems Improvement Agreement with the Federal and State governments for the purpose of improving care for residents and enabling LHH to attain compliance with regulatory requirements.
12/01/22	A Federally mandated Quality Improvement Expert (QIE) published the first "Root Cause Analysis Findings and Recommendations." The RCA set forth 8 problems and 47 root causes.
Dec 20, 2022	CDPH issued LHH 12 "B" citations (at $3,000 each) related to the deaths of 12 discharged residents (of 57 total discharged residents).
Jan 2023	CMS approved LHH's 41-page Action Plan.
Jun 2023	CCSF agreed to settle a lawsuit for $2.2 million, related to abuse of 11 LHH residents.
Aug 2023	LHH was recertified to participate in the Medicaid program.

34. As detailed in Table 2, the failure of governance at LHH from at least 2019 prevented LHH from complying with its statutory obligation to implement policies and procedures for the protection of resident rights, their confidential information, and to prevent patient abuse and neglect. More specifically:

a. In 2018 and 2019, about 40 LHH residents were over drugged and/or sexually abused.

b. In June 2019, CCSF held a press conference to divulge to the public for the first time the over drugging and sexual abuse.[5]

c. On September 3, 2019, CCSF issued a Reform Plan for LHH's full compliance with skilled nursing facility regulations.

d. For the next four years, the Reform Plan was a near total failure and LHH continued to abuse, neglect, and harm residents. During that span:

[5] In a further example of the lack of accountability at LHH following from the failure of governance, LHH allowed then-Executive Director Mivic Hirose to resign from that position but remain an employee of CCSF as a Clinical Nurse Specialist. https://www.sfexaminer.com/archives/ex-hospital-ceo-still-employed-by-sf-after-patient-abuse-scandal/article_1a411ead-ff30-5824-b14e-e1c0a8eb607c.html

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- LHH was repeatedly cited by regulators for serious breaches of regulations.
- LHH eventually was decertified for participation in the Medicare and Medicaid programs.
- LHH incurred approximately $30.6 million in costs related to its governance and management failures (so far, and not including consulting or legal fees, or future legal settlements).

e. The Reform Plan failed because LHH failed to address its colossal failures of governance and management.

f. LHH's failures in governance and management were not inevitable, as reflected in its relatively successful effort to limit the spread of COVID-19 at the hospital between March – July 2020.

g. CCSF-LHH could not fix itself. It needed prodding from the federal government to put its house in order. The federal government mandated a compliance Action Plan monitored by Quality Improvement Experts (QIEs). Because LHH's systems of governance and management were broken so badly for so long, LHH struggled to complete the Action Plan. Without the scrutiny and guidance of LHH's performance by nursing home experts, (1) LHH would not have been recertified by MediCal, and (2) LHH will in the future slide back into regulatory non-compliance.

35. After decertification in July and August of 2022, LHH caused to be conducted two mock surveys. The mock surveys demonstrated LHH would not have passed a Medicare recertification survey at that time after finding 101 deficiencies spanning nearly all disciplines. Seven items were identified as "immediate jeopardy" findings. LHH concluded, "LHH would not pass a CMS certification survey if it was

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conducted today." Deposition Ex. 23, p. 2.[6] Despite LHH's claim after the mock surveys that "Laguna Honda is doing the hard work of making system level changes to address the deficiencies noted by our regulators and in our own assessments" (*see id.*), only five months later a December 1, 2022, Root Cause Analysis documented numerous repeat findings. *See* Appendix D, Table 13 (June-July 2022 Mock Survey Findings Compared to December 1, 2022 Root Cause Analysis Findings, Specific to Mock Survey Findings).

36. Published four years after the Department of Public Health (DPH) released a "60-day Laguna Honda Reform Plan" that included the "critical component" of "ensuring compliance" with all regulations (CCSF-TJOHNSON_035362),[7] the December 2022 Root Cause Analysis (RCA) identified and analyzed the systemwide failures that caused LHH's decertification for failing to substantially comply with federal and state regulatory requirements and its own policies and procedures. CCSF-TJOHNSON_031892.[8] Subsequent Root Cause Analysis reports and monthly monitoring reports reinforced the findings and conclusions contained in the December report and highlighted a common thread throughout – the overall failure of governance at LHH.[9] Given the systemic causes underlying LHH's governance problems, LHH leaders' progress was minimal at best until it received the assistance of a subject matter expert QIE.

37. LHH relied for almost two decades on hospital professionals – not nursing home professionals – to lead LHH. The hospital professionals employed by LHH lacked the competence to run a large nursing home. Yet LHH's Governing Body did not ensure that a licensed nursing home administrator was named LHH's

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[6] *See* Umpierre Decl., Ex. G.

[7] *See* Umpierre Decl., Ex. A (Depo. Ex. 17).

[8] *See* Umpierre Decl., Ex. H (Depo. Ex. 24).

[9] *See* Umpierre Decl., Exs. H-M (RCA reports); Exs. N-S (Monitoring reports).

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Executive Administrator until June 26, 2023.[10] Despite the September 2019 Reform Plan commitment to hire a permanent CEO, the Governing Body waited too long to hire a duly qualified Executive Administrator. The delay in appointing a qualified Executive Administrator was a primary governance failure leading to CMS' decertification of LHH. 42CFR, §483.75(f) (Governance and leadership).

38. Between 2019 and 2023, LHH was assessed financial penalties equal to $2.1 million for its breaches of professional standards. LHH paid $1.4 million due to negotiated discounts. (Table 3)

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[10] SFChronicle.com, Aug 14, 2023, "S.F.'s Laguna Honda nursing home takes major step toward ending 18-month crisis."

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Table 3. Known Financial Penalties Assessed to LHH, 2019-2023.
Source: http://www.stoplhhdownsize.com/LHH_Consultant_and_Lawsuit_Costs_Soar_Part-2_23-07-31.pdf

Date	Penalty Assessed	Penalty Paid	Reason(s) for Penalty
03/14/19	$20,000	$13,000	"A" citation for a resident who injured himself while smoking in bed with an oxygen machine present.
05/21/19	$20,000	$13,000	"A" citation for a resident who fell from a toilet on 03/26/18 after a nurse walked away from her. The resident shattered her hip, requiring surgery.
09/30/19	$1,123,400	$730,210	Placing residents in immediate jeopardy of abuse for 156 days.
09/30/19	$126,000	$126,000	Denial of payment for new admissions.
10/30/19	$4,290	$2,789	CMS civil monetary penalty for sex abuse scandal.
Dec 2019	$100,000	$100,000	"AA" citation later reduced to "A' citation.
Dec 2019	$38,000	$24,700	19 "B" citations related to sex abuse scandal.
12/03/21	$250,000	$187,500	Deliberate breach of protected health information
03/30/22	$407,770	$203,885	CDPH civil monetary penalties for 11 inspections between 10/14/21 – 04/13/22.
12/20/22	$36,000	$36,000	12 "B" Citations related to resident transfer trauma.
TOTAL	**$2,125,460**	**$1,437,084**	

39. Since 2021, LHH has entered into at least two legal settlements equal to $3.0 million related to the issues addressed in this declaration. (Table 4).

Table 4. Known Settlements Linked to LHH Breaches, 2019-2023.
Source: http://www.stoplhhdownsize.com/LHH_Consultant_and_Lawsuit_Costs_Soar_Part-2_23-07-31.pdf

Date	Case Name	Settlement Amount
05/28/21	11 "Does"	$2,223,500
07/20/21	Abdullah	$800,000
TBD	Coutts vs. CCSF/LHH	Pending
TBD	Johnson et. al. vs. CCSF et. al.	TBD
TBD	Felder vs. CCSF	TBD
TBD	Sanchez, Lieu, Pham vs. CCSF/LHH (wrongful death cluster 1)	TBD
TBD	Wrongful death cluster 2	TBD
	TOTAL	**$3,023,500**

40. Due to its breaches of regulations, professional standards, and LHH policies between 2019 and 2023—and not including consultants, legal fees, and likely future legal settlements—LHH already has incurred costs equal to approximately $30.6 million (Table 5).

Table 5. Summary of Financial Cost of LHH Breaches, 2019-2023.

Area of Cost	Amount Paid
Paid amount of assessed penalties for regulatory violations	$1,437,084
Legal settlements to date	$3,023,500
Additional costs [see Appendix D, Table 14]	$26,175,514
TOTAL	**$30,636,098**

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These costs amount to a breach of the LHH Governing Body's fiduciary duty to act in LHH's best financial interest as stated in the bylaws of LHH. CCSF-JOHNDOE1_023194, Article 4, §3.E(1).[11]

EXPERT OPNION 1: The hundreds of substantiated regulatory violations committed by LHH between 2019 and 2023 reflect a colossal failure of governance and management by the LHH Governing Body and LHH managers.

38. LHH's Governing Body and facility managers failed to ensure that the facility: (1) used its resources to attain or maintain residents' highest practicable well-being; (2) developed and implemented policies and procedures regarding the management and operation of the facility, including policies developed to ensure the protection of resident rights and confidential information and to prevent abuse and neglect; and (3) operate the facility in compliance with local, state, and federal requirements.[12]

39. Federal regulations require that:

a. "A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain

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[11] *See* Umpierre Decl., Ex. BB (Depo Ex. 2).

[12] Margaret Rykowski testified as LHH's corporate designee that LHH was subject to Title 22 of the California Code of Regulations and LHH was required to follow Medicare and Medicaid regulations, which in part require LHH to develop and implement policies and procedures governing its operations. Ms. Rykowski also testified that LHH expects all its employees will follow the hospital's policies and procedures (Rykowski deposition transcript, 40:9-21; Umpierre Decl., Ex. LL). I concur with Ms. Rykowski's specific testimony, and it is my opinion that LHH was required to comply with state and federal regulations and was required to develop and implement policies and procedures, including those for the protection of residents' rights and their confidential information, and for the prevention of abuse and neglect. In addition, the San Francisco Department of Public Health Code of Conduct effective 11/14/2018 stated that DPH is dedicated to providing services "in compliance with all applicable laws, rules, and regulations" CCSF-JOHNDOE1_026866 (Umpierre Decl., Ex. EE [Depo Ex. 5]).

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the highest practicable physical, mental and psychosocial well-being of each resident." 42CFR §483.70.

b. "The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies[13] regarding the management and operation of the facility." 42CFR, §483.70(d). **Regarding facility-wide policies**. Per professional standards and regulatory requirements, U.S. nursing homes must establish and implement numerous policies. Not every policy covers the same scope of residents. Thus, some limited-scope policies apply to only a subset of residents, such as those fed by tube, or those with cognitive impairment. Other policies apply to all residents. That is, the scope is every resident at every time. Facility-wide policies that apply to all residents at all times without any consideration of any individual resident characteristic include, for example, policies on: abuse prevention and investigation, resident rights, resident dignity, life safety, fire safety, accident hazards, privacy, confidentiality, care planning, nutritional status and quality of life. My opinions highlight and emphasize LHH's repeated breaches of numerous ***facility-wide policies***, that applied to ***all facility residents at all times***.

40. The Governing Body of LHH is the San Francisco Health Commission.

[13] Margaret Rykowski testified as LHH's corporate designee that LHH policies "would go up through the CEO and then eventually be presented to the [Governing Body's Joint Conference Committee]" (Rykowski deposition transcript, 30:16-31:1; Umpierre Decl., Ex. LL). This testimony is consistent with professional standards and federal regulations that require a skilled nursing facility governing body to be legally responsible for establishing and implementing policies and procedures.

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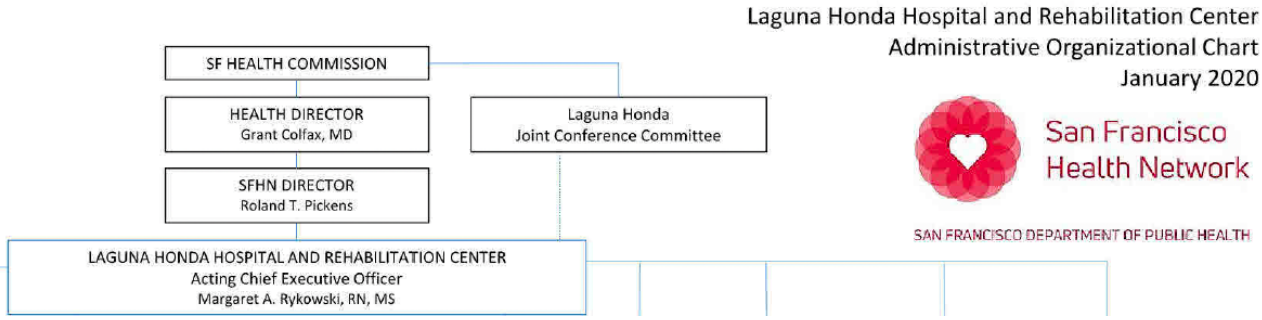
CCSF-JOHNDOE1_023192.[14] The Mayor of San Francisco appoints all members of the Governing Body. CCSF-JOHNDOE1_023193, Article IV, § 1.A.

41. LHH Governing Body members include a 12-member Joint Conference Committee (JCC) which meets at least 8 times per year[15] and has "broad authority to oversee the operation of [LHH]." CCSF-JOHNDOE1_023202, Article IX, § 2. The JCC provides final approval of LHH policies and procedures (Rykowski deposition transcript, 72:8-12; Umpierre Decl., Ex. LL).

Figure 1. Laguna Honda Governance/Senior Leadership Structure, Jan 2020 [Rykowski PMK Depo Exhibit 3, p. 5]. Ultimately, all listed positions answered to the Mayor of San Francisco.



42. The JCC is comprised of the following members (CCSF-JOHNDOE1_023201, Article IX, §1.B. & F)[16]:

a. Three Commissioners (also Rykowski deposition transcript, 17:3-20);

b. The San Francisco Director of Health;[17]

c. The LHH Chief Executive Officer;

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[14] *See* Umpierre Decl., Ex. BB (Depo Ex. 2).

[15] Margaret Rykowski testified as LHH's corporate designee that the JCC met monthly "for as long as I can remember." Umpierre Decl., Ex. LL (Rykowski Depo at 21:20-22:16).

[16] *See* Umpierre Decl. Ex. BB (Depo Ex. 2).

[17] The San Francisco Director of Health is the Chief Executive Officer of the Governing Body, who is appointed by the Mayor of San Francisco and the Governing Body to "monitor the performance of the LHH Executive Administrator." CCSF-JOHNDOE1_023194, Article IV, § 3.D; CCSF-JOHNDOE1_023196, Article VI, § 1.A (Umpierre Decl., Ex. BB [Depo Ex. 2]).

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d. The LHH Chief Nursing Officer;

e. The LHH Chief Operating Officer;

f. The LHH Chief Financial Officer;

g. The LHH Chief Quality Officer;

h. The LHH Chief of Medical Staff;

i. The LHH Vice Chief of Medical Staff;

j. The LHH Chief Medical Officer.

43. As reflected in summary Table 6, LHH's Governing Body repeatedly failed to carry out its core duties and responsibilities as mandated in its Bylaws.

Table 6. LHH Governing Body Breaches of Its Core Duties and Responsibilities.

Core Duty or Responsibility of the LHH Governing Body per Bylaws[18]	**How the LHH Governing Body Failed to Carry Out Its Duty or Responsibility Between 2019-2023**
Take all appropriate steps to fulfill LHH's Mission [Article IV, §3.I (CCSF-JOHNDOE1_023195)]	The Governing Body failed to take all appropriate steps stop LHH continuously failing to fulfill the LHH Mission.
Operate LHH in accordance and compliance with applicable laws [Article IV, §3.A. & L (CCSF-JOHNDOE1_023194-95)]	LHH incurred 243 regulatory violations between 2019-2023, 21 of which were for actual harm or for placing residents at immediate jeopardy of harm or injury. LHH was decertified from participation in the Medicare and Medicaid provider programs on April 14, 2022.
Monitor the performance of the Director of Health, who monitored the performance of the LHH Executive Administrator [Article IV, §3.D (CCSF-JOHNDOE1_023194)]	As of this writing there is no evidence the Governing Body monitored the performance of the Director of Health or LHH Executive Administrator.
Hold the Medical Staff accountable for any legal requirements [Article IV, §3.J (CCSF-JOHNDOE1_023195)].	In February 2023 Grant Colfax, SF Public Health Director, and member of the LHH Governing Body and Joint Conference Committee, was quoted as saying, "We are really supporting a new culture of accountability."[19] In other words: the culture prior to 2023 was not a culture of accountability, although the Governing Body Bylaws **required** LHH to be a culture of accountability. There is, too, a mountain of evidence that as of Feb 2023, LHH was not remotely close to embodying a culture of accountability.
Allocate resources for improving resident safety [Article IV, §3.H (CCSF-JOHNDOE1_023195)]	While resources may have been allocated, while Public Health Director Colfax claimed on 06/28/19 that LHH

[18] *See* Umpierre Decl., Ex. BB (CCSF-JOHNDOE1_023192; Depo. Ex. 2).

[19] www.KQED.org, 02/24/23, "Health Secretary Xavier Becerra Visits San Francisco Hospital Fighting Off Closure."

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	was "especially" committed to patient safety,[20] and while the LHH 2018-2019 Facility Assessment stated "improving our culture of safety" would be a 2019-2020 focus,[21] the resources and focus on safety did not result in improved resident safety. In fact, related to patient safety, the opposite occurred: LHH was issued actual harm or IJ deficiencies in 2021, 2022, and 2023. It was decertified from participation in the Medicare and Medicaid provider programs on April 14, 2022.
Provide an accessible forum in which all staff can report on monitoring/evaluating the quality of patient/resident care [Article IV, §3.G (CCSF-JOHNDOE1_023195)]	As of this writing, there is no evidence that LHH provided all staff a forum in which they could report on monitoring and evaluating the quality of resident care.
Promote performance improvement [Article IV, §3 (CCSF-JOHNDOE1_023194-96)]	Whatever performance improvement may have been promoted was overshadowed by LHH's ongoing failures to attain even minimal compliance with regulatory and professional standards.

44. As reflected in summary Table 7, LHH Executive Administrators similarly failed in their assigned responsibilities.

Table 7. LHH Executive Administrator Breaches of Core Responsibilities.

Core Responsibility of the LHH Executive Administrator per Bylaws[22]	**How the LHH Executive Administrator Failed to Carry Out His/Her Responsibilities Between 2019-2023**
Ensure LHH complies with laws and regulations [Article VII, §3.I (CCSF-JOHNDOE1_023198)]	LHH incurred 243 regulatory violations between 2019-2023, 21 of which were for actual harm or for placing residents at immediate jeopardy of harm or injury. LHH was decertified from participation in the Medicare and Medicaid provider programs on April 14, 2022.
Implement LHH policies [Article VII, §3.J (CCSF-JOHNDOE1_023198)]	Policy violations during the period 2019-2023 are too numerous for listing here. Four such violations cited by CDPH included: "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response" "Illicit or Diverted drugs and/or Paraphernalia Possession/use by Residents or Visitors" "Notification and Documentation of Change in Resident Condition"

[20] KQED, 06/28/19, "'Hurtful, Offensive and Heartbreaking': Major Patient Abuse Scandal Hits S.F.'s Laguna Honda Hospital."

[21] *See* Umpierre Decl., Ex. CC (CCSF-JOHNDOE1_029161; Depo Ex. 6).

[22] *See* Umpierre Decl., Ex. BB (CCSF-JOHNDOE1_023192; Depo Ex. 2).

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	"Fire Response Plan Policy" "Behavioral Risk Assessment and Care Planning"
Ensure that each LHH program, service, site or department has effective leadership [Article VII, §3.E (CCSF-JOHNDOE1_023198)]	For 18 years, the LHH Executive Administrator was not a nursing home administrator. Turnover of managers who reported to the Executive Administrator were at times significantly higher than industry averages.[23] Executive rounding in nursing units didn't start until 03/15/23.[24]
Ensure the same standard of care throughout the Hospital [Article VII, §3.N (CCSF-JOHNDOE1_023199)]	In July 2019, residents of North 1 and North 2 Units (40% of whose residents were cognitively impaired) were subject to inordinate episodes of abuse[25].
Ensure that care is provided safely [Article VII, §3.P (CCSF-JOHNDOE1_023199)]	21 actual harm/immediate jeopardy deficiencies including immediate jeopardy deficiencies related specifically to resident safety.
Measure and assess the effectiveness of performance improvement activities [Article VII, §3.U (CCSF-JOHNDOE1_023199)]	QIE measurements and assessments of performance improvement repeatedly concluded that LHH was continually failing to effectively improve care quality, as evidenced by ongoing breaches of professional standards. When conducting its 12/01/22 Root Cause Analysis, the QIE determined that LHH's QAPI program was deficient.[26]

45. LHH's Quality Assurance and Performance Improvement (QAPI) Program was deficient and therefore put LHH residents at continuing risk of harm

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[23] For example, in 2020 and 2022, LHH management turnover was 2-3 times higher than industry norms. *See* Appendix D, Figure 4 (Turnover, LHH Leaders, June 2019 – July 2023). In four of five years between 2019 and 2023, Executive Administrator turnover was twice industry norms, despite CCSF-LHH's September 2019 Reform Plan commitment to "appoint a permanent CEO." *See* Appendix D, Figure 5 (LHH Executive Administrator Turnover, 2019-2023). Leadership instability—especially of the Executive Administrator—contributed and exacerbated LHH's governance failures.

[24] *See* Umpierre Decl., Ex. P (Monitoring Rpt. #3; CCSF-TJOHNSON_031754).

[25] Susan Duong, Nursing Director for North 2 and North 3 units, testified that the majority of residents in the North 2 Unit have some sort of cognitive loss or dementia (*Abdullah vs. CCSF et. al*, San Francisco Superior Court, Case No. CGC-20-583155, Deposition transcript, 02/18/21, p. 23).

[26] *See* Umpierre Decl., Ex. H (CCSF-TJOHNSON_031900; Depo Ex. 24).

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(see Table 7.5 and Appendix F).

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Table 7.5. LHH Failures to Fulfill QAPI Elements.

QAPI Element	CCSF-LHH's Failure(s) to Fulfill this QAPI Element, and the Ramifications for All LHH Residents
Design and scope	→A hallmark of skilled nursing facility QAPI programs is the prioritization of resident safety and compliantly implementing all systems of care. However, between 2019-2023, LHH failed to prioritize resident safety and failed to compliant administer the facility. LHH's numerous ongoing deficient practices related specifically to resident accidents, life safety, and resident abuse (as detailed by CDPH evaluators and the HSAG Quality Improvement Experts [QIEs]) put ***all*** LHH residents at risk of ongoing harm. In fact, many LHH residents *were* harmed due to LHH failures of systems of care.
Governance and leadership	→Per this QAPI element, the governing body develops a culture of open communication that sets facility-wide expectations around safety, resident rights, and staff accountability. However: →LHH had a culture of silence, not a culture of open communication. The culture of silence meant that for years, abuse of residents was underreported and not thoroughly investigated. The culture of silence put all LHH residents at risk for continuing abuse. →LHH staff were unaware of expectations regarding resident safety and resident rights. This lack of awareness was evidenced by LHH staff not knowing how to screen visitors for illicit substances, and not knowing how to respond to emergencies including fire alarms. Staff ignorance of safety expectations is evidence of a broken QAPI program that put all LHH residents at risk for harm. →The LHH governing body failed to ensure that LHH managers held LHH staff accountable to performance expectations around resident safety and resident rights. Indeed, the QIEs determined that LHH's culture was a culture of almost no accountability. Repeated regulatory deficiencies related to resident abuse, accident hazards, and an unsafe environment indicate that LHH staff were not held accountable in these areas that affected all LHH residents at all times.
Feedback, data systems, and monitoring	→This QAPI element includes planning to prevent recurrences of non-compliant practices. →Without doubt, LHH's data systems feedback and quality monitoring efforts were deficient between 2019-2023 because the same deficient practices, affecting all LHH residents (i.e., abuse prevention/investigation, unsafe environment), kept recurring.
Performance improvement projects	→This QAPI element focuses on intervening in areas that need attention. →LHH's failures with respect to resident abuse and resident safety kept recurring. Which is evidenced that LHH's QAPI program was deficient in resolving issues to completion. By failing for years to resolve issues relevant to all residents' safety and rights, LHH demonstrated that its QAPI program was deficient.
Systematic analysis and systematic action	→This QAPI element emphasizes the use of Root Cause Analysis and a review of all organizational systems to prevent future adverse events. →In June and July 2022, a mock survey resulted in 101 deficiencies, including 7 immediate jeopardy findings. Many findings were recurrences of prior deficient findings. Clearly the LHH QAPI program had failed to prevent adverse events from recurring. →On 12/01/22, the QIE documented 47 root causes of LHH's deficient and noncompliant systems of care & services. These root causes affected eight problem areas affecting the majority of LHH residents. The sheer number of root causes is evidence of LHH's failure to address and resolve root causes prior to 12/01/22. Those failures speak to LHH's broken QAPI program.

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46. LHH's regulatory and operational failures between 2019 and June 25, 2023, were due in part to the facility's Executive Administrator lacking training, background, and experience as a licensed skilled nursing facility administrator. Between November 1, 2004, and June 25, 2023, the LHH Executive Administrator was not a nursing home administrator (Table 8). The Governing Body's failure to ensure that a duly qualified Executive Administrator led the facility (while being supported by a team of licensed nursing home administrators and a Director of Nursing and Medical Director with skilled nursing experience) was a colossal breach of professional standards. Because of LHH's documented failures in 2018 and 2019, the LHH Governing Body should have promptly hired an LHH Executive Administrator (and team of licensed nursing home administrators) far earlier than June 26, 2023, but did not.

Table 8. LHH Executive Administrators, 2004 - 2023.

Name	Term	Licensed NHA
John Kanaley	11/01/04 – 03/19/09	No
Mivic Hirose, RN	03/20/09 – 06/27/19	No
Margaret Rykowksi	06/28/19[27] – 05/31/20[28]	No
Michael Phillips	06/01/20 – 06/01/22	No
Roland Pickens	06/02/22 – 06/25/23	No
Sandra Simon	06/26/23 – present	Yes

47. On December 1, 2022, the federally mandated Quality Improvement Expert (QIE) published the "Root Cause Analysis Findings and Recommendations." This Root Cause Analysis (RCA) and six subsequent RCAs were required by the Settlement and Systems Improvement Agreement of November 2022. CCSF-TJOHNSON_023012-15.[29]

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[27] https://www.sfdph.org/dph/files/newsMediadocs/2019PR/PR-LagunaHondaPatientCare.pdf

[28] https://www.sfdph.org/dph/files/newsMediadocs/2020PR/DPH-Statement-on-Laguna-Honda-Hospital-CEO-Transition.pdf

[29] *See* Umpierre Decl., Ex. F (Depo Ex. 22).

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48. The December 2022 RCA is a glaring indictment of LHH's colossal failures of governance and management. CCSF-TJOHNSON_031892.[30] Published four years after Mayor of San Francisco London Breed and CCSF-LHH leaders unveiled to the citizens and taxpayers of San Francisco a Reform Plan for LHH that included "first and foremost" the "critical component" of "ensuring compliance with all State and Federal Regulations," the RCA repudiates Mayor Breed's commitment to regulatory compliance. The 48-page report identified 8 problem areas with 47 root causes. Numerous findings detailed shockingly bad governance and shockingly bad management.

49. The December 2022 RCA confirmed that for at least 4 years, LHH leaders had made little to no progress in addressing LHH's known and longstanding patterns of resident abuse, neglect, and poor care quality.

50. Significant findings contained in the December 2022 RCA include, but are not limited to the following. *See also* Appendix D, Tables 15 & 16 for detailed listing of 12/01/22 RCA findings.

a. **There was no leadership presence and inadequate leadership communication**. Despite the September 2019 Reform Plan's commitment to "change the organizational culture at LHH" (CCSF-TJOHNSON_035367),[31] LHH leaders had a limited presence on nursing units (CCSF-TJOHNSON_031902),[32] did not consistently conduct rounds in the facility (CCSF-TJOHNSON_031917), and did not communicate with direct care staff to promote quality of care (CCSF-TJOHNSON_031902).

b. **LHH applied inconsistent discipline, if any, to staff who**

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[30] *See* Umpierre Decl., Ex. H (Depo Ex. 24).

[31] *See* Umpierre Decl., Ex. A (Depo Ex. 17).

[32] *See* Umpierre Decl., Ex. H (Depo Ex. 24).

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violated policies, mistreated residents, and failed to complete mandatory training (CCSF-TJOHNSON_031931). Despite the Reform Plan's commitment to "best practices" in employee discipline, LHH did not use progressive disciplinary action for non-compliant staff behaviors including behaviors affecting resident rights and dignity (CCSF-TJOHNSON_031919).

c. **LHH was a culture of blame with minimal accountability structures (CCSF-TJOHNSON_031928).** LHH was "reactive and not proactive" (CCSF-TJOHNSON_031928).

d. **There was inadequate awareness of how to investigate abuse.** Despite the September 2019 Reform Plan's commitment to recognizing and reporting abuse, LHH nursing staff were not appropriately trained on how to conduct a thorough and comprehensive abuse and neglect investigation. ***The last formal training had occurred in 2016*** (CCSF-TJOHNSON_031921, emphasis added).

e. **LHH admitted behavioral patients for whom it could not provide appropriate care.** LHH staff did not have the expertise to treat and manage residents with complex behavioral needs (CCSF-TJOHNSON_031909).

f. **Physical restraints were used inappropriately.** Physical restraint practices were not compliant with regulations (and therefore LHH policies) (CCSF-TJOHNSON_031918).

g. **Staff did not know how to create SNF care plans (CCSF-TJOHNSON_031924).** Relatedly: (i) care plans were rarely used with direct caregivers (CCSF-TJOHNSON_031929); (ii) nurse leaders had inconsistent and ineffective participation in the care

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plan process (CCSF-TJOHNSON_031925); (iii) care plans were not updated and not quality reviewed (CCSF-TJOHNSON_031926); and (iv) care plans were not in a readable format (CCSF-TJOHNSON_031928).

h. **Shift change communications was inadequate.** Often, CNAs were excluded from change of shift communications. There was no standard format for shift change communications (CCSF-TJOHNSON_031907).

i. **Security staff didn't know how to prohibit illicit substances or screen visitors.** Security staff were not trained on LHH policies and procedures and didn't know how to screen visitors (CCSF-TJOHNSON_031933). This increased the likelihood of illicit substances entering the facility (CCSF-TJOHNSON_031911).

j. **Staff education was ineffective.** Staff training relies heavily on read and sign, often in a rushed mode demanding same-day staff signatures (CCSF-TJOHNSON_031932). The electronic learning system is English only without additional adult learning techniques for a multi-lingual staff that encounter many barriers to computer accessibility (CCSF-TJOHNSON_031911, -31).

k. **The grievance process was ineffective.** The grievance process was not being followed (CCSF-TJOHNSON_031919) and grievance data was "just numbers" (CCSF-TJOHNSON_031922).

l. **Residents were not screened for physical decline.** LHH did not regularly screen residents for declines in range of motion, balance, and activities of daily living (CCSF-TJOHNSON_031920).

m. **Policies were not linked to SNF regulations.** LHH did not

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develop policies that cross walked to nursing home regulations (CCSF-TJOHNSON_031915).

n. **17 herbal supplements were at a resident's bedside for 6 months.** In April 2022, LHH was issued a deficiency for a resident who had 17 herbal supplements at the bedside. On 10/26/22 (*6 months later*), all 17 supplements were still at the bedside (CCSF-TJOHNSON_031915, emphasis added).

o. **Direct care staff were not involved in quality improvement.** Direct care staff and medical staff were not active in quality improvement activities (CCSF-TJOHNSON_031899). *See* Appendix F regarding QAPI.

51. Findings in the QIE's RCA reports are indicative of the lack of oversight and control exhibited by LHH management that resulted from the overall governance failures described herein, and which prevented LHH from ensuring compliance with its statutory and regulatory obligations to implement nursing home policies and procedures, including LHH policies and procedures for the protection of residents' rights and their confidential information, and to prevent resident abuse and neglect.

EXPERT OPINION 2: The failure of governance at LHH from 2019 through at least the time of its recertification in August 2023 prevented LHH from complying with its statutory obligation to implement nursing home policies and procedures, including LHH policies for the protection of resident rights and their confidential information, and to prevent resident abuse and neglect.

52. As reflected in Figure 2, following, between 2019 and 2023, LHH incurred 243 total deficiencies. Twenty-one (21) of the deficiencies were rare for their scope and severity because of actual harm to numerous residents or the risk of immediate jeopardy of resident harm (Tables 9, 10, 11). LHH's failures also resulted in decertification from Medicare and Medicaid on April 14, 2022 (rare for a nursing

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home), and total costs to LHH (so far) of $30.6 million, not including millions of additional dollars for consulting fees, legal fees, and anticipated future legal settlements. These costs amounted to a breach of the LHH Governing Body's fiduciary duty to act in LHH's best financial interest.

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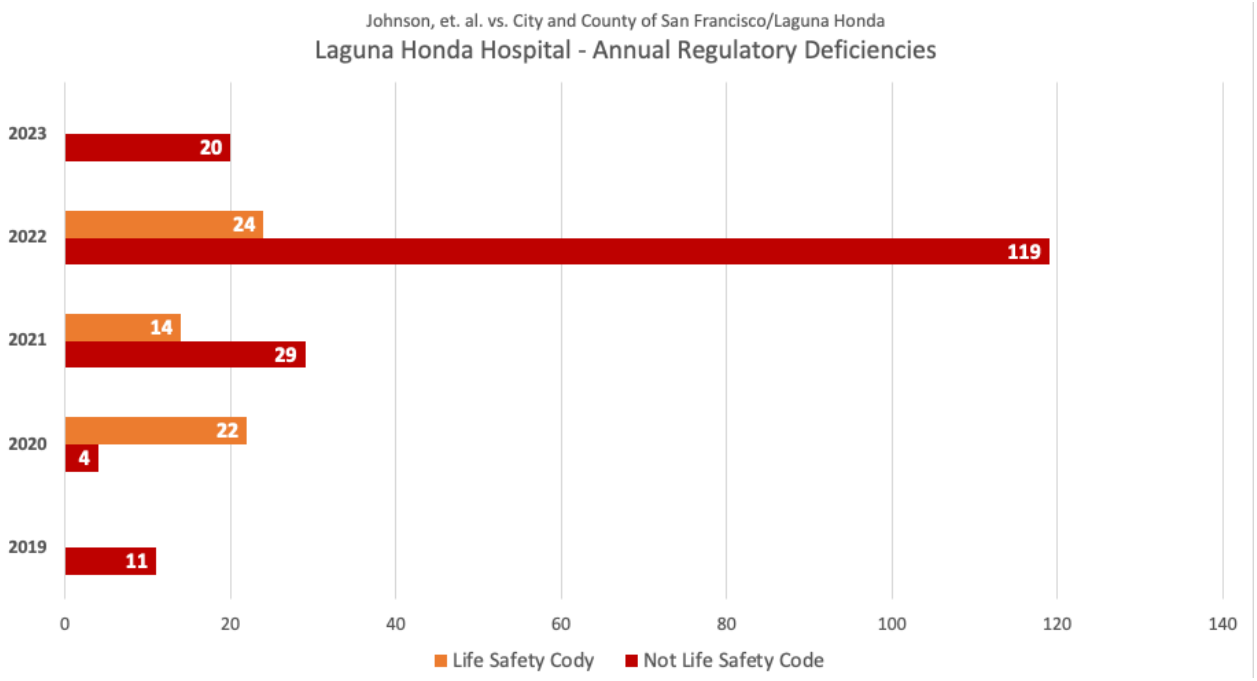
Figure 2. LHH incurred 243 total deficiencies between 2019-2023.

Source: https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/SearchResult.aspx



53. Because of LHH's size, surveyors focused on proportionally fewer residents. Surveyor protocols for resident sample sizes during recertification surveys meant that surveyors focused on 1.4 to 5.1 times fewer LHH residents than they would have in smaller facilities.

54. In addition, COVID resulted in fewer deficiencies because surveyors were not visiting facilities. The COVID-19 pandemic resulted in a decrease in the number of deficiencies issued to California nursing homes, especially in 2020 and 2021.

55. Many of the 243 regulatory deficiencies issued to LHH between 2019 and 2023 were rare in their scope and severity for a U.S. nursing home. The scopes and severities cannot be reasonably explained away as an artifact of LHH's large size. If anything, LHH's size and accompanying resources should have provided it added protection from wide scope/high severity deficiencies such as those summarized in Tables 9, 10 and 11.

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Table 9. Between 2019-2023, LHH's Regulatory Violations Were Rare for a U.S. Nursing Home. LHH's Regulatory Violations Were *Highly* Atypical for a U.S. Nursing Home.

Percent of facilities in country issued Ftag at specified scope and severity letter (5% or fewer facilities cited)

			ACTUAL HARM OR IMMEDIATE JEOPARDY					
F-tag	What happened	D	G	H	I	J	K	L
F583	Privacy rights of 19 residents breached						2019 - 0.01%* *only one in the county	
F600	2019 K = 7 residents abused; 2021 D = 1 resident abused	2021 - 13.5%					2019 - 0.1%	
F605	5 residents chemically restrained						2019 - 0.01%* *only one in the county	
F607	2020 D = 21 residents abused; 2021 D = failed to report abuse; 2023 D = no support for abuse	2020 - 4.9% 2021 - 7.1% 2023 - 5.8%						2019 - 0.3%
F609	Failed to report abuse	2020 - 10.9%						
F684	No weekly assessments for surgical wound, 1 resident.		2022 - 5.2%					
F685	Failed to provide treatment to prevent stroke		2021 - 0.01%* *1 of 2 in the country					
F686	No preventive treatment for 4 residents		2022 - 5.6%					
F688	Failed to prevent decline in mobility, 2 residents		2022 - 0.3%					
F689	2019 G = 1 resident hip fx; 2019 H = 4 residents drugged; 2020 G = 1 resident bone fx; 2021 G = 1 resid finger fx; 2021 H = unsafe for 710 resids; 2022 K = unsafe for 706 resids; 2022 L = unsafe for 575 resids; 2023 J = hazards to suicidal resid.		2019 - 12.7% 2020 - 8% 2021 - 11.7%	2019 - 3.5% 2021 - 4.3%		2023 - 4.9%	2022 - 0.9%	2022 - 0.1%
F692	Failed to ensure nutritional status for 4 residents		2022 - 1.8%					
F755	Resident had stroke due to medication error		2021 - 0.3%					
F760	Resident hospitalized due to medication error		2021 - 1.4%					
F761	Didn't secure hoarded opioids.					2020 - 0.02%* *1 of 3 in the country		
F921	Failed fire response plan for 575 residents							2022 - 0.02%* *1 of 3 in the country

Source: https://qcor.cms.gov/main.jsp

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Legend
Immediate jeopardy
Actual harm
No actual harm, but related to Abuse/Neglect
Administrative penalty
Citation with a fine

Table 10. 2019-2023 Regulatory Deficiencies, Citations, and Penalties Issued to Laguna Honda for: (i) Immediate Jeopardy to Resident Health or Safety; (ii) Actual Resident Harm; (iii) Resident Abuse; (iv) Breaches of Resident Privacy; and (v) Transfer Trauma.

	Survey Date (per CalHealthFind; link)				
	2019	2020	2021	2022	2023
Accident Hazards	02/07/19 (Date Survey Completed) F689. SS=G (actual harm). Failure to provide supervision to 1 resident, resulting in a hip fracture. 07/12/19 (Date Survey Completed) F689. SS=H (actual harm). Failed to ensure the safety for 4 residents when they had positive toxicology results for illicit drugs.	05/21/20 (Survey Date) 12/28/21 (Date Survey Completed) F689. SS=G (actual harm). Failed to ensure 1 resident was buckled in vehicle, resulting in a fall and tibia (shin bone) fracture.	05/13/21 (Survey Date) 01/13/22 (Date Survey Completed) F689. SS=G (actual harm). Failed to provide a safe environment for 1 resident, resuliting in a finger fracture and bruise to the chest. 08/15/21 (Survey Date) 10/14/21 (Date Survey Completed) F689. SS=H (actual harm). Failed to ensure safe environment for all 710 residents.	03/15/22 (Survey Date) 03/22/22 (Date Survey Completed) F689. SS=K (immediate jeopardy). Failed to ensure safe environment for all 706 residents (4 findings). 11/28/22 (Survey Date) 12/16/22 (Date Survey Completed) F689. SS=L (immediate jeopardy, 12/06/22 - 12/13/22) for failing to ensure a safe environment for all 575 residents (5 findings).	04/12/23 (Survey Date) 05/22/23 (Date Survey Completed) F689. SS=J (immediate jeopardy). Failed to ensure a safe environment, free of accidents and hazards for 1 resident (related to suicide attempts).
Breached Resident Privacy				12/20/21: $250,000 penalty for deliberate breach of PHI	
Develop/Implement Abuse/Neglect Policies	07/12/19 (Date Survey Completed) F607. SS=L (immediate jeopardy). Failed to develop and implement its abuse prevention and reporting policy when 21 residents were subjected to physical, verbal and mental abuse by staff members. 09/06/19 (Date Survey Completed) F607. SS=D. Failed to ensure a thorough investigation of abuse for 1 resident.		03/11/21 (Survey Date) 07/19/21 (Date Survey Completed) F607. SS=D. Failed to follow their abuse and neglect policies and procedures to report abuse/neglect to the state within 5 days.		02-06-23 (Survey Date) 02-09-23 (Date Survey Completed) F607. SS=D. Failed to implement its Abuse and Neglect Policy and Procedure when there was no documented evidence of a Medical Social Worker and psychological support for 1 resident.
Failure to report abuse		01/05/20 (Survey Date) 09/04/20 (Date Survey Completed) F609. SS=D. Failed to report suspected abuse for 1 resident within two hours.			
Free from Abuse & Neglect	07/12/19 (Date Survey Completed) F600. SS=K (immediate jeopardy). Failed to protect 7 residents from verbal, physical and mental abuse by staff members.		09/16/21 (Survey Date) 03/30/22 (Date Survey Completed) F600. SS=D. Failed to ensure 1 resident was a free from abuse when a caregiver hit the resident one the face, resulting in a cut on the lip.		
Label/Store Drugs		09/17/20 (Survey Date) 10/02/20 (Date Survey Completed) F761. SS=J (immediate jeopardy, 09/30/20 - 10/02/20). Failed to assure medications were secure and administered properly to residents when 1 resident had been hoarding opioids over 2 years, having the potential to reach 60 other residents in the resident's unit.			

Source: https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/SearchResult.aspx

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Immediate jeopardy
Actual harm
No actual harm, but related to Abuse/Neglect
Administrative penalty
Citation with a fine

Table 11. 2019-2023 Regulatory Deficiencies, Citations, and Penalties Issued to Laguna Honda for: (i) Immediate Jeopardy to Resident Health or Safety; (ii) Actual Resident Harm; (iii) Resident Abuse; (iv) Breaches of Resident Privacy; and (v) Transfer Trauma.

	Survey Date (per CalHealthFind; link)				
	2019	2020	2021	2022	2023
Medication Errors			03/18/21 (Survey Date) 7/20/21 (Date Survey Completed) F760. SS=G (actual harm). Failed to protect signifant medication error for 1 resident, resulting in hospitalization.		
Nutrition-Hydration				12/16/22: F692. SS=G (actual harm). Failed to ensure nutritional status of 4 residents.	
Pharmacy Services, Procedures, Records			12/14/21 (Survey Date) 02/03/22 (Date Survey Completed) F755. SS=G (actual harm). Failed to ensure hypertensive medication were administered to 1 resident, resulting in a stroke and increased level of care after hospitalization.		
Pressure Ulcers				11/28/22 (Survey Date) 12/16/22 (Date Survey Completed) F686. SS=G (actual harm). Failed to provide preventive care and treatment for 4 residents.	
Privacy/Confidentiality of Records	07/12/19 (Date Survey Completed) F583. SS=K (immediate jeopardy). Failed to ensure the rights to privacy and confidentiality of 19 residents when photos and videos of residents were taken and shared by staff members.				
Quality of Care			12/14/21 (Survey Date) 02/03/22 (Date Survey Completed) F685. SS=G (actual harm). Failed to provide treatment and care to maintain normal BP for 1 resident, resulting in a stroke.	11/28/22 (Survey Date) 12/16/22 (Date Survey Completed) F684. SS=G (actual harm). Failed to ensure weekly assessments of a surgical wound for 1 resident.	
Range of Motion				11/28/22 (Survey Date) 12/16/22 (Date Survey Completed) F688. SS=G (actual harm). Failed to prevent decline in mobility or function for 2 residents.	
Right to be Free from Chemical Restraints	07/12/19 (Date Survey Completed) F605. SS=K (immediate jeopardy). Failed to ensure that 5 residents were free from chemical restraints when they had been intentionally administered non-prescribed medications for staff convenience.				
Safe Environment				11/28/22 (Survey Date) 12/16/22 (Date Survey Completed) F921. SS=L (immediate jeopardy, 12/06/22 - 12/13/22). Failure to implement the fire response plan for all 575 residents.	
Transfer Trauma				12/20/22: 12 '8' Citations with total fines $36,000 for violations in Aug22 & Sep22	

Source: https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/SearchResult.aspx

56. LHH was decertified from participation in the Medicare and Medicaid provider programs on April 14, 2022, because CMS determined LHH was not in substantial compliance with the regulatory requirements of 42 C.F.R. Part 483,

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Subpart B. CCSF-TJOHNSON_023003.[33] Decertification of a U.S. nursing home was and is rare. Between 2019 and 2023, 0.1% or less of U.S. nursing homes were involuntarily decertified by Medicare, and only two nursing homes with more than 200 beds were involuntarily decertified. (Table 12)

Table 12. Medicare/Medicaid* Nursing Homes Involuntarily Terminated from Medicare.

Year	Involuntarily Terminated Providers	Total Providers	Percent Terminated	Percent Not Terminated	Terminated and More than 200 beds (licensed beds)
2019	7	14,619	0.04%	99.96%	0
2020	4	14,510	0.03%	99.97%	0
2021	15	14,446	0.10%	99.90%	1 (204)
2022	15	14,340	0.10%	99.90%	1 (543)
2023	9	14,190	0.06%	99.94%	0

*Dually certified SNFs including Distinct Part SNFs. [Source: https://qcor.cms.gov/index_new.jsp]

EXPERT OPINION 3: The governance and management failures at LHH were not pre-ordained. The LHH Governing Body and executive leaders had the capacity to govern and manage competently, but with respect to protecting residents' rights they did not.

57. LHH expertly governed and managed its COVID response between March – July 2020. When long-term care facilities were accounting for about half U.S. COVID deaths in the first four months of 2020, only 19 of 721 residents tested positive, and only 50 of 1,800 staff tested positive. That is because for five months LHH governed and managed its 2020 COVID-19 response with focus, competence, and a reliance on subject matter experts.

58. LHH's approach to managing COVID-19 between March-July 2020 included, in part: (i) establishing a COVID-19 Command Center; (ii) having the Mayor of San Francisco request assistance from, eventually, two State infection control specialists and 6 Federal Centers for Disease Control (CDC) nurses and epidemiologists; (iii) strict contact tracing; and (iii) double quarantining residents (for

[33] *See* Umpierre Decl. Ex. F (Depo Ex. 22).

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28 days instead of 14 days).[34]

59. On the other hand, for years, including the four years after LHH became aware of an abuse scandal under its own roof, LHH's Governing Body and executives failed to marshal the same focus, the same competence, and the same reliance on subject matter experts (including experienced nursing home administrators) in responding to incidents of resident abuse, threats to resident safety, and breaches of care quality. Sadly, for years, hundreds of LHH residents were put at immediate jeopardy of harm, and/or were harmed by LHH's systemic failure to ensure its policies and procedures, including its facility-wide policies to protect all residents' rights and confidential information and to prevent the abuse and neglect of all of them.

EXPERT OPINION 4: If LHH does not continue to engage skilled nursing facility subject matter experts (SMEs), LHH will slip back into its yearslong pattern and practice of non-compliance with regulatory and professional standards.

60. Despite a yearslong pattern of noncompliance with regulatory and professional standards, and despite an Action Plan deadline of May 13, 2023 mandated by the Federal government[35] addressing 21 areas of required compliance, LHH leaders failed to decisively address its governance and management failures until as late as 1Q23 and 2Q23. As reflected in Figure 3, Action Plan elements were non-compliant into May 2023.

[34] "A deadly coronavirus outbreak seemed inevitable at SF's Laguna Honda nursing home—but that's not what happened," July 27, 2020, http://www.sfchronicle.com/.

[35] CCSF-TJOHNSON_023015 (Settlement and Systems Improvement Agreement, ¶ 11(a) [Umpierre Decl., Ex. F (Depo Ex. 22)].

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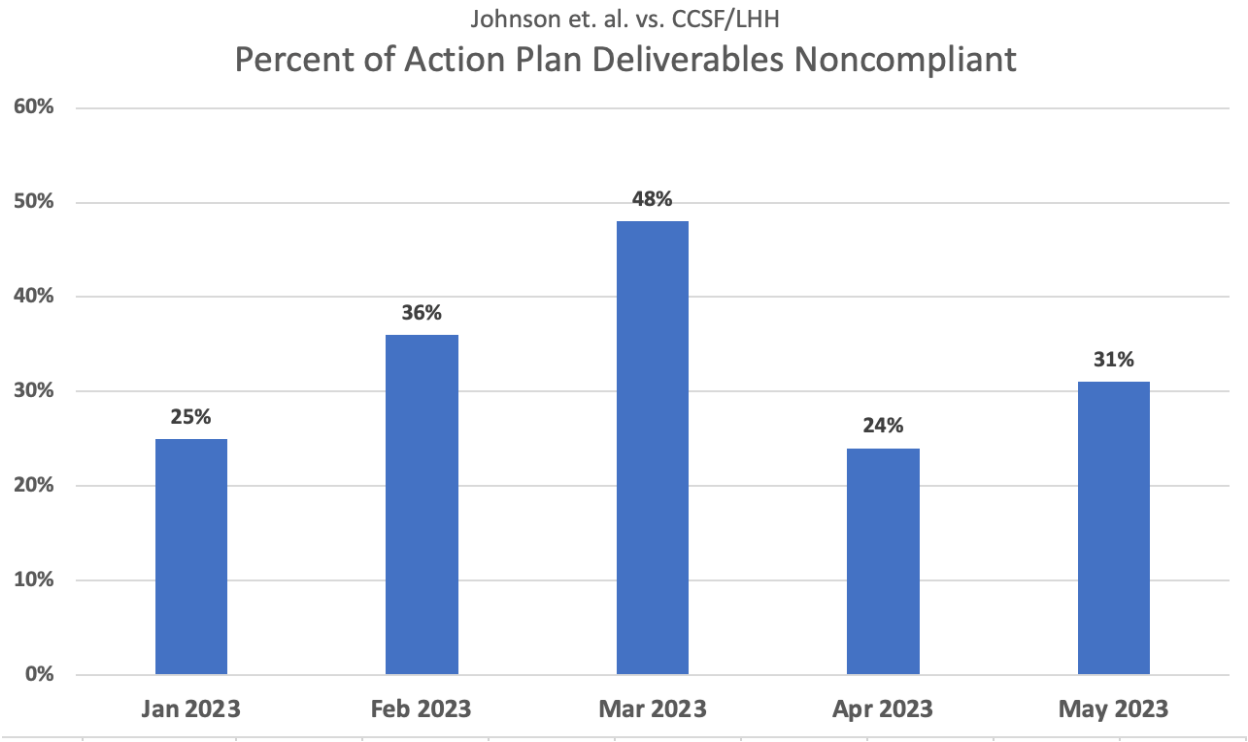
Figure 3. Monthly Percent of Action Plan Deliverables Not Compliant with the Action Plan for Restoring LHH to Compliance with Federal Requirements by May 13, 2023, as Determined by the Quality Improvement Expert (QIE).



61. Table 12 is a summary of evidence that LHH's Governing Body and management failed to act promptly to remedy its broken systems of care and resident safety. Tables 17 and 18, contained in Appendix D, provide greater detail.

Table 12. As Late as 1Q3 and 2Q23, LHH Was Still Noncompliant with Standards.
Summary evidence that LHH's governing entity and management failed to act promptly to remedy its broken systems of care and resident safety. Tables 17 and 18 at Appendix D below provide greater detail.

Date	Evidence of LHH's Failure to Adopt Compliant Practices as Late as 1Q23 and 2Q23
03/15/23	Start of executive rounding in 13 nursing units (CCSF-TJOHNSON_031754; Monitoring Rpt. 3).[36]
04/05/23	An infection prevention champion for North Nursing Unit 2 had not yet been trained (CCSF-TJOHNSON_031786-87; Monitoring Rpt. 4).[37]
Apr 2023	A Resident/Safety Advocate was appointed (CCSF-TJOHNSON_031797; Monitoring Rpt. 4) and documentation on abuse reporting was only 75% compliant (CCSF-TJOHNSON_032013; RCA #6].[38]
04/06/23	Inappropriately, residents still were being allowed to go out on pass and LHH did not recognize the risk of regulatory vulnerability these findings presented. A task force was immediately formed, but only upon the prompting of the QIE

[36] *See* Umpierre Decl., Ex. P.

[37] *See* Umpierre Decl., Ex. Q.

[38] *See* Umpierre Decl., Ex. L (Depo Ex. 25).

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	(CCSF-TJOHNSON_031797; Monitoring Rpt. 4).
04/12/23	LHH staff were non-responsive to a fire alarm (CCSF-TJOHNSON_031797; Monitoring Rpt. 4).
04/21/23	LHH staff were not completing care plan reviews at a rate to meet the 05/13/23 deadline, despite working on reviews since Nov 2022. QIE has to escalate to LHH leaders (CCSF-TJOHNSON_031798; Monitoring Rpt. 4).
05/08/23	CMS placed LHH under immediate jeopardy for failing to provide a plan for staff monitoring a suicidal resident.
May 2023	The QIE noted a negative trend for several abuse-related activities, including inconsistent documentation, lack of documentation, lack of physician notification and lack of individualized care plan review. In response, LHH created visual aids, a tip sheet, daily abuse investigation huddles, and a checklist for documentation compliance (CCSF-TJOHNSON_031834-35; Monitoring Rpt. 5).[39] ***LHH's failure to develop and implement an abuse documentation checklist until May 2023 is a stark example of LHH's incompetent governance and management***.
Jun 2023	LHH initiated CCBMs (Consistent Care at the Bedside Managers), external, SNF-experienced clinical monitors (CCSF-TJOHNSON_031866; Monitoring Rpt. 6).[40]
06/26/23	LHH did not designate an abuse coordinator until the 06/26/23 hiring of an Executive Administrator who is a nursing home administrator (Rykowski deposition transcript, 223:4-20).[41]

62. Even after the Action Plan deadline of May 13, 2013, LHH continued to fail to comply with its policies and procedures and regulatory requirements.

a. Call light compliance for May 2023 was only 58%. CCSF-TJOHNSON_032015.[42]

b. A standard work process for "Thorough Investigations" was not created until June 9, 2023. CCSF-TJOHNSON_032016.

c. A standard work process for grievances was not created until June 16, 2023. CCSF-TJOHNSON_032001, CCSF-TJOHNSON_032016.

d. As of June 29, 2023, only 54% of staff had completed abuse and neglect training. CCSF-TJOHNSON_032018.

[39] *See* Umpierre Decl., Ex. R.

[40] *See* Umpierre Decl., Ex. S.

[41] *See* Umpierre Decl., Ex. LL

[42] *See* Umpierre Decl., Ex. L (Depo Ex. 25, RCA #6).

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e. In June 2023, pain assessments after administration of as-needed pain medication were compliant only 71% of the time. CCSF-TJOHNSON_032029.[43]

f. A July 2023 review concluded "care plans are not thoroughly reviewed and monitored for accuracy." CCSF-TJOHNSON_032029.

63. LHH will not maintain and sustain performance improvement and substantial regulatory compliance if its Executive Administrator does not and/or cannot take the lead role in ensuring that LHH systems of management are robust. The current Sustainability Plan was developed by the QIE to ensure LHH maintained and sustained the Action Plan after May 2023. The QIE met one-on-one with all 11 executive sponsors to review the Sustainability Plan. In my opinion, the LHH Executive Administrator should have been present for all of the one-on-one meetings, but in a breach of standards was not. 42CFR, §483.75(f) (Governance and leadership).

I declare under penalty of perjury under the laws of the State of California and the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed this _11_th day of January 2024 in Berkeley, California.

Christopher Cherney

Christopher Cherney

[43] *See* Umpierre Decl., Ex. M (RCA #7).

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APPENDIX A. Cherney CV.

CHRISTOPHER CHERNEY

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Consulting

Skilled Review Consulting, LLC **Sep 2017-present**

Principal. Christopher provides consulting services on nursing home and long-term care facility administration and operations. In this role Christopher has for example: (i) consulted on more than 300 cases in 21 states involving the standard of care for skilled nursing facilities; (ii) provided consultation to a mid-sized for-profit nursing home chain organization on risk mitigation; (iii) served as a stipulated Monitor of confidential settlement agreement, and (iv) conducted on-site inspections in advance of regulatory visits.

Centers for Medicare and Medicaid Services **July 2023 – present**

Contracted expert regarding nursing home administration.

California District Attorneys **Sep 2017-present**

- ***Kern County.*** Subject matter expert on skilled nursing facility administration (Sep 2017-present).
- ***Santa Cruz County.*** Subject matter expert on skilled nursing facility administration (Apr 2019-present)
- ***Alameda County.*** Expert consultant to an investigation of a skilled nursing facility (Sep 2020-present).

Court Appointed Monitor **May 2020-present**

- ***Superior Court of Santa Cruz***. Monitors a 144-bed skilled nursing facility. (May 2020-present.)
- ***Superior Court of Los Angeles***. Monitors a 99-bed skilled nursing facility. (Dec 2020-present.)
- ***Superior Court of Kern County.*** Quality Compliance Specialist for 120-bed skilled nursing facility. (March 2022-present.)

California Department of Justice/Attorney General **Dec 2020-present**

- ***Project Guardians Task Force Member.*** Part of an interdisciplinary task force that inspects skilled nursing facilities (Dec 2020-present) in civil and criminal investigations.
- ***Project Leader***. Christopher leads a team of experts evaluating records in seven California skilled nursing facilities (Dec 2021-present).
- ***Expert Consultant, Healthcare Rights and Access Section.*** Christopher was contracted to perform a fitness review of the purchaser of a non-profit continuing care retirement community (Dec 2021-present).

State Attorneys General (not California) **Apr 2022-present**

Subject matter expert on long term care facility administration and nursing staffing.

- ***Confidential State Attorney General*** (April 2022 – present).
- ***Massachusetts Attorney General*** (August 2022 – present).
- ***New York Attorney General*** (August 2022-present).
- ***Tennessee Attorney General*** (contracting underway).

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Healthcare Management/Leadership

Mercy Retirement & Care Center **Jul 2019–Sep 2019**
Interim Health Care Administrator. Oakland, California. Interim Administrator of 59-bed nursing home.

Cambridge Healthcare **Oct 2018–Dec 2018**
Interim Administrator. Professional Post-Acute Center, San Rafael, California.

Kindred Healthcare **Aug 2015–Aug 2017**
Executive Director. Tunnell Transitional Care and Rehabilitation Center, San Francisco, California. Administrator of 180-bed, post-acute facility. Kindred divested its nursing home division August 31, 2017.

Kaiser Permanente Post-Acute Care Center **Feb 2001–Jul 2015**
Assistant Administrator of Kaiser's first freestanding skilled nursing facility, San Leandro, California. As the first employee of this 176-bed facility, Christopher coordinated all aspects of facility start-up. He co-managed, with the Administrator, 328 employees, a $35 million annual budget, and 132 inpatients per day.

Nursing Home Administrator **Dec '96–Sep 2000**
Over a four-year period, Christopher served as the licensed administrator of three skilled nursing facilities:

Rounseville Rehabilitation Center, Oakland, California, 70 beds	*Dec '96–April '99*
Florin Health Care Center, Sacramento, CA, 122 beds (interim)	*May '99–July '99*
Courtyard Care Center, Hayward, California, 74 beds	*Aug '99–Sep 2000*

University Teaching — Adjunct Faculty Member

San Jose State University, Health Science Department **Jan 2013 – present**
- Overall teaching effectiveness (across 1,034 students): 4.8 out of 5.0.
- Courses taught: Health Policy and Law; Policies and Services in Aging; Health Care Organization & Administration; Health Care Economics; Managed Healthcare; Skills of Health Administration/ Mgmt.

San Francisco State University, Social Work Department **Jan 2014 – present**
- Courses taught: Theories of Aging; Aging and the Continuum of Care.

California State University East Bay, Health Sciences Dept **Aug 2019 – present**
- Courses taught: Health Policy Research and Analysis (Section Leader for 24 undergraduate students)

Education

San Francisco State University, M.A. **May 2012**
Masters in Gerontology, with an emphasis on the social policy of aging. GPA=4.0.

Harvard University, B.A. **June 1988**
Major, Biochemical Sciences. Minor, South Asian languages and culture. Last two years' GPA 3.51. Rowed varsity lightweight crew, third boat.

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Voluntary Service

Berkeley High School Development Group **2017-2020**
Served on committee of 25 persons to support the mission of Berkeley High School.

California Physicians Alliance (CaPA) **2011-2017**
In May 2014, Christopher was elected to the Board of Directors.

School of the Americas Watch, East Bay **2003-2017**
In 2010, Christopher spearheaded fundraising for a meeting in Venezuela of activists from 19 countries.

Richmond College Prep School, Richmond, Calif. **2007-2013**
Member, Development Committee, for this charter school. See: www.rcpschools.org

National Multiple Sclerosis Society **1998 – 2005**
Christopher co-developed the nursing home visitor program.

Nursing home ombudsman **Aug 1995–2008**

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Awards

- 2015 recipient of PNHP-California Tireless Activist Award.
- 2013 recipient of Distinguished Alumni Award, San Francisco State University.
- 2012 recipient of the San Francisco State University Graduate Award for Distinguished Achievement.
- 2012 recipient of the San Francisco State University Long-Term Care Administration Scholarship.
- 2008 recipient of the First Annual Founder's Award, Richmond Children's Foundation.

Publications – Health Care

Book chapters

- *Long-Term Care Administration and Management: Effective Practices and Quality Programs in Elder Care*, Springer Publishing, February 2014.
  - Chapter 6, "The Skilled Nursing Facility," with Edwin Cabigao, RN, PhD.
  - Chapter 12, "Litigation & Arbitration in Long-Term Care," with Denise Platt, RN, JD.

Article

- *Reforming For-Profit Nursing Homes*, Street Spirit, May 2006, http://www.thestreetspirit.org/Mayreal2006/nursing.htm

Other

- Healthcare Impact Statement, August 2, 2022: https://oag.ca.gov/system/files/media/cnmh-impact-report.pdf
- Book Review (co-authored with Darlene Yee): "Nursing Home Federal Requirements," *Educational Gerontology*, 2015.
- Contributor: *20 Common Nursing Home Problems and the Laws to Resolve Them*, by Eric Carlson, 2006.
- Contributor: *Nursing Home Staffing*, 2003, National Citizen's Coalition for Nursing Home Reform

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Conference Presentations

Symposia Keynote Addresses

- *Psychoactive Drug Usage in California Nursing Homes*. Oxnard, March 24, 2011; Sacramento, October 26, 2011; South San Francisco, October 27, 2011; San Diego, June 4, 2012; Los Angeles, June 5, 2012.

Conference Presentations/Webinars

- Webinar, May 2020, *Developing a Testifying Witness Practice*, Forensic Expert Witness Association.
- Webinar, *Expert Witnesses in Elder Abuse Cases*, April 2020, California District Attorneys Association.
- 2019 National Association of Women Judges Annual Conference. Panelist: "Protecting our Elders - Problems and Solutions." October 16, 2019, Los Angeles.
- Webinar, *Medical Records for Ombudsmen*, in coordination with State Long Term Care Ombudsman, September 19, 2018.
- 2013 Annual Meeting of Physicians for a National Health Program, Boston. *Skilled Nursing Facilities and Single Payer Health Care.*
- California Advocates for Nursing Home Reform (CANHR) Elder Law Conference (2003-2020).
  - 2022: *How SNFs Can Manage Litigation Risk*. Monterey.
  - 2020: *SNF Discovery COVID-19*, via Zoom.
  - 2019: (1) *Patient Driven Payment Model*; (2) *Phase 2 Requirements of Participation*. Monterey.
  - 2018: (1) *Deposition Strategies*; (2) *Understanding EBITDA*; (3) *Mock Trial*. Monterey.
  - 2017: (1) *Regulatory Update;* (2) *Case Vetting*. Monterey.
  - 2016: *Skilled Nursing Facility Defendant Perspectives*. Monterey.
  - 2015: *Skilled Nursing Facility Operations Update*. Monterey.
  - 2014: *The Nursing Process* and *Update on Antipsychotic Medication Administration in SNFs*. Monterey
  - 2013: *Aids to Discovery*. Monterey.
  - 2012: *Animating Skilled Nursing Facility Data*. Monterey.
  - 2011: (1) *Operational Control of the SNF*. (2) *Resident Rights & Psychoactive Drugs*. Monterey.
  - 2010: Expert witness for the plaintiff and the defense, all-day mock trial. Monterey.
  - 2009: *Skilled Nursing Facility Resident Changes of Condition*. Long Beach.
  - 2008: (1) *Psychotropic Drug Usage in Nursing Homes* & (2) *Documentation Strategies*. Monterey.
  - 2007: *Nursing Home Administrator Analysis of Case Referrals*. Berkeley.
  - 2006: *The Nursing Process as Context for Nursing Home Operations*. Manhattan Beach.
  - 2005: *The Nursing Home Provider's Perspective on Finance, Risk, Staffing*. Monterey.
  - 2004: *Expert Witness Panelist*. Pasadena.
  - 2003: *Nursing Home Administrator's Perspective*. Berkeley.
- 2007 Aging Services of California Annual Conference: *Treatment of Obese Residents in Skilled Nursing Facilities*. Sacramento, California.
- 2006 Annual Meeting, National Citizen's Coalition for Nursing Home Reform (NCCNHR): *What Is Happening in the Nursing Home Industry,* Washington, DC.

Radio

- "Use of Psychoactive Drugs in Nursing Homes," May 14, 2011, NewsTalk Radio KVTA, AM1520, Ventura, California. (Start at 19 mins and 40 seconds.) →http://greymatters.podomatic.com

- "Senior Issues and the Law," July 22, 2012, KFBK NewsTalk Radio, AM1530, Sacramento, California.

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APPENDIX B. Christopher Cherney Qualifications to Provide Opinions as to the Standard of Care Applicable to Skilled Nursing Facilities.

California Regulations: Administrators Are Responsible for a Facility's Provision of Care and Services

⇒ California regulations are clear: nursing home administrators such as Mr. Cherney must be active and engaged leaders of the interdisciplinary team, and responsible for implementing policies and procedures related to the provision of care and services to skilled nursing facility residents. Specifically, Health & Safety Code §1416.68(a) establishes the responsibilities of a nursing home administrator:

> It is the responsibility of the nursing home administrator as the managing officer of the facility to plan, organize, direct, and control the day-to-day functions of a facility and to maintain the facility's compliance with applicable laws, rules, and regulations.

Consistent with this regulatory requirement, a nursing home administrator supervises all department managers, *including the Director of Nursing*.

⇒ 22 C.C.R. §72513 states that that "Each skilled nursing facility shall employ or otherwise provide an administrator to carry out the policies of the licensee." (*See also* 22 C.C.R. §72501.) 22 C.C.R. §72523 further requires "written patient care policies and procedures." 22 C.C.R. §72513 makes the nursing home administrator or his/her designee responsible for screening patients for admission "to ensure that the facility admits only those patients for whom it can provide adequate care." Per 22 C.C.R. §72525, the administrator must also be a member of the patient care policy committee and the pharmaceutical services committee. The regulations are unambiguous: the administrator plays a leading role in ensuring that staff carry out policies and procedures related to the provision of care.

Federal Regulations: The Administrator is Responsible for Managing the Facility

Federal regulations also place responsibility on the administrator of a skilled nursing facility for managing all disciplines that must work together in order to provide care to residents. According to 42 C.F.R §483.70, a skilled nursing facility's governing body must appoint the administrator, who is licensed by the State, is responsible for management of the facility, and reports to and is accountable to the governing body.

National Association of Long-Term Care Administrator Boards: Administrators Ensure Plans of Care Are Implemented

The National Association of Long-Term Care Administrator Boards, which credentials nursing home administrators, including Mr. Cherney and Defendants' own administrators, has identified a list of 74 specific "Domains of Practice" that make up an Administrator's practice. These Domains include clinical duties, including ensuring "plans of care are evidence-based, established, implemented, updated and monitored…" and ensuring the "planning, development, implementation/execution, monitoring and evaluation of" services and care offered by various departments (See: Domains). The Domains of Practice make clear that a nursing home administrator plays a vital operational role in the provision of care and services by the interdisciplinary team of care providers, including licensed nurses, physicians, pharmacists, therapists, dieticians, etc.

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The LHH Executive Administrator (EA) Job Description [job description] Confirms: The Executive Administrator Ensures the Provision of Quality Patient Care

The LHH Executive Administrator job description outlines the vital role that a facility administrator plays in the provision of quality care and services in a skilled nursing facility. LHH's job description makes clear that the LHH Administrator directs the provision of resident care and drives the quality of care. Specifically, LHH's job description states the following (emphasis added):

⇒ "Commitment to providing exceptional care and services"

⇒ "Ensures delivery of compassionate quality care and services…"

Cherney Trial and Arbitration Testimony Has Included Clinical Issues

⇒ *Cavin vs. Windsor Anaheim, et. al (September 2022, California).* Mr. Cherney was qualified by Arbitrator Jay Horton to testify regarding pressure ulcer development and prevention, avoidable vs. unavoidable pressure ulcers, nursing staffing, care planning, turning and repositioning, oral intake, hygiene care, nutritional status, care refusals, and Minimum Data Set assessments.

⇒ *Ledesma et al v. Mariner Health Central, Inc., et al (2021, California).* In July 2021, Mr. Cherney was qualified by Judge Evelio M. Grillo to testify in the six-month long trial of *Ledesma*, *et al.* v. *Mariner Health Central, Inc., et al.,* where he testified regarding skilled nursing facility standard of care on behalf of ten individual residents. Specifically, he testified about the management of clinical issues including pressure ulcers, weight loss, hygiene, tube feeding, falls, physician orders, and nursing staffing, among other issues related to the care and services provided by a skilled nursing facility. Mr. Cherney was the Plaintiffs' principal expert regarding the standard of care in skilled nursing facilities and subsequent to his testimony on corporate control, clinical issues, administrative issues and their interplay, the jury awarded $13.5 million ($4.6 million in compensatory damages and $8.9 million in punitive damages).

⇒ *Tovar v. Mariner (2018, California).* Mr. Cherney was qualified to testify as a standard of care expert regarding clinical issues in *Tovar v. Mariner,* a 2019 two-week long JAMS Arbitration as Plaintiffs' counsel's expert, in front of Judge Richard Silver, (Ret.) who sat on the bench in Monterey County for 25 years. Primary clinical issues included falls prevention, care planning, and nursing staffing. Judge Silver issued a confidential award to the plaintiff.

⇒ *Nguyen vs. Windsor Fullerton (2018, California).* In this arbitration, in which plaintiffs received a confidential award, Mr. Cherney provided expert testimony on accidents, nursing staffing, and clinical competency.

⇒ *Lewis v. Brown Nursing Home (2019, Alabama).* In this arbitration, in which plaintiffs received a confidential award, Mr. Cherney provided expert testimony regarding falls prevention, nursing assessments, care plans, nursing staffing, and policies and procedures.

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Cherney as Court Appointed Monitor Has Evaluated Numerous Clinical Issues

Since May of 2020, Mr. Cherney has served as a Court-appointed Monitor of three skilled nursing facilities in California. In this role, he evaluates the facilities' compliance with their policies/procedures and standards regarding the following clinical issues (among other issues): pressure ulcer development, weight loss, accidents/incidents, medication administration, medication storage, physician orders, clinical documentation, nursing staff competencies, infection control, and nursing staffing sufficiency. In his role as a Court-appointed Monitor since May 2020 in Santa Cruz continuing today, since December 2020 in Los Angeles continuing today, and since March 2020 in Bakersfield continuing today, Mr. Cherney has been empowered by the courts in each jurisdiction to ensure each facility complies with professional standards including those standards directly related to the provision of care to facility residents from disciplines including nursing, physicians, pharmacists, registered dieticians, and rehabilitation staff. He reviews facilities' compliance with medication administration and treatment administration standards and policies and procedures, and routinely reviews interdisciplinary care documentation. In Santa Cruz, the Court has ordered 24/7/365 access by Mr. Cherney to the facility's electronic medical record, and Mr. Cherney reviews clinical records as often as is necessary to fulfill his duties as set forth in that facility's Preliminary Injunction.

Cherney's Work for the California Department of Justice and California District Attorneys Includes Assessment and Evaluation of Clinical Issues

⇒ *California Department of Justice/Attorney General.* Mr. Cherney is contracted with the California Department of Justice/Attorney General. He is working on four current projects:

1. ***Investigation of seven skilled nursing facilities***. Mr. Cherney leads a team of skilled nursing facility professionals who are evaluating the regulatory and clinical compliance of seven skilled nursing facilities. Clinical aspects of care provision include but are not limited to: weight loss, pressure ulcers, falls with and without injury, pain management, and Medicare quality measures.
2. ***Review of asset purchase***. Mr. Cherney was contracted in 2021 to aid the Attorney General in analyzing the impacts on skilled nursing care quality and access to long term care related to a proposed purchase of a non-profit skilled nursing facility.
3. ***Operation Guardians***. Mr. Cherney is a member of an interdisciplinary team that evaluates the regulatory compliance of long-term care facilities statewide.
4. ***COVID investigation.*** Mr. Cherney is a subject matter expert in a criminal case involving a long-term care facility's response to the COVID pandemic.

⇒ *Alameda County*. Mr. Cherney is contracted with Alameda County as a subject matter expert on skilled nursing facility administration. He is currently involved in a criminal case regarding, in part, nursing staffing sufficiency at a Northern California skilled nursing facility in the COVID era.

⇒ *Kern County*. For several years, Mr. Cherney has been contracted with Kern County as a subject matter expert who advises on issues related to long term care administration and service quality.

⇒ *Santa Cruz County*. For several years, Mr. Cherney has been contracted with Santa Cruz County as a subject matter expert who advises on issues related to long term care administration and service quality.

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Appendix C. Documents Reviewed.

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Appendix D. Supplemental Tables and Figures.

Table 13. June-July 2022 Mock Survey Findings Compared to December 1, 2022, Root Cause Analysis Findings, Specific to Mock Survey Findings.

Repeat finding. No repeat finding.

Mock Survey Finding Area	Corrective Action [Depo Ex. 23[44] page number]	Finding on 12/01/22 Root Cause Analysis[45] [RCA page]
Infection Control	LHH is reviewing the entire Infection Prevention and Control Program [6-7]	The Infection Prevention and Control Program does not follow regulatory requirements [CCSF-TJOHNSON_031903]
Accident Hazards	Task charge nurses with ensuring that balcony doors are locked [7].	During a power outage, secured area doors were not supervised [CCSF-TJOHNSON_031937]
Food Safety	Ensure food is properly stored [7]	No further findings.
Essential Equipment, Safe Operating Condition	Ensure medical equipment preventive maintenance is completed on time. [7]	No further findings.
Storage of Drugs	Ensure expired medications removed. Ensure medication carts are locked. [7-8]	Staff fail to check for expired medications [CCSF-TJOHNSON_031916]. Licensed nurses are not securing medication carts [CCSF-TJOHNSON_031913].
Fire/Life Safety	Ensure doors closed and latched per code. [8]	No further findings.
Administration	Exam rooms have been converted to offices without required CDPH approval. [8]	No further findings.
Emergency Preparedness	A staff member could not explain emergency evacuation procedures. [9]	Timely evacuation of the administration building did not occur [CCSF-TJOHNSON_031937].
Physical Environment	Showers dirty. Staff no ID badge. [9]	No further findings.
Freedom from Abuse, Neglect, Exploitation	Call lights were canceled without staff responding. [9]	Lack of timely call light response [CCSF-TJOHNSON_031920].
Radiology	Promptly process dosimetry badges. [9-10]	No further findings.
Pest Control Program	Remove pest traps from clean storage areas. [10]	No further findings.
Antibiotic Stewardship	Reinitiate Antimicrobial Stewardship meetings. [10]	No further findings.
Self-administration of drugs	Inconsistent nursing documentation. [10]	The completion of a self-administration assessment was "not consistent with" regulations [CCSF-TJOHNSON_031916]
Recertification	24/7 enhanced rounding. [12]	"LHH leadership does not

[44] *See* Umpierre Decl., Ex. H (Depo Ex. 23).

[45] *See* Umpierre Decl., Ex. I (Depo Ex. 24).

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Strategies		consistently conduct rounds in the facility" [CCSF-TJOHNSON_031917] "Charge nurse rounds are not occurring as intended" [CCSF-TJOHNSON_031916].

Table 14. Additional Costs Linked to LHH Breaches, 2019-2023.

Source: http://www.stoplhhdownsize.com/LHH_Consultant_and_Lawsuit_Costs_Soar_Part-2_23-07-31.pdf

Date	Additional cost	Amount
2019-2023	Lost MediCal revenue	$22,300,000
FY2023-2024	Addition of 14 full time equivalents (FTEs) related to LHH's recertification	$2,500,547
Unknown	Two additional nursing home administrator positions	$682,518
2023	Restraint Reduction Initiative related to LHH application for CMS recertification	$692,449
	TOTAL	**$26,175,514**

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Table 15. 12/01/22 Root Cause Analysis by Quality Improvement Expert: First 4 Problem Areas Had 20 Root Causes. Especially glaring breach.

Problem Area	# of Root Causes	Root Causes [Root Cause Analysis page numbers]	Other Observations [Root Cause Analysis page numbers]
QAPI program is ineffective	5	LHH's QAPI is specific to an acute hospital setting, not a SNF setting. [CCSF-TJOHNSON_031898]	After 2 months, staff do not understand data on standardized huddle boards. [CCSF-TJOHNSON_031901]
		Focused on data reporting, not action to ensure compliance. [CCSF-TJOHNSON_031898]	Data sample sizes do not match the size of the facility. [CCSF-TJOHNSON_031902]
		Direct care staff and medical staff are not active in QAPI. [CCSF-TJOHNSON_031899]	Decisions are made by upper managers with slow or no trickle down to direct care levels. [CCSF-TJOHNSON_031902]
		QAPI policies not current with professional standards. [CCSF-TJOHNSON_031899]	Leadership has a limited presence on the units. [CCSF-TJOHNSON_031902]
		Staff aren't properly trained on QAPI process. 4 new Quality Management hires have no SNF or helathcare quality experience. QM staffing is unstable. [CCSF-TJOHNSON_031901-02]	Leadership does not communicate at all regarding urgent, care-related issues. [CCSF-TJOHNSON_031902]
Infection Prevention and Control	7	Lack of nursing involvement. Nurses don't know if residents have infections. [CCSF-TJOHNSON_031903]	The facility is using inappropriate disinfecting solutions/wipes for cleaning some equipment. [CCSF-TJOHNSON_031905]
		The infection prevention and control risk assessment was designed for a hospital, and is not specific to SNF requirements. [CCSF-TJOHNSON_031906]	Infection control policies were not reviewed annually. [CCSF-TJOHNSON_031906]
		Non-compliant policies and procedures. [CCSF-TJOHNSON_031904]	A common practice for LHH is to hire individuals without nursing home background who do not know SNF regulations. [CCSF-TJOHNSON_031906]
		Inadequate electronic health record (EHR), not fully configured for the SNF setting.	The facility does not use strong adult learning principles in training and educating on infection prevention and control.
		Only 1 IPC specialist to 350 residents, instead of 1:100. The facility should employ no less than 6 Infection Control professionals but employs only 2. [CCSF-TJOHNSON_031907]	The facility does not have use progressive disciplinary action for non-compliant behaviors. [CCSF-TJOHNSON_031907]
		Insufficient hand hygiene and PPE audits. [CCSF-TJOHNSON_031904]	The EHR is not leveraged to ease infection prevention and control burden. [CCSF-TJOHNSON_031907]
		Lack of effective IPC education of staff. [CCSF-TJOHNSON_031905]	Nursing staff communication at shift change is inconsistent and not standardized. Often, CNAs are excluded. [CCSF-TJOHNSON_031907]
Behavioral Health and Substance Abuse	4	LHH staff are not well trained and do not have the expertise to treat and manage resident with complex behavioral needs. [CCSF-TJOHNSON_031909]	The needs of residents with complex behavioral needs are not accurately reflected in the Facility Assessment. [CCSF-TJOHNSON_031911]
		Care plans are not updated due to invalid (and surmountable) staff concerns regarding confidentiality. [CCSF-TJOHNSON_031909-10]	There is a lack of safety in the environment related to highly suspected or witnessed illicit substances on a resident's person. [CCSF-TJOHNSON_031911]
		Understaffed Behavioral Emergency Response Team (BERT). Only two RNs were hired for this role, which is inadequate for the size, scope and complexity of LHH's population of residents. [CCSF-TJOHNSON_031912]	
		Security staff not trained on LHH policies and procedures. This increases the likelihood of illicit substances entering the facility. [CCSF-TJOHNSON_031911]	
Medication Management and Administration	4	Medication self administration policies are not routinely followed. [CCSF-TJOHNSON_031913]	There are unsecured herbal supplements at the bedside without physician orders. [CCSF-TJOHNSON_031915]
		Non-compliance with safe medication management practices. [CCSF-TJOHNSON_031913-14]	Nurses do not safely store or dispose of medications. They do not check expiration dates or secure medication carts. [CCSF-TJOHNSON_031915]
		Lack of interdisciplinary team collaboration. [CCSF-TJOHNSON_031914]	There is inconsistent implementation of drug regimen reviews (required by SNF regulations). [CCSF-TJOHNSON_031914]
		Lack of herbal supplement safety verification process. [CCSF-TJOHNSON_031914]	The facility does not develop policies that crosswalk directly to regulations. [CCSF-TJOHNSON_031915]
			LHH has a poor process specific to the sequencing of policy and procedure changes and communication of those changes to all staff. There is also a delay in the policy approval process often taking 3-4 months due to the many committee approvals required. [CCSF-TJOHNSON_031915]
			LHH does not follow up on educational requests for staff who have been observed showing deviations in their medication administration practice. [CCSF-TJOHNSON_031915]

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Table 16. 12/01/22 Root Cause Analysis by Quality Improvement Expert: Second 4 Problem Areas Had 27 Root Causes. Especially glaring breach.

Problem Area	# of Root Causes	Root Causes [Root Cause Analysis page numbers]	Other Observations [Root Cause Analysis page numbers]
Resident Rights and Freedom from Harm	8	Lack of consistent leadership rounding. [CCSF-TJOHNSON_031917]	Physical restraints often did not include documented consent. [CCSF-TJOHNSON_031918]
		LHH does not have a strong, proactive process to identify early abuse triggers between residents. This increases the likelihood residents may experience harm. [CCSF-TJOHNSON_031917-18]	Grievance forms are not readily accessible to residents. [CCSF-TJOHNSON_031918]
		Physical restraint practices are not compliant with regulations. [CCSF-TJOHNSON_031918]	Staff do not knock on doors and ask for permission to enter rooms. [CCSF-TJOHNSON_031919]
		Low staff awareness of the grievance process. [CCSF-TJOHNSON_031918]	Staff stand while assisting residents with meals. [CCSF-TJOHNSON_031919]
		LHH staff have not fully embraced resident-centered practices such as consistent assignments, hourly rounding, or no pass zones. [CCSF-TJOHNSON_031918]	The grievance process it not being followed. Grievance data are just numbers. [CCSF-TJOHNSON_031919-20]
		There is no progressive disciplinary process for non-compliant staff behaviors affected resident rights and dignity. [CCSF-TJOHNSON_031919]	Lack of timely call light response. [CCSF-TJOHNSON_031920]
		Ineffective Resident Council meetings. [CCSF-TJOHNSON_031919]	LHH does not regularly screen residents for declines in range of motion, balance, and activities of daily living. [CCSF-TJOHNSON_031920]
		Lack of formalized restorative nursing program. [23]	Nursing staff are not appropriately trained on how to conduct a thorough and comprehensive abuse and neglect investigation (e.g., not interviewing enough residents or staff). The last formal training occurred in 2016. [CCSF-TJOHNSON_031921]
			When allegations of abuse occur, staff are not separating residents to prevent future altercations and abuse. [CCSF-TJOHNSON_031921]
Comprehensive Care Plans and Quality of Care	7	The interdisciplinary team does not have the knowledge to develop SNF care plans. [CCSF-TJOHNSON_031924]	CNAs do not have a Kardex system. [CCSF-TJOHNSON_031925]
		The MDS department lacks leadership oversight and accountability. [CCSF-TJOHNSON_031924]	LHH does not update care plans. [CCSF-TJOHNSON_031926]
		LHH does not use consistent nursing assignments. [CCSF-TJOHNSON_031924-25]	Care plans were not quality reviewed. [CCSF-TJOHNSON_031926]
		Nurse leaders have inconsistent and ineffective participation in the care plan process. [CCSF-TJOHNSON_031925]	MDS Department is a considerable distance from the nursing units, which limits direct contact with residents. [CCSF-TJOHNSON_031927]
		The EHR is not optimized for the SNF setting. [CCSF-TJOHNSON_031925]	There are no competencies for nursing staff related to pain assessments. [CCSF-TJOHNSON_031927]
		Non-licensed caregivers have limited access to care plans. [CCSF-TJOHNSON_031925]	
		Staff do not have the knowledge to care plan the unique needs of residents with behaviors and substance use disorders. [CCSF-TJOHNSON_031926]	
Competent Staff, Training, and Quality of Care	6	Lack of leadership with SNF experience. [CCSF-TJOHNSON_031930]	There is low staff compliance with completing annual competencies. [CCSF-TJOHNSON_031932]
		LHH leaders and middle management do not consistently perform routine care rounds. [CCSF-TJOHNSON_031930-31]	When LHH staff use "read and sign" it is in a rushed mode often requiring same-day, on-demand signature without the ability to ask questions for comprehension. [CCSF-TJOHNSON_031932]
		There are no consequences for employees and medical staff not completing mandatory education. [CCSF-TJOHNSON_031931]	Security staff don't know how to screen visitors. [CCSF-TJOHNSON_031933]
		The Department of Education and Training is diverted into many HR responsibilities. [CCSF-TJOHNSON_031931]	Staff violate the Code of Conduct. [CCSF-TJOHNSON_031933]
		Staff training relies heavily on read and sign. The electornic system is English only without additional adult learning techniques for a multi-lingual staff that encounter many barriers to computer accessbility. [CCSF-TJOHNSON_031931-32]	Some staff do not have an LHH email which is required for log-in to the electronic learning module. [CCSF-TJOHNSON_031934]
		LHH leaders are not members of SNF associations. [CCSF-TJOHNSON_031932]	
Emergency Preparedness Program (EPP)	6	Lack of alternative communication methods during emergencies. No radios or mass text messaging. [CCSF-TJOHNSON_031935]	There are no maps for emergency shut offs. [CCSF-TJOHNSON_031938]
		Leadership has not made emergency preparedness a priority, which leads to a lack of a sense of urgency or indifference by staff. [CCSF-TJOHNSON_031936-37]	The Emergency Preparedness Plan binder was unable to be located since May 2022. [CCSF-TJOHNSON_031938]
		Hazard vulnerability exercises are not routintely conducted. [CCSF-TJOHNSON_031937]	LHH has an ineffective process for conducting drills. [CCSF-TJOHNSON_031938]
		EPP resources are not readily accessible to staff. This increases the likelihood staff do not respond appropriately. [CCSF-TJOHNSON_031937]	LHH staff lack urgency when responding to actual emergency activations. [CCSF-TJOHNSON_031938]
		EP training is completed online and is available only in English, resulting in limited comprehension. [CCSF-TJOHNSON_031937]	The Hospital Incident Command System is only initiated at the leadership level. [CCSF-TJOHNSON_031939]
		Residents and visitors are unaware of the emergency plan. [CCSF-TJOHNSON_031938]	LHH lacks internal and external collaboration for EP. [CCSF-TJOHNSON_031939]

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Table 17. Quality Improvement Expert (QIE) Findings of Continuing Noncompliance, Jan – Feb 2023.

Date	Key Findings of Continuing Noncompliance [Monitoring Report page numbers]
Jan 2023: QIE Monitoring Report 1 [Umpierre Decl., Ex. O]	Action Plan. 31 of 126 deliverables (25%) needed to be revised and required coaching by the QIE expert to meet the intent of the Action Plan. Revisions were required for "general inattention to details." Deliverables did not undergo internal quality checks by LHH executives. Some LHH staff did not get Action Plan communications. LHH planned to conduct infection control rounds only once per week and the QIE expert suggested a higher frequency. The Behavioral Emergency Response Team (BERT) had only 3 members. LHH needs to more quickly correct care plans. [CCSF-TJOHNSON_031690-91; CCSF-TJOHNSON_031700-03]
	01/11/23: The LHH menu system was not routinely monitored to ensure residents receive ordered diets. [CCSF-TJOHNSON_031687]
	01/11/23: LHH lacked a systemwide approach to monitor weight variance and wound status and to assess the effectiveness of interventions. [CCSF-TJOHNSON_031687]
	01/11/23: LHH lacked consistency in issuing required notices when a resident was transferred emergently. [CCSF-TJOHNSON_031687]
	01/12/23: The wound care program did not continue to function after the retirement of a wound care nurse. [CCSF-TJOHNSON_031687]
	01/12/23: Staff lacked knowledge of SNF fire & life safety regulations. [CCSF-TJOHNSON_031688]
	01/12/23: Staff poorly implemented interventions after abuse allegations. [CCSF-TJOHNSON_031688]
	01/13/23: QIE expert identified that an LHH staff member worked ~6 months on a 47 resident unit with a tuberculosis conversion without appropriate notification. 6 residents had a prior documented history of positive tuberculin skin test. [CCSF-TJOHNSON_031692]
	01/23/23: Only 25 of 34 nurse leaders and managers attended the Nursing Executive Meeting. [CCSF-TJOHNSON_031683]
	01/24/23: Grievance notices in South 2 and South 3 Units were incorrect. [CCSF-TJOHNSON_031683]
	01/26/23: Mezzanine South staff huddle did not review the huddle board or data. [5-6]
	01/26/23: Care Planning Performance Improvement Meeting. Some staff were reluctant to have the subject matter expert consultant involved in care plan meetings. [CCSF-TJOHNSON_031684-85]
Feb 2023: QIE Monitoring Report 2 [Umpierre Decl., Ex. P]	Action Plan. 48 of 133 deliverables (36%) needed revision by QIE. Continuing "general inattention to details." 72% of pressure ulcers were classified as Stage 3 or higher and there were inconsistencies in wound measurement and documentation. [CCSF-TJOHNSON_031726-28; CCSF-TJOHNSON_031738-42]
	02/06/23: Poor performance notifying physicians of abnormal lab results and conducting pre- and post-pain assessments when pain medication is administered. [CCSF-TJOHNSON_031711]
	02/07/23: A family member reported that a fall hadn't been previously reported to him/her. [CCSF-TJOHNSON_031712]
	02/08/23: Spanish language and North 1, 2, 3, & 4 grievances notices were incorrect, despite Jan 2023 finding re same issue. [CCSF-TJOHNSON_031712]
	02/16/23: The Acting Chief Medical Officer reported that not all Action Plan information filters down to the staff level, where the work needs to be operationalized. [CCSF-TJOHNSON_031721]
	02/20/23: Huddle boards on South 5 and South 6 had not been updated since 09/06/22, 5-plus months previously. [CCSF-TJOHNSON_031715]
	02/20/23: 8 of 9 staff failed to know what to do when a code red is announced. [CCSF-TJOHNSON_031722]
	02/21/23: There was a lack of initiative to address long-standing poor-performing metrics (including reporting abnormal vital signs to physicians) and a failure to improve the feedback loop regarding the Performance Improvement and Patient Safety (PIPS) Meeting (LHH's name for QAPI). The QIE observed no follow-up for two weeks after the PIPS meeting. [CCSF-TJOHNSON_031717]
	02/23/23: During a code red drill, some staff members did not demonstrate urgency to check and close resident doors. [CCSF-TJOHNSON_031718]
	02/24/23: A South 4 staff huddle lasted less than 5 minutes. [CCSF-TJOHNSON_031719]
Mar 2023: QIE Monitoring Report 3 [Umpierre Decl., Ex. Q]	Action Plan. 38 of 77 deliverables (48%) needed to be revised by the QIE. Key QIE concerns: (i) a pattern of resident elopement without escalating to leadership; (ii) care plans were not compliant; (iii) staff were not completing care plan audits as expected; (iv) non-compliant use of physical restraints; (v) LHH leadership "thought" elements of compliance for physical restraints were in place; (vi) 1:1 sitters were not provided to residents who needed them; (vii) LHH leaders were unaware of gaps in 1:1 sitters. QIE concerns had to be escalated for immediate interventions. [CCSF-TJOHNSON_031761-63; CCSF-TJOHNSON_031774-79]

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Table 18. Quality Improvement Expert (QIE) Findings of Continuing Noncompliance, Jan – Feb 2023.

Date	Key Findings of Continuing Noncompliance [Monitoring Report page numbers]
	03/03/23: The QIE had to stress to executive leaders the importance of regularly rounding units and attending unit-based QAPI meetings to support staff and ensure accountability. [OCSF-TJOHNSON_031750]
	03/08/23: Grievance boxes were labeled "Suggestions." [OCSF-TJOHNSON_031750]
	03/08/23: Nursing Unit North 5 huddle did not use the huddle board. [OCSF-TJOHNSON_031751]
	03/15/23: The start of at least weekly executive rounding on 13 nursing units. [OCSF-TJOHNSON_031757]
	03/20/23: The 2023 Facility Assessment incorporated old, inaccurate data. [OCSF-TJOHNSON_031757]
	03/20/23: Some units were not obtaining weekly weights as ordered. [OCSF-TJOHNSON_031755]
	03/21/23: North Tower nursing unit grievance boxes were labeled only in English. [OCSF-TJOHNSON_031752]
	03/21/23: Huddles for North Tower nursing units had inconsistent information and a lack of standardization despite an established huddle board process. [OCSF-TJOHNSON_031752]
	03/23/23: Read and sign education packets were in break rooms instead of interactive and in-person training, despite 27 unique education and training milestones due by April 30, 2023. [OCSF-TJOHNSON_031755-56]
Apr 2023: QIE Monitoring Report 4 [Umpierre Decl., Ex. R]	**Action Plan.** 30 of 122 Action Plan deliverables (24%) needed to be revised by the QIE. Key concerns escalated by the QIE included: (i) residents inappropriately were allowed to go out on pass and LHH did not recognize risk or regulatory vulnerability these findings presented; (ii) staff were non-responsive to a fire alarm and generally confused; (iii) LHH did not have a designated smoke area for COVID-positive residents; (iv) the slow pace of completing resident care plan reviews. [OCSF-TJOHNSON_031801-02; OCSF-TJOHNSON_031813-21]
	04/04/23: Grievance boxes still labeled only in English. [OCSF-TJOHNSON_031790]
	04/05/23: North 2 Nursing Unit infection prevention champion had not yet received training as a champion and did not attend the 04/05/21 QAPI Infection Control meeting. [OCSF-TJOHNSON_031790-91]
	04/06/23: Lack of critical thinking at the bedside resulting in a delayed or inappropriate response. [OCSF-TJOHNSON_031795]
	04/18/23: There was confusion about issuing bed hold notices and notices of transfer/discharge because there were two separate policies. [OCSF-TJOHNSON_031798]
	04/18/23: The electronic health record is not user friendly to help nurses record wound treatments. Some staff don't know how to navigate HER to appropriately document daily care in the detail required. [OCSF-TJOHNSON_031798]
May 2023: QIE Monitoring Report 5 [Umpierre Decl., Ex. S]	**Action Plan.** 13 of 42 deliverables (31%) needed to be revised by the QIE. QIE concerns included a negative trend for several abuse-related activities. [OCSF-TJOHNSON_031837; OCSF-TJOHNSON_031845-53]
	05/17/23: 6 stairwell door alarms were not reactivated after an emergency generator test. [OCSF-TJOHNSON_031831]
	05/17/23: Two of 3 Aides were standing up while feeding residents. [OCSF-TJOHNSON_031832]
	05/23/23 - 05/26/23: LHH did not have a policy/procedure for suicidal ideation/response. [OCSF-TJOHNSON_031834]
Jun 2023: QIE Monitoring Report 6 [Umpierre Decl, Ex. T]	06/14/23: QIE referenced LHH's "continued areas of struggle" including: facility-reported incidents, effective daily monitoring, clinical areas: falls, physical restraints, elopements, changes in condition, behavioral health. [OCSF-TJOHNSON_031869; OCSF-TJOHNSON_031886-90]
	06/14/23: "Culture change remans a significant challenge." [OCSF-TJOHNSON_031869]
	06/23/23: The CMS monitoring survey report for June 5 and 9 was 144 pages with 20 F-tag deficiencies. [OCSF-TJOHNSON_031871]

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Figure 4. Turnover, LHH Leaders, June 2019 – July 2023.

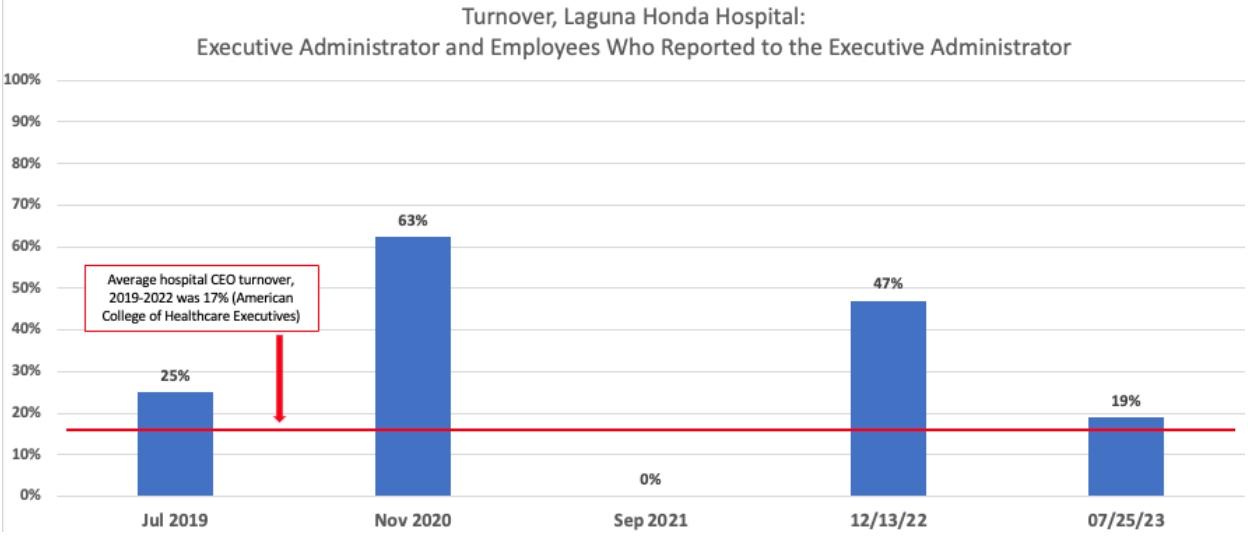
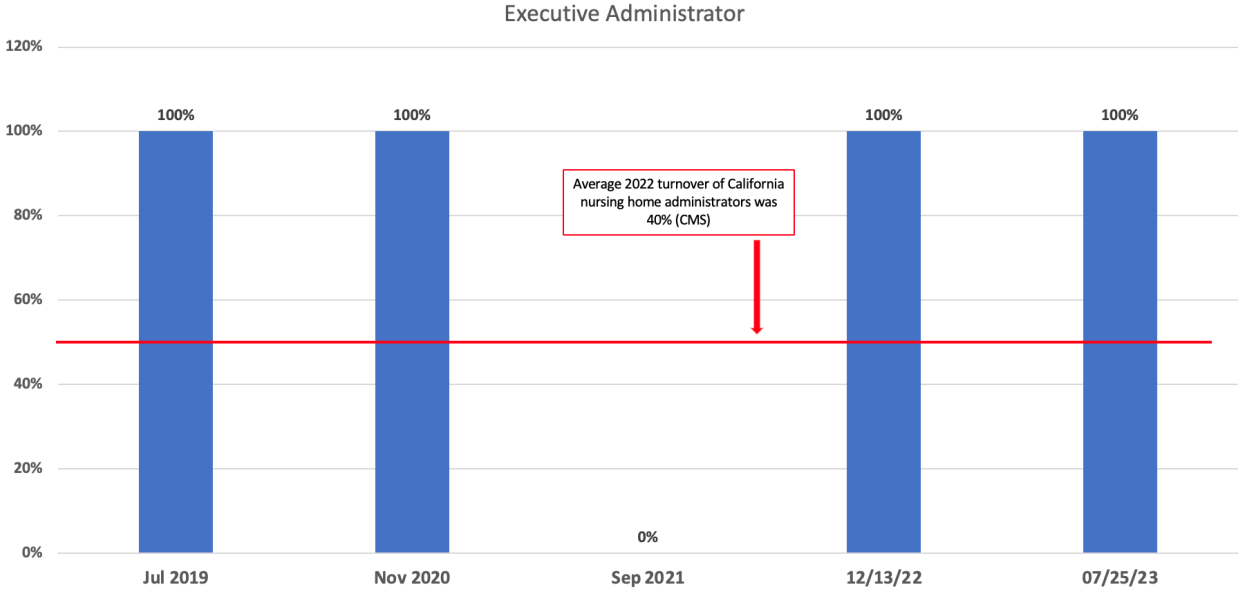


Figure 5. LHH Executive Administrator Turnover, 2019-2023.

Source for 2022 CA NHA turnover: https://nursinghome411.org/data/staffing/staffing-q3-2022/



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Appendix E. Contextualizing LHH's Rates of Deficiencies

Regarding Recertification Survey Resident Sample Sizes

Between 2019-2023, LHH's rate of total deficiencies per 100 licensed beds was less than State averages (Figure 6). However, per Federal rules, a disproportionately low percent of LHH residents were reviewed during annual recertification surveys. In fact, only about 5% of LHH residents were required to be reviewed by surveyors during a recertification survey (Figure 8). Compared to smaller nursing homes, surveyors reviewed 1.4 to 5.1 times fewer residents during an LHH recertification survey (Figure 9). It is estimated that, had a larger sample size been reviewed during LHH's recertification surveys in 2021 and 2022 (the only two years for which recertification surveys are publicly available), LHH's rate of deficiencies per 100 beds would have increased (because recertification-only deficiencies would have increased), especially in 2022 (Figure 7). In sum, ***LHH's large size gave it an advantage*** over smaller facilities with respect to being cited for potential noncompliance.

Figure 6. Rate of Total Deficiencies per 100 Licensed Beds, 2019-2023.
Sources: https://qcor.cms.gov/main.jsp &
https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/SearchResult.aspx

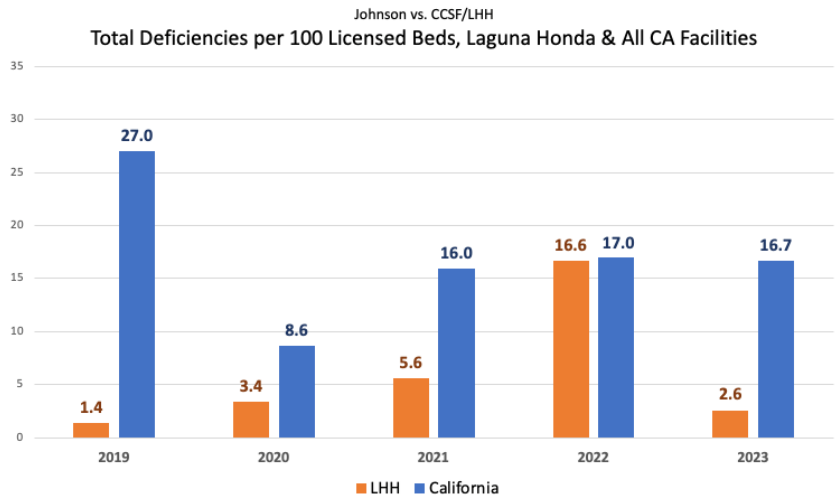

Figure 7. LHH Adjusted Rate of Recertification Survey-Only Deficiencies per 100 Beds for Larger Sample Sizes of Residents.

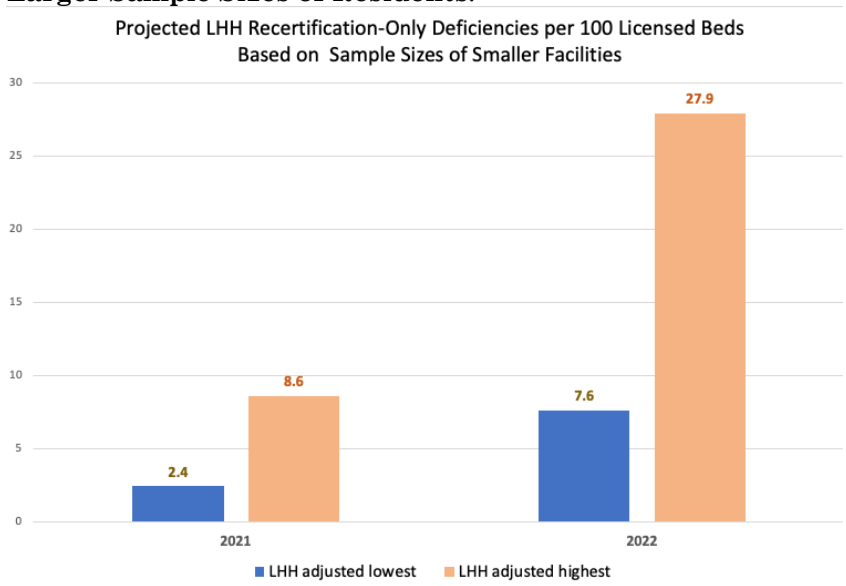

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Figure 8. In 2022, Only 5.2% of LHH Residents Were Reviewed During the 2022 Recertification Survey. Source: https://nursinghome411.org/wp-content/uploads/2021/08/SOM-Appendix-P.pdf

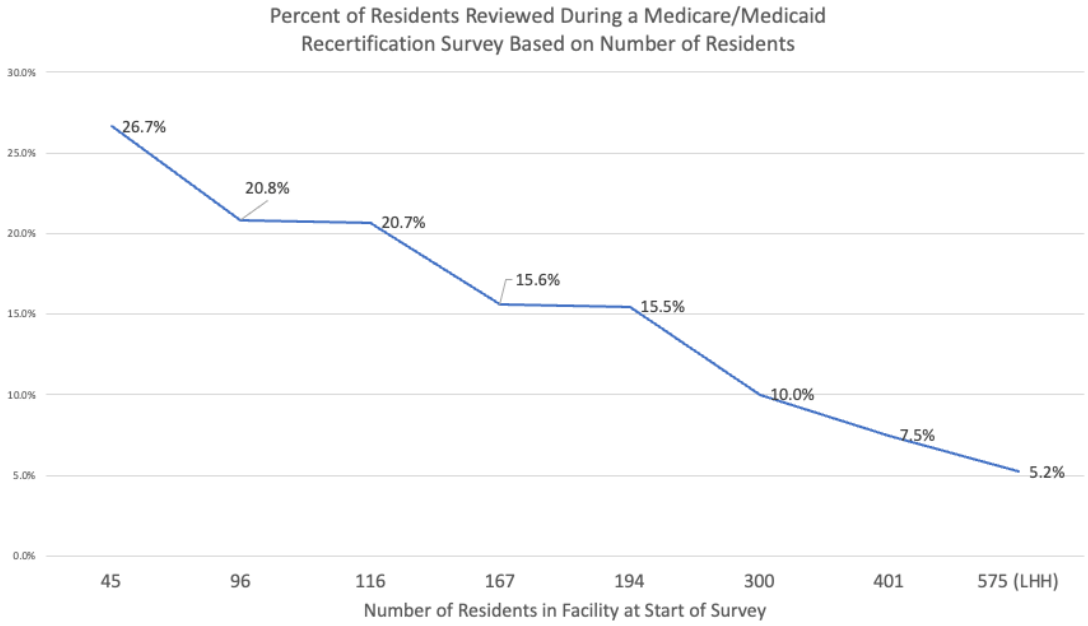
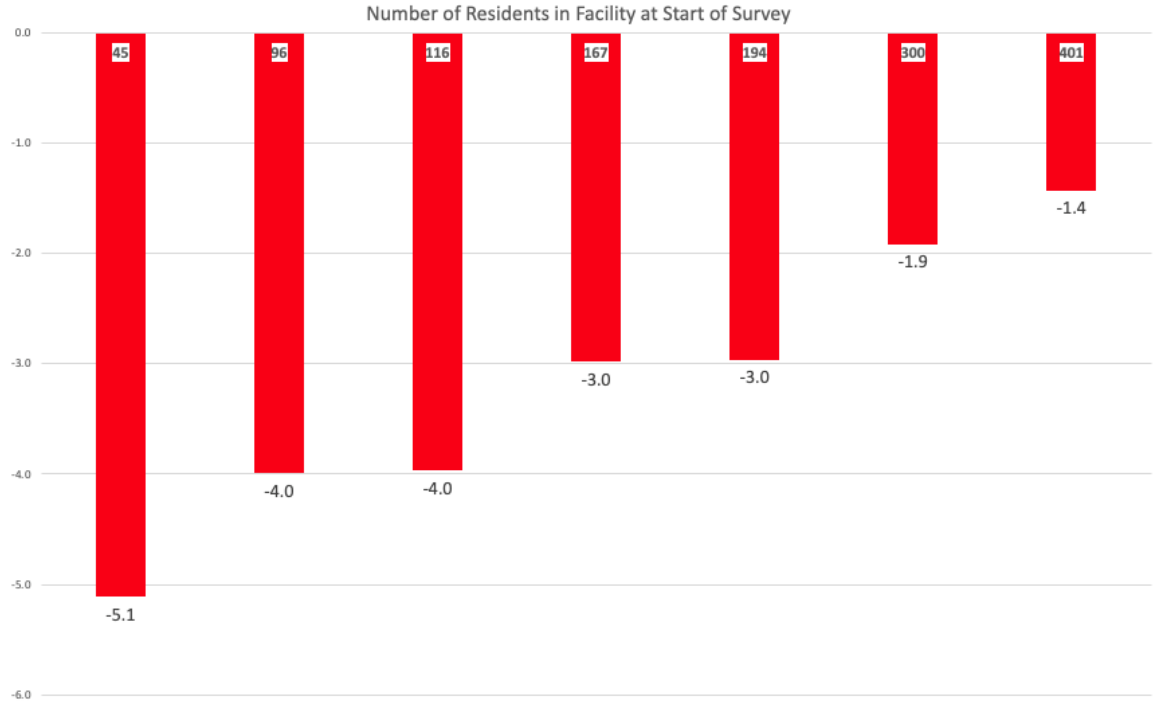


Figure 9. In 2022, During Recertification, Surveyors Reviewed 1.4 to 5.1 Times Fewer LHH Residents than in Smaller Nursing Homes.
Source: https://nursinghome411.org/wp-content/uploads/2021/08/SOM-Appendix-P.pdf



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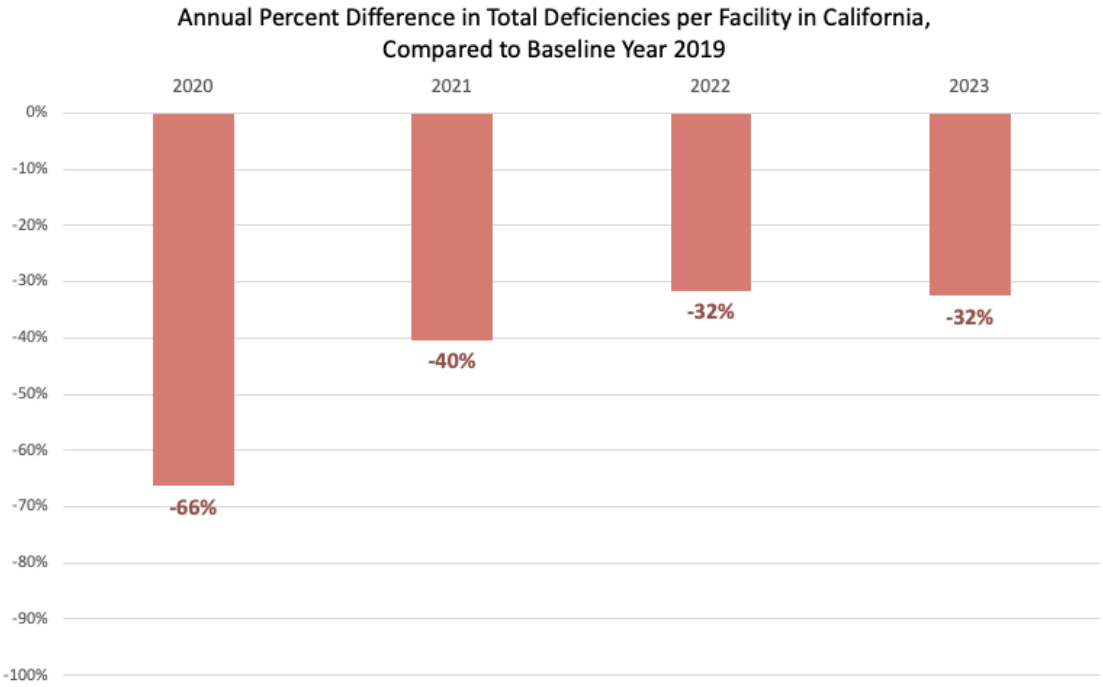
Regarding a Significant Decrease in California Deficiencies Due to COVID-19 Pandemic

After 2019, the number of deficiencies issued to California skilled nursing facilities dropped significantly (Figure 10). Like all California SNFs, LHH was under less regulatory scrutiny in the years 2020-2023.

Figure 10. Deficiencies to California Facilities Plummeted After 2019, Due to COVID-19



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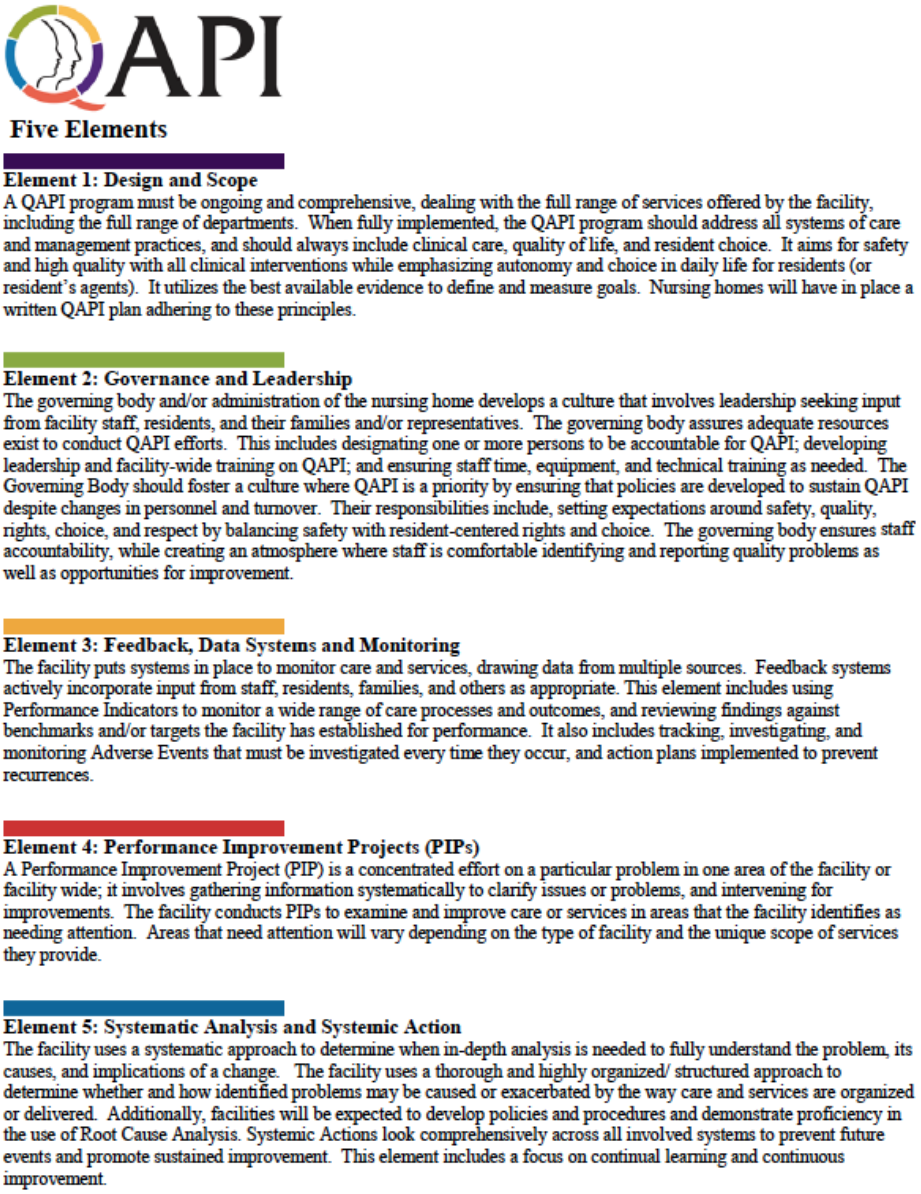
Appendix F. Quality Assurance and Performance Improvement (QAPI, pronounced kwa-pee). Effective November 28, 2019, new Federal regulations at 42CFR, §483.75 regarding QAPI were implemented. Essentially, every nursing home was required to "develop, implement and maintain an effective, comprehensive and data-driven QAPI program…"

Moreover, responsibility for the QAPI program was the responsibility of "the governing body and/or executive leadership," who were "accountable for ensuring that" [42CFR, §483.75(f)]:

- The QAPI program was maintained and sustained, including during transitions of leadership.
- "Clear expectations are set around safety, quality, rights, choice, and respect."

Figure 11. QAPI Five Elements. [Source: CMS QAPI Five Elements]



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Johnson v. City and County of San Francisco
San Francisco County Superior Court, Case No. CPF-20-517064

PROOF OF SERVICE

I, the undersigned, declare:

I am a citizen of the United States of America, am over the age of eighteen (18) years, and not a party to the within action. I am an employee of Stebner Gertler Guadagni & Kawamoto, and my business address is 870 Market Street, Suite 1285, San Francisco, California 94102. On the date below, I caused to be served the following documents:

DECLARATION OF CHRISTOPHER CHERNEY IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

on the parties involved, addressed as follows:

Sara Peters Khaldoun A. Baghdadi Joseph Nicholson **WALKUP, MELODIA, KELLY & SCHOENBERGER** 650 California Street, 26th Floor San Francisco, CA 94108-2615 Tel: 415-981-7210 Fax: 415-391-6965 Email: speters@walkuplawoffice.com Email: kbaghdadi@WalkupLawOffice.com Email: jnicholson@walkuplawoffice.com Email: lmiranda@WalkupLawOffice.com Email: lconnors@walkuplawoffice.com Email: wrosierarauz@WalkupLawOffice.com ***Co-Counsel for Plaintiffs***	Mark D. Lipton Henry Lifton Louise Simpson **OFFICE OF THE CITY ATTORNEY DENNIS HERRERA** 4 Fox Plaza 1390 Market Street, Sixth Floor San Francisco, CA 94102-5408 Tel: (415) 554-4218 Fax: (415) 554-3837 E-Mail: Mark.lipton@sfcityatty.org; E-Mail: Henry.Lifton@sfcityatty.org; E-Mail: Louise.Simpson@sfcityatty.org; E-Mail: Amy.Zehring@sfcityatty.org; E-Mail: Anita.Murdock@sfcityatty.org; E-Mail: zuzana.ikels@sfcityatty.org ***Counsel for Defendant City and County of San Francisco***
Kirsten Fish **NEEDHAM, KEPNER & FISH LLP** 1960 The Alameda, Suite 210 San Jose, CA 95126 Phone: (408) 261-4226; Fax: (408) 244-7815 E-mail: kfish@nkf-law.com ***Co-Counsel for Plaintiffs***	Niall P. McCarthy Anne Marie Murphy Blair Kittle **COTCHETT, PITRE & MCCARTHY, LLP** San Francisco Airport Office Center 840 Malcolm Road Burlingame, CA 94010 Telephone: (650) 697-6000 Facsimile: (650) 697-0577 Email: nmccarthy@cpmlegal.com; Email: amurphy@cpmlegal.com; Email: jlazarte@cpmlegal.com Email: shernandez@cpmlegal.com Email: marquez@cpmlegal.com Email: bkittle@cpmlegal.com ***Co-Counsel for Plaintiffs***

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_____ **BY EMAIL/ELECTRONIC SUBMISSION**: Only by e-mailing the document(s) listed above to the persons at the e-mail address(es) listed on this date pursuant to Code of Civil Procedure § 1010.6 and California Rules of Court Rule 2.251. No electronic message or other indication that the transmission was unsuccessful was received within a reasonable time after the submission.

X **BY ELECTRONIC SERVICE:** I electronically filed the document(s) listed above with the Clerk of the Court by using the Court's approved E-filing provider, File&Serve Express, and caused a copy of said document(s) to be E-Served through File&Serve Express to the persons at the e-mail address(es) listed above on this date. No electronic message or other indication that the transmission was unsuccessful was received within a reasonable time after the submission.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed at San Francisco, California on January 16, 2024.

Ann Williams