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Attorneys for Defendant
CITY AND COUNTY OF SAN FRANCISCO

ELECTRONICALLY
F I L E D
Superior Court of California, County of San Francisco
03/18/2024
Clerk of the Court
BY: SANDRA SCHIRO
Deputy Clerk

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

UNLIMITED JURISDICTION

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,

vs.

CITY AND COUNTY OF SAN FRANCISCO, and DOES ONE through TWENTY,

Defendants.

Case No. CPF-20-517064

DECLARATION OF NAWZANEEN Z. TALAI IN SUPPORT OF DEFENDANT CITY AND COUNTY OF SAN FRANCISCO'S OPPOSITION TO PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

Hearing Date: May 24, 2024
Time: 9:30 a.m.
Place: Dept. 613

For All Purposes: Hon. Andrew Y.S. Cheng

Date Action Filed: March 24, 2020
Trial Date: None Set

I, NAWZANEEN Z. TALAI, declare:

1. I have personal knowledge of the contents of this declaration, except where indicated otherwise, and I could and would testify competently thereto if called upon to do so.

2. I have been the Chief Quality Officer at Laguna Honda Hospital & Rehabilitation Center (Laguna Honda) since November 2020 and served as the acting Chief Quality Officer from June to November 2020. Before that I was the Manager of Administration Services for two years and a Senior Administrative Analyst for three years. I have a masters degree in public health and am a certified professional in healthcare quality.

3. In my role as the Chief Quality Officer I routinely engage with the California Department of Public Health (CDPH) and serve as the facility's point person for responding to CDPH investigations, deficiencies, and plans of correction. I also oversee the facility's quality assurance and performance improvement (QAPI) program.

4. Laguna Honda is licensed by CDPH as a general acute care hospital with 11 acute care beds and a distinct part skilled nursing facility with 769 skilled nursing beds. The facility is separated into 13 units or "neighborhoods," each with 60 beds.

5. Laguna Honda relies on federal and state funding paid by Medicare and Medicaid. Ninety-eight percent of Laguna Honda's residents are Medicare and/or Medicaid beneficiaries. Laguna Honda is a safety net hospital for San Francisco residents with complex skilled nursing needs. The patient population reflects San Francisco's population, some residents experience substance use disorder or homelessness. The residents are diverse: some are elderly, many have family who are unable to care for them, some suffer from mental health complications such as schizophrenia, traumatic brain injuries, or other cognitive impairments, such as dementia or Alzheimer's.

6. In 2019, as part of an unrelated HR incident, a personal care assistant (PCA) disclosed to HR that another licensed vocational nurse (LVN) had texted him photographs of residents without their consent. Laguna Honda investigated the incident, secured the PCA's and LVN's cell phones, and determined the alleged abuse involved five employees, three licensed vocational nurses (LVNs) and two personal care assistants (PCAs) on our North 1 and North 2 units. Laguna Honda secured the five employees' cell phones. The investigation into the incidents revealed that all instances of alleged

abuse involved these five employees. Laguna Honda self-reported these incidents to CDPH. Each of the five employees resigned in May 2019 after the San Francisco Department of Public Health proposed that they be dismissed from their positions. Based on the fact that each employee resigned before being terminated, the City designated each employee's services as unsatisfactory.

7. CDPH surveyed the facility as a result of the self-report. On July 12, 2019, CDPH issued a statement of deficiencies alleging various deficiency tags related to abuse, use of chemical restraints, and photographing residents without their consent. The facility completed a plan of correction to address these deficiencies.

8. On September 6, 2019, CDPH returned for a first revisit survey to clear the deficiencies. Laguna Honda did not clear all of the deficiencies because additional photographs had been discovered. CDPH issued a statement of deficiencies and Laguna Honda completed an additional plan of correction. Attached hereto as Exhibit 1 is a true and correct copy of the September 6, 2019 Statement of Deficiencies.

9. On October 15, 2019, CDPH returned for a second revisit survey and cleared the facility of all remaining deficiencies. CDPH determined that Laguna Honda was in substantial compliance, which means that CDPH had evidence that the facility had successfully implemented the corrections in its plan of correction and substantially complied with federal regulations for skilled nursing facilities. Attached hereto as Exhibit 2 is a true and correct copy of the October 15, 2019 letter from CDPH clearing the facility of all remaining deficiencies.

10. Following these incidents, Laguna Honda instituted a big push to inform staff about requirements as a mandated reported and the abuse regulations. The facility wanted to encourage staff at all levels to report allegations of abuse even if they are ultimately unsubstantiated.

11. That initiative was successful because there was a significant uptick in reports of abuse immediately following in 2020. Staff members would rather report suspected abuse than not report, even if the reports were ultimately unsubstantiated.

12. The majority of abuse allegations are unsubstantiated. Substantiated means that the incident in question occurred and is not the same thing as not being in substantial compliance with federal regulations.

13. Based on a review of facility records, in 2020, there were 285 allegations of abuse, of which the facility determined 136 were unsubstantiated, 3 unknown, and 146 substantiated. Only three resulted in a CDPH deficiency (representing 1% of the 285 allegations of abuse), all of which were scope and severity of level D, meaning that that it was an isolated incident with no actual harm but with potential for more than minimal harm. The facility's 2020 cases are not complete because CDPH has a significant backlog, including 18 cases that are still pending.

14. There is a significant backlog of cases that CDPH has not resolved from 2020 because of the impacts of COVID-19 across the State. Beginning in March 2020, the City issued a series of stay-at-home orders that included specific restrictions on Laguna Honda. Residents had to shelter in place and the facility was effectively closed to all visitors unless a resident was near end-of-life. Whenever any resident tested positive for COVID-19, we would move that resident to the South 5 unit but everyone else on the resident's unit would quarantine for 14 days of testing.

15. During this period, CDPH imposed new reporting and programmatic requirements that evolved on a day-by-day, month-by-month basis as the scientific community's understanding of the disease evolved. Eventually the facility had to report, on a daily and weekly basis, various indicators including staff testing, staff cases, staff symptoms, resident testing, resident cases, and resident symptoms. Then, when the vaccine arrived, we'd report the number of staff and residents who received the vaccine and how many doses we had onsite.

16. CDPH's programmatic requirements included infection prevention and control measures, a COVID-19 management plan, and a staffing plan—all of which needed to be provided to CDPH. It was a lot to comply with all these requirements.

17. The substantive requirements regarding abuse reporting did not change during this time.

18. Laguna Honda was very successful in responding to COVID-19 compared to other skilled nursing and long-term care facilities. The facility had a dedicated infection prevention and control nurse. Laguna Honda implemented a rigorous mitigation plan, which was nationally recognized.

19. In July 2021, two residents suffered from non-fatal overdoses from illicit substances and were transported to local emergency departments. Laguna Honda self-reported these incidents to CDPH.

20. CDPH investigated the incidents in August 2021 and returned in October 2021 to conduct an extended survey, meaning surveyors were looking at a broader scope than just the facility-reported incidents. On October 14, 2021, CDPH issued a statement of deficiencies citing the facility for a failure to prohibit illicit drug use, residents possessed contraband and lighters, and failure to properly dispose of confiscated items. The facility completed a plan of correction to address all deficiencies. Attached hereto as Exhibit 3 is a true and correct copy of the October 14, 2021 Statement of Deficiencies.

21. CDPH's October 14, 2021 Statement of Deficiencies triggered a six-month enforcement cycle, meaning that the facility had to return to substantial compliance with the Medicare regulations, as determined by CDPH or the Centers for Medicare and Medicaid Services (CMS), or would be terminated at the end of the six-month period. The six-month clock does not reset when the facility receives new deficiencies, even if those deficiencies are received on the very end of the six-month period.

22. On January 21, 2022, CDPH returned to conduct a first revisit survey that determined that three residents possessed contraband during a clinical search. The facility again completed a plan of correction. Attached hereto as Exhibit 4 is a true and correct copy of the January 21, 2022 Statement of Deficiencies.

23. On March 28, 2022, CDPH conducted a second revisit survey that determined that one resident on oxygen was in possession of a lighter, two residents were observed smoking, and residents were found in possession of contraband. The facility completed a plan of correction. Attached hereto as Exhibit 5 is a true and correct copy of the March 28, 2022 Statement of Deficiencies.

24. On April 13, 2022, CDPH conducted a final revisit survey that cited no deficiencies related to illicit substances or contraband. Instead, CDPH cited one resident who was taking herbal supplements, three residents who did not have revised care plans, two residents did not receive routine medications, one resident did not have range of motion serves implemented, three residents had scissors, one resident did not have a physician's order for oxygen followed, one resident did not have a pain assessment completed, facility did not properly store medication, and staff did not wear

appropriate personal protective equipment (PPE) while providing resident care. Attached hereto as Exhibit 6 is a true and correct copy of the April 13, 2022 Statement of Deficiencies.

25. During the same six-month time period, CDPH issued seven other statements of deficiencies that were unrelated to the October 14 survey and the revisit surveys. The facility provided plans of correction for all surveys, which CDPH either cleared or did not provide a response. Attached hereto as Exhibits 7 (Oct. 15, 2021), 8 (Nov. 5, 2021), 9 (Dec. 21, 2021), 10 (Dec. 28, 2021), 11 (Jan. 13, 2022), 12 (Feb. 3, 2022), and 13 (Mar. 30, 2022) are Statements of Deficiencies received by Laguna Honda.

26. On April 14, 2022, the Centers for Medicare and Medicaid Services (CMS) decertified Laguna Honda from the Medicare and Medicaid programs.

27. There is no connection between the deficiencies cited in 2019 and the deficiencies leading to decertification. The incidents disclosed in 2019 were isolated to two units and the facility was able to identify and remove the bad actors. Between the July and September 2019 statements of deficiencies and the facility's decertification from Medicare and Medicaid, CDPH did not cite any abuse deficiency tags with a widespread scope.

28. CMS continued funding care at the facility but, to obtain the funding, Laguna Honda had to file a notice of facility closure and implement a facility closure plan. This plan involved transferring all residents (at the beginning of the transfers, on May 6, 2022, the patient census was 686), to other SNFs and discharge locations. The facility reported its progress on transfers and discharges to CMS and CDPH on a daily and weekly basis. The facility called hundreds of facilities every week, and transferred 41 residents and discharged 16 residents. Three of the discharged residents went to shelters. Receiving facilities accepted the low-risk residents, which meant elderly residents including some on hospice care. In July 2022, CMS and CDPH ordered a pause on the transfers of residents to other facilities.

29. As a result of a settlement agreement with CMS and CDPH, Laguna Honda continued the pause on transfers and discharges and received continued funding through at least November 2023. In return, CMS required the facility to hire an outside consultant to serve as a quality improvement expert (QIE), performing a root cause analysis on the deficiencies, and implementing an action plan to

address the root causes identified. Laguna Honda also hired consultants to improve other aspects of the facility and hosted a federal monitor who reported directly to CMS. Attached hereto as Exhibit 14 is a true and correct copy of the contract with Health Services Advisory Group, Inc. to serve as the QIE.

30. CMS and CDPH also conducted monitoring surveys once every 90 days. For any deficiencies noted during those surveys, Laguna Honda engaged its QIE to perform a new root cause analysis and action plan for those new deficiencies.

31. Laguna Honda has currently spent over $31 million on improving the facility as a result of being decertified from Medicare and Medicaid. The facility expects to spend an additional $8 million on unpaid invoices. This includes: $36,834,325 on consultants (of which $28,854,290 has already been paid and $7,980,035 has yet to be paid); $1,154,445 on registry nurses, $912,486 on beds, $19,459 on bed add-ons, and $210,130 on mattresses; $102,688 on professional membership fees; $34,683 on fire life safety equipment; and $159,609 on Epic (medical record) expenses. The facility also paid $203,885 in civil monetary penalties to CMS as part of the settlement agreement. The facility has also spent $3,277,187 in capital project expenses from April 2022 to the present to address projects necessary for recertification, with an additional $26,697,481 in future charges on those projects.

32. According to Appendix PP of the State Operations Manual and Medicare regulations, a SNF's written policies to protect residents from abuse must include the following elements: screening, training, prevention, identification, investigation, protection, and reporting/response. Violating this requirement would be a deficiency under deficiency tag "F607."

33. Whenever there is an incident that rises to the level of abuse, or appears to be abuse, staff at the facility are required to report alleged abuse immediately and at least within two hours. Reporting is required to several different people, including the local Ombudsman, the Sheriff's Office, Quality Management, and CDPH. Simply because an alleged abuse event is report does not mean that the event occurred, or was abuse, or meant that the facility was deficient in some way. The facility investigates each allegation to determine whether it was substantiated, meaning that the event occurred, or unsubstantiated, meaning the event did not occur.

34. To investigate abuse, staff need to be interviewed to determine what happened and what their impressions of the event are. Residents are also interviewed and the facility talks with them about the allegations. The investigation also looks into the behaviors, interactions, medical diagnoses, the resident's decision-making capacity, and whether this has happened before. When the investigation involves an allegation of staff to resident abuse, the investigation will ask residents about their concerns and how they feel about a particular staff person. Ultimately, the interviews are dependent on the facts of the case. Questions are always adjusted depending on the allegation.

35. Staff are trained on the signs and symptoms of abuse. The Laguna Honda abuse policy requires new employees to receive training upon hire on abuse, both to recognize the signs and symptoms of abuse, and to know what conduct is not permitted. Training is also provided annually, and on an "as needed" basis depending on whether a case involving a staff member is substantiated or unsubstantiated.

36. The Department of Education and Training (DET) is responsible for providing the abuse training. DET maintains records regarding staff completion rates of training. Attached hereto as Exhibit 15, is true and correct copies of staff completion rates for abuse and resident rights training from 2019 through 2023.

37. When CDPH comes on site to investigate abuse, they ask for the facility's abuse policy and any other related policies. Surveyors will go to the unit where the incident occurred and round the unit, talking to the staff and residents involved. They will navigate through Laguna Honda's electronic medical record for the charting regarding the incident.

38. Ultimately, CDPH determines whether the facility did everything it was supposed to do under both its own policies and the State Operations Manual. CDPH cites deficiency tag F607 when the facility fails to implement its policies, even if the allegation is unsubstantiated. For example, CDPH could cite F607 if the staff member accused of abuse was not placed on paid administrative leave or if the resident's care plan was not updated.

39. In the July 12, 2019 Statement of Deficiencies, CDPH cited Laguna Honda for violating deficiency tag F607. During the period from October 14, 2021 to April 14, 2022, CDPH did not cite any deficiencies under deficiency tag F607.

40. When residents are admitted to Laguna Honda, the facility is required to use the CDPH standard admission agreement.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration was executed on March 18, 2024, in San Francisco, California.

NAWZANEEN Z. TALAI

EXHIBIT 1

State of California-Health and Human Services Agency
California Department of Public Health

SUSAN FANELLI
Acting Director

GAVIN NEWSOM
Governor

September 25, 2019

Letter 8

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Ms. Margaret Rykowski, Administrator
Laguna Honda Hospital & Rehabilitation Ctr D/p SNF
375 Laguna Honda Blvd.
San Francisco, CA 94116-1411

Dear Ms. Rykowski:

On September 6, 2019, a first revisit was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency or "CDPH"), to verify if your facility achieved and maintained compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. However, based on CDPH's revisit conducted on September 6, 2019, your facility is not in substantial compliance with the following participation requirement(s):

F557 483.10(e)(2) Respect, Dignity/Right to have Prsnl Property
F600 483.12(a)(1) Free from Abuse and Neglect
F607 483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies
F689 483.25 (d)(1)(2) Free of Accident Hazards/Supervision/Devices
F755 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)

A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS- 2567. Failure to submit an acceptable POC by the due date may result in termination of your provider agreement or imposition of alternate remedies by the CMS and/or State Medicaid.**

Providers may now submit their plan of correction (POC) as a separate document attachment or may continue to document the POC on the right side of the CMS Form 2567- "Statement of Deficiencies and Plan of Correction" and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State Agency.

Recommended Remedies
The recommended remedies for imposition include the following:

[X] A civil money penalty will be recommended to CMS Regional Office if substantial compliance has not been achieved. (§488.430)

[X] Termination effective January 12, 2020. (§488.456)

Denial of Payment for New Admissions (DPNA)
Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective October 12, 2019. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit. The CMS Regional Office may impose revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies, to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have any questions concerning this letter, please contact Doris Jordan, District Administrator at (415) 330-6353.

Sincerely,

Doris Jordan HFEM I

Diana Marana, R.N.
District Manager
Licensing and Certification

Enclosure *(CMS 2567)*

DM:cr

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	R-C 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a first revisit of an Abbreviated Standard Survey conducted from 9/3/19 to 9/6/19. Revisit of facility reported incidents: CA00623517, CA00639036, CA00639047, CA00639051, CA00639848, CA00639918, CA00639866, CA00640598, CA00621775, CA00638524 and CA00621433 Additional facility reported incidents investigated: CA00648637, CA00650413 and CA00648652 The inspection was limited to the specific facility reported incidents investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 40537, Health Facilities Evaluator Nurse 33819, Health Facilities Evaluator Nurse 40619, Health Facilities Evaluator Nurse 29548, Health Facilities Evaluator Nurse 26917, Pharmaceutical Consultant 29915, Health Facilities Evaluator Nurse Federal deficiencies F583 and F605 were corrected. Federal deficiencies F600 was still not in compliance and F557, F607, F689 and F755 were written as a result of facility reported incidents CA00648637, CA00650413 and CA00648652 .	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	R-C 09/06/2019

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F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents are treated with dignity and respect when two staff members (Porter 1 and Patient Care Assistant 1) were photographed laying in a compromised position at the foot part of the bed of one of 18 sampled residents (Resident 34) while Resident 34 sat upright on the bed. The deficient practice could potentially have negative psychsocial outcome on the resident. Findings: Resident 34 was admitted with a diagnosis of cortical blindness (partial or total loss of eyesight). The Minimum Data Set (an assessment tool), dated 6/26/19, indicated a Brief Interview for Mental Status (a screener for cognitive impairment), score of "15" indicated that Resident 34 is, "cognitively intact". Section G of the Minimum Data Set, dated 6/26/19, indicated a functional status of, "independent", regarding mobility. During a review of the facility's digitally encrypted	F 557		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	R-C 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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F 557	Continued From page 2 files of photos, videos and text messages from the personal cellular phone of Licensed Vocational Nurse (LVN) 1, included two photographs dated 1/15/18 at 1:22 pm. Photograph 1, labeled IMG - 7052, showed Resident 34 sitting upright in bed from neck to foot, wearing dark shoes and partially covered with a stained white material, two staff members, identified by the facility as Porter 1 and Patient Care Assistant (PCA)1, were laying across the foot of the bed. Porter 1 was on top of PCA 1, their heads were in proximity to each other. Porter 1, who was wearing a blue shirt with a baseball cap looks like his left hand was under the head part of PCA 1, with dark long hair laying underneath him. Photograph 2, labeled IMG - 7053, also showed a stained white material and the Resident 34's feet with dark shoes and two staff members, Porter 1 and PCA1. Porter 1 is on top of PCA1 laying on the foot part of the bed. During a review of the facility document titled "Preliminary Report", dated 7/30/2019: it indicated " ...as part of concurrent Human Resources investigation regarding the pictures and videos discovered on staff member's cell phone ..." with an incident date of 7/ 2018, at [Facility Name] North One Neighborhood, "two photographs dated 1/15/18, showed two staff members laying on the foot of the resident's bed, while the resident sat up right further up the bed." The report identified Resident 34, Porter 1 and PCA1 as the two staff members. During an observation with concurrent interview on 8/2/19 at 3:45 PM with Resident 34, Resident 34 was in bed. She said, "Hi. Go away. I'm tired." to the surveyor.	F 557		

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F 557	Continued From page 3 During an interview with the Director of Quality Management (DQM), on 8/13/19, at 2:04 pm, she stated, "the city attorney interviewed the two staff in the picture and they said they accidentally fell on the resident's bed and no other explanation given why the two staff are on top of each other in the resident's bed..." During an interview with Porter 1, on 8/13/19, at 2:48 pm, he stated that no one had talked to him about the incident of abuse the last two weeks. During an interview with the Director of Regulatory Affairs (DRA), on 8/13/19, at 3 pm, he stated, "the two employees accidentally fell onto the resident's bed ..." During a subsequent interview with the Director of Quality Management (DQM) on 8/22/19, at 4 pm, she stated "Porter 1 was told yesterday by his supervisor that he will be reassigned to a non-patient area, he was upset and he called off today ..." During a review of document titled "Investigation of Alleged Abuse", page five (5) of six (6) Part VII: Conclusion, dated 7/31/19, entered by DRA, indicated " ...I conclude that the abuse is not substantiated ...abuse on the part of the two staff members in the picture was not substantiated, as they both stated that the fall/trip was accidental ..."The investigation did not provide any details or logical explanation on how the two staff "accidentally fell" on the resident's bed in a compromised position.	F 557		
{F 600} SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	{F 600}		

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{F 600}	Continued From page 4 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure an environment free from abuse for all residents, when a corrective action to conduct employee supervision and check in with all nursing staff members to identify staff burn out and to provide opportunities for staff to privately voice concerns with regards to any peers was not implemented in 3 of 4 randomly selected nursing units (Units 1, 2 and 3). Failure to implement action plans regarding staff supervision is a potential risk for residents, who may be subject to abuse by staff. Findings: Record review of the the facility's plan of correction (POC) dated 8/9/19, indicated "...Corrective Actions: ...15. Nurse Managers for all Neighborhoods [Units] initiated a standardized tool and process to conduct employee supervision and check in with all nursing staff	{F 600}		

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{F 600}	Continued From page 5	{F 600}		

members, this supervision...employee interview to identify any staff burn out, and establish venue if employee have any concerns with regards to any peers or overall feedback...This process gives staff an opportunity to raise concerns privately and allows the Nurse Manager to observe staff performance...Completion Date: July 15 and ongoing..."

Record review of a facility form titled, "Nurse Manager Employee Supervision and Check In (FY (Fiscal Year) 2019 Thru FY 2020" showed four columns identifying the date, unit, employee's name and shift of when an employee would be supervised by the Nurse Manager on "A. Care Observation: Staff demonstrated providing care in a manner that took account resident's comfort, safety, and dignity... B. Communication: Staff Demonstrated respectful and therapeutic communication..."

During an interview with the Nurse Manager of Unit North 1 (NM 1), on 9/3/19 10:30 AM, NM 1 stated, "Yes, I am expected to do check-in with 1 staff member daily, Monday to Friday, about 5 staff every week...This has been in place for about 7-8 weeks since mid July..."

During an interview with the Manager of Administration (MOA) and the Director of Quality Management (DQM) on 9/4/19 at 1:25 PM, while reviewing data from the facility's POC, MOA stated, "No, we do not know how many staff members have been interviewed by each Nurse Manager from each unit...Nurse Managers in all units are expected to complete these check-in since about July 15...I understand this is an important item since the incidents of abuse involved the issue of supervision..." A random

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{F 600}	Continued From page 6 sample of employees rosters from 4 of the facility's 13 units was requested. Record review of a facility form titled "[Nursing Unit] Staff Check -In", of nursing staff roster interviewed by the Nurse Manager of Unit 1 indicated 12 of 43 staff members had been interviewed per POC Corrective Action #15. (28 %). Record review of the same form for Unit 2, of nursing staff roster interviewed by the Nurse Manager of Unit 2 indicated 18 of 50 staff members had been interviewed per POC Corrective Action #15. (36%). Record review of nursing staff roster interviewed by the Nurse Manager of Unit 3 indicated 5 of 55 staff members had been interviewed per POC Corrective Action #15. (9%). During an interview with DQM on 9/5/19 at 10:15 AM, upon reviewing the information above for Units 1, 2 and 3, DQM stated "...Yes, I agree the numbers are not even the majority of staff. It has been a few weeks since July 15...Yes, I know that the investigated incidents of abuse involved the issue of staff supervision and staff did not report them..." During an interview with the Risk Manager Director, (RMD), on 9/6/19 at 11 AM, upon reviewing the numbers of staff from Units 1, 2 and 3 undergoing "check-in" with their manager, per the POC language, RMD stated "Yes, I get it... the numbers should be higher after the findings related to supervision of staff...it has been a lot work..."	{F 600}		

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{F 607}	Continued From page 7	{F 607}		
{F 607} SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a thorough investigation of abuse for one of 18 sampled residents (Resident 34) when two staff members (Porter 1 and Patient Care Assistant 1) were photographed laying at the foot part of Resident 34's bed while the resident sat upright on the bed. This failure had the potential to compromise Resident 34's psychosocial well-being. Findings: Resident 34 was admitted with a diagnosis of cortical blindness (partial or total loss of eyesight). The Minimum Data Set (an assessment tool), dated 6/26/19, indicated a Brief Interview for Mental Status (a screener for cognitive impairment), score of "15" indicated that Resident 34 is, "cognitively intact". Section G of the Minimum Data Set, dated 6/26/19, indicated a functional status of, "independent", regarding	{F 607}		

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{F 607}	Continued From page 8 mobility. During a review of the facility's digitally encrypted files of photos, videos and text messages from the personal cellular phone of Licensed Vocational Nurse (LVN) 1, included two photographs dated 1/15/18 at 1:22 pm. Photograph 1, labeled IMG - 7052, showed Resident 34 sitting upright in bed from neck to foot, wearing dark shoes and partially covered with a stained white material, two staff members, identified by the facility as Porter 1 and Patient Care Assistant (PCA)1, were laying across the foot of the bed. Porter 1 was on top of PCA 1, their heads were in proximity to each other. Porter 1, who was wearing a blue shirt with a baseball cap looks like his left hand was under the head part of PCA 1, with dark long hair laying underneath him. Photograph 2, labeled IMG - 7053, also showed a stained white material and the Resident 34's feet with dark shoes and two staff members, Porter 1 and PCA1. Porter1 is on top of PCA 1 across the foot part of the bed. During a review of the facility document titled "Preliminary Report", dated 7/30/2019: it indicated " ...as part of concurrent Human Resources investigation regarding the pictures and videos discovered on staff member's cell phone ..." with an incident date of 7/ 2018, at [Facility Name] North One Neighborhood, "two photographs dated 1/15/18, showed two staff members laying on the foot of the resident's bed, while the resident sat up right further up the bed." The report identified Resident 34, Porter 1 and PCA1 as the two staff members. During an interview with the Director of Quality Management (DQM), on 8/13/19, at 2:04 pm, she	{F 607}		

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{F 607}	Continued From page 9 stated, "the city attorney interviewed the two staff in the picture and they said they accidentally fell on the resident's bed and no other explanation given why the two staff are on top of each other in the resident's bed..." During an interview with Porter 1, on 8/13/19, at 2:48 pm, he stated that no one had talked to him about the incident of abuse the last two weeks. During an interview with the Director of Regulatory Affairs (DRA), on 8/13/19, at 3 pm, he stated, "the two employees accidentally fell onto the resident's bed ..." During a subsequent interview with the Director of Quality Management (DQM) on 8/22/19, at 4 pm, she stated "Porter 1 was told yesterday by his supervisor that he will be reassigned to a non-patient area, he was upset and he called off today ..." During a review of document titled "Investigation of Alleged Abuse", page five (5) of six (6) Part VII: Conclusion, dated 7/31/19, entered by DRA, indicated " ...I conclude that the abuse is not substantiated ...abuse on the part of the two staff members in the picture was not substantiated, as they both stated that the fall/trip was accidental ..."The investigation did not provide any details or logical explanation on how the two staff "accidentally fell" on the resident's bed in a compromised position. During a review of the facility policy and procedure titled "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting	{F 607}		

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{F 607}	Continued From page 10 and Response dated July 9, 2019 indicated "[Facility Name] shall promote an environment that enhances resident well-being and protects residents from abuse ... 4. Identification ...(a) Abuse may result in psychological, behavioral or psychosocial outcomes. The following signs may alert [Facility Name] staff ...(iv) illogical accounts given by resident or staff member ..."	{F 607}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision to one of 18 sampled residents (Resident 33) when the resident eloped from the facility on 8/12/19 at 12:26 PM. Resident 33 was found collapsed in a park and sent to a hospital for DKA (diabetic ketoacidosis -occurs when the body produces high levels of blood acids called ketones), atrial fibrillation with relatively rapid venticular response (rapid irregular heart rate) on 8/14/19 at 9:50 AM. This deficient practice placed the resident at risk for serious injury or death. Findings:	{F 689}		

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{F 689}	Continued From page 11 Record review of physician's notes dated 6/15/18 on Neuropsychological Capacity Evaluation for Resident 33 indicated the resident had diagnoses including DM (diabetes mellitus) type 2, and peripheral neuropathy . The resident had a significant decline in cognitive functioning with a history of crack cocaine, speed, alcohol, and cannabis use. He demonstrated a lack of insight and displayed impairment in executive functioning. During observation on 9/4/19 at 10:00 AM, Resident 33 was dressed with a colorful sequenced dress with earrings and necklace. The resident had a sitter at the bedside. During an interview on 9/4/19 at 10:05 AM, Resident 33 admitted he had gone out of the facility several times. Stated that he was hospitalized, the last time he went out of the facility. During an interview with RN 3 on 9/4/19 at 10:45 AM, RN 3 said that he saw Resident 33 leave the unit on 8/12/19 at around 8:30 AM, with the thought that Resident 33 had a written Out On Pass (OOP) by the physician. During an interview with RN 4 on 9/4/19 at 11:00 AM confirmed that there was no written OOP order but rather a previous order dated 8/29/19 for "participation in organized out-of-hospital function ..." Record review of facility's policy and procedure titled, "Leave of Absence (Out On Pass) revised 5/14/19 indicated, "Residents who wish to leave the grounds of Laguna Honda Hospital and	{F 689}		

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{F 689}	Continued From page 12 Rehabilitation Center (LHH) shall have written orders from their attending physician and appropriate pass medication. Compliance/Adherence with Pass Privilege:When leaving on pass and on returning from pass, residents shall check in and out with the nursing staff on the care unit." Review of MD Note 8/14/19 1:49 PM , " ... I have remained reluctant to grant passes for resident to go ..." Record review of RN 3's Nurses Notes dated 8/12/19 at 12:26 PM indicated, "Resident left out on pass today around 8:30 AM to the community ..." Review of physician's notes dated 8/20/19 11:46 AM, " ...the next thing we heard about the resident was he had been admitted to a hospital ...sick with severe hyperglycemia/DKA. ..."	{F 689}		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		

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F 755	Continued From page 13 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide pharmaceutical services to meet the needs of each resident as evidence by: 1. The staff failed to properly dispose of medications in accordance with facility policy. 2. The facility failed to have developed a policy to dispose of disguised (hidden in food) medications. These failures resulted in Resident 31 taking medications and self-administering medications that were not prescribed which then exposed Resident 31 to the side effects of multiple non-prescribed medications. Findings:	F 755		

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F 755	Continued From page 14	F 755		

1. A review on 8/14/19 of Resident 31's clinical record indicated that Resident 31 has a medical history of dementia, schizophrenia, and psychogenic polydipsia (excessive drinking). Resident 31 was prescribed Olanzapine to treat these conditions. Resident 31 had behaviors that manifested as taking used cups out of the garbage bin and then filling the cups with water and drinking the contents. Resident 31's Minimum Data Set (MDS) assessment dated 5/18/19 indicated a Brief Interview of Mental Status (BIMS) score of 0 which indicated that Resident 31 had significant cognitive deficits.

During an interview on 8/14/19 at 10:51 AM, Physician 1 stated Resident 31 was her patient. Physician 1 also stated that Resident 31 had been disrobing which was not a behavior that Resident 31 had exhibited in the past. Physician 1 then ordered a urine toxicology screen (Utox) because of Resident 31's unusual behavior on 7/23/19 which then resulted in a positive test for Levetiracetam (Keppra anti-seizure medication). Physician 1 said that she reordered the Utox again on 7/29/19 which tested positive for Hydrocodone (opioid medication) and Gabapentin (Neurontin anti-seizure medication). Physician 1 also said that the Levetiracetam, Hydrocodone, and Gabapentin were non-prescribed medications.

A review on 8/14/19 of Resident 31's Interdisciplinary Team Meeting Note dated 8/7/19 at 9:30 AM indicated, "Utox test carried out on 7/23/19 revealed patient had Keppra in his urine sample. Even though patient did not have order for Keppra. A repeat test on 7/29/19 revealed he had hydrocodone and Neurontin in urine sample even though resident did not have order for these

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 15 too ...Resident has behavior by grabbing ...patient cups and picking up cups from garbage and adding more water from it and drinking from it. Also since many other residents have their meds disguised its possible he drank from it." During an interview on 8/14/19 at 9:15 AM, Registered Nurse (RN) 1 stated that she saw Resident 31 take medication cups from the medication cart trash bin around 7/23/19 and 7/29/19. RN 1 also stated that she had seen Resident 31 take cups before and fill them with water and drink the contents of what was inside the cups. She said that Resident 31 also would take and hoarded any type of cup. RN 1 said that she had seen Resident 31 take and drink from cups in the trash for the last 8 years. She also said that if you try and take the cups away from Resident 31 he would be combative. During an observation on 8/15/19 at 8:52 AM of three medication cart trash bins with open lids contained the following: *Medication Cart Trash Bin 1-multiple used cups, a unidentifiable bottle of medication opened, and two used liquid medication cups with remnants of solution. *Medication Cart Trash Bin 2-two unit dose medication packages opened, a medication cup that had crushed medications that was visible in some sort of yellow paste, part of a medication capsule. *Medication Cart Trash Bin 3-one unit dose medication package opened, a cup with orange solution and visible particles of medications. During an interview on 9/04/19 between 2:24 PM and 2:27 PM, RN 2, LVN 1, and LVN 2 all stated that after administering medications that they	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	R-C 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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F 755	Continued From page 16 would discard the used medication cups into the medication cart trash bin. They stated that the medication cart trash bin where left open instead of closing the lid so the contents of the trash were visible. The above indicated that the nurses would leave used medication cups with medication left in the cups which could be available for residents to take and self-administer the left over medication. A review on 9/5/19 of the facility policy dated 7/9/19 entitled, "Medication Administration" indicated "If medications have been prepared/removed from packaging, and resident does not take, medication must be wasted and documented in eMAR ...Medications that are not administered must be disposed of in the appropriate medical waste container ..." During an interview on 9/5/19 at 10:27 AM, the Director of Pharmacy stated that non-hazardous medications were to be disposed of in the white and blue bins and hazardous (potential threat to public health) medications were to be disposed of in the yellow bins. The DOP said that the medication cart trash bin should not have any medications discarded in it. 2. During an interview on 8/14/19 at 8:41 AM Administrator 1 stated that Resident 32 was the only resident that was on Hydrocodone where Resident 31 resided. He said that Resident 31 and Resident 32 resided in a locked unit. He also stated that Resident 32 had his medication disguised because he did not like taking his medications. Resident 32 would take his medications with ice cream.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 17 During an interview on 8/14/19 at 11:06 AM the Laboratory Services Personnel 1 stated that for Resident 31 to test positive for Hydrocodone he would have had to have taken more than a ½ a tablet of Resident 32's Hydrocodone. If it was less than a ½ a tablet Resident 31 would not have tested positive. The above indicated that Resident 32's Hydrocodone was disguised in ice cream which would mean that Resident 31 had to have taken Resident 32's ice cream which would have had more than a ½ a tablet of Hydrocodone. During an interview on 9/5/19 at 10:27 AM the DOP stated that there was no specific facility policy that addressed disposal of medications that are disguised. She acknowledged that developing and implementing facility policy to securely dispose of disguised medications could prevent reoccurrence of residents taking medications that were not prescribed.	F 755		

EXHIBIT 2

State of California-Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

RECEIVED
2019 OCT 28 PM 4:31

October 24, 2019

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Ms. Margaret Rykowski, Administrator
Laguna Honda Hospital & Rehabilitation Ctr D/P SNF
375 Laguna Honda Blvd.
San Francisco, CA 94116-1411

Dear Ms. Rykowski:

A second revisit survey for the abbreviated survey was conducted on October 15, 2019 by the California Department of Public Health, Licensing and Certification Program for all previous deficiencies cited at your facility on July 12, 2019. Your facility is in compliance with federal participation requirements for participating in the Medicare and/or Medicaid program(s).

Please see attached 2567.

If you have questions, please contact Doris Jordan, District Administrator at (415) 330-6353.

Sincerely, Pamela A Frazier HCES for

Diana Marana, R.N.
District Manager
Licensing and Certification

Enclosure *(CMS 2567)*

DM:cr

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a 2nd Re-Visit of an Abbreviated Survey from 10/14/19 to 10/15/19. Revisit of complaints CA00621775 and CA00621433 and facility reported incidents CA00623517, CA00639036, CA00639047, CA00639051, CA00639848, CA00639918, CA00639866, CA00640598 and CA00638524. The inspection was limited to the revisit and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 33819, Health Facilities Evaluator Nurse; Surveyor 40537, Health Facilities Evaluator Nurse; Surveyor 40619, Health Facilities Evaluator Nurse Federal deficiencies F557, F600, F607, F689 and F755 were corrected.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

EXHIBIT 3

State of California-Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Rcvd Laguna Honda Hosp Admin
2021 DEC 17 PM12:27

December 16, 2021

Letter 6b

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Michael Phillips, Administrator
Laguna Honda Hospital & Rehabilitation Ctr D/P SNF
375 Laguna Honda Blvd.
San Francisco, CA 94116-1411

Dear Mr. Phillips:

On October 14, 2021, an abbreviated survey for facility reported incident nos. CA00675386, CA00744774, CA00745390, CA00747134, CA00746900 and CA00747220 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[ ] Widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (F).

[ ] Isolated deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (G).

[X] A pattern of deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (H).

[ ] Widespread deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (I).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit.
All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)
A POC for the deficiencies must be submitted within **10 days from receipt of the CMS-2567**. Failure to submit an acceptable POC by the due date may result in termination of your provider agreement or imposition of alternate remedies by the CMS and/or State Medicaid Agency.

Providers may now submit their lan of correction (POC) as a separate document attachment or may continue to document the POC on the right side of the CMS Form 2567- "Statement of Deficiencies and Plan of Correction" and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken
- What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State Agency.

Immediate Imposition of Remedies Required
Irrespective of a state recommendation to impose or not impose a remedy, the CMS San Francisco RO must immediately impose, without permitting a facility an opportunity to correct deficiencies, one or more federal remedies.

Remedies
The remedies immediately imposed include the following:

[X] Immediate imposition of a civil money penalty.

The CMS San Francisco Regional Office (RO) or the State Medicaid Agency will impose a civil money penalty, and a notice of imposition will be sent to you.

[X] Termination of your provider agreement on April 14, 2022 if substantial compliance is not achieved by that time.

[X] Directed Plan of Correction

[X] Directed In-Service Training

Substandard Quality of Care

Your facility's noncompliance with the following has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and §488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care as well as the state board responsible for licensing the facility's administrator will be notified of the substandard quality of care.

In order for us to satisfy these notification requirements, and in accordance with §488.325(g), you are required to provide the following information to this agency within 10 working days of your receipt of the letter:

- The name and address of the attending physician of each resident found to have received substandard quality of care, as identified in the list of affected residents provided to you during the exit conference or as enclosed.

Please note that, in accordance with §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of alternative remedies.

Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco RO, we are giving formal notice of imposition of statutory DPNA effective January 14, 2022. This remedy will take effect on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS San Francisco RO will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation

Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for

a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon the subsequent revisit, it is determined your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter will be imposed by the CMS San Francisco RO beginning on October 14, 2021 and continue until substantial compliance is achieved. Additionally, the CMS San Francisco RO may impose revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies, to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005.

This request must be sent during the same 10 days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact Pinky Suriben, District Administrator at (415) 330-6353.

Sincerely,

Diana Marana, R.N.
District Manager
Licensing and Certification

cc:
Yvonne Pon
Health Insurance Specialist
Centers for Medicare & Medicaid Services (CMS)
San Francisco Survey & Enforcement Division
Long Term Care Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Facility reported incident: CA00744774 Facility reported incident:: CA00745390 Facility reported incident: CA00747134 Facility reported incident: CA00746900 Facility reported incident: CA00675386 Facility reported incident: CA00747220. The census at the beginning of the survey was 710. The sample size was 37 residents. The inspection was limited to the specific facility reported incidents investigated and does not represent the findings of a full inspection of the facility. The facility reported incident number CA00747220 was substantiated without regulatory violation. The facility reported incidents numbers CA00744774, CA00745390, CA00747134, CA00746900 and CA00675386 were substantiated with regulatory violations. The highest scope and severity was "H" -F 689 - Substandard Quality of Care (SQC) Representing the Departmen of Public Health: 40903, Pharmaceutical Consultant 36814, Health Facilities Evaluator Manager 1	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 40009, Health Facilities Evaluator Nurse 40454, Health Facilities Evaluator Nurse 41545, Health Facilities Evaluator Nurse 45439, Health Facilities Evaluator Nurse	F 000		
F 689 SS=H	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure safe environment for all residents when the facility did not implement policies and procedures for the following practices: a. Prohibiting use and possession of illicit drugs: Thirteen out of 37 sampled residents (Resident 1, Resident 3, Resident 4, Resident 2, Resident 7, Resident 27, Resident 28, Resident 11, Resident 24, Resident 29, Resident 31, Resident 18, and Resident 32) were tested positive for non-prescribed substances. Use of such substances resulted in outcome as follows: i. Resident 1 and Resident 3 experienced a life-threatening emergency and was hospitalized, ii. Change of level of consciousness (deep sleep, difficulties to arouse, unconsciousness) for Resident 4 and 27, iii. Falls for Residents 2 and 32,	F 689		

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F 689	Continued From page 2 iv. Behavior changes for Residents 11, 18, 24, and 29. b. Possession of contrabands (a banned or illegal item), trading illicit substances, and consuming marijuana and alcohol inside the facility: Twenty three of 37 sampled residents (Resident 14, Resident 3, Resident 4, Resident 5, Resident 2, Resident 27, Resident 11, Resident 17, Resident 13, Resident 15, Resident 16, Resident 23, Resident 20, Resident 26, Resident 21, Resident 19, Resident 25, Resident 32, Resident 12, Resident 18, Resident 33, Resident 10, and Resident 24) were found in possession of marijuana (cannabis or "weeds" a plant-based that has mind altering recreational use), syringes, pocket-knife, scissors, smoking paraphernalia (equipment used for a particular activity), and bottles of alcohol. Access to contrabands posed a safety hazard that jeopardize the health and safety of the residents, staff, and visitors. c. Monitoring and implementing care plan for 11 of 37 sampled residents who were identified as safe and unsafe smokers (Resident 2, Resident 27, Resident 17, Resident 34, Resident 18, Resident 20, Resident 26, Resident 14, Resident 25, Resident 24, and Resident 19). Unsafe possession of ignitable items had the potential to cause burn injuries and significant harm to residents, staff, and visitors. d. Storing lighters, combustibles in specific secure place according to policy to prevent misuse and control access. e. Tracking and disposition of confiscated contrabands for 16 of 37 sampled residents	F 689		

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F 689	Continued From page 3 (Resident 17, Resident 35, Resident 36, Resident 37, Resident 13, Resident 15, Resident 23, Resident 19, Resident 11, Resident 25, Resident 12, Resident 4, Resident 10, Resident 21, Resident 34, and Resident 2). This failure had the potential for diversion, misuse or uncontrolled redistribution of confiscated contrabands and further harm to residents, staff, and visitors. The failed practices placed all residents to unsafe living environment and negative health outcomes. Findings: a1. Review of Resident 1's "Code Blue Note" (Code Blue is a health emergency when a resident experienced a medical emergency), dated 7/22/21 at 8:47 PM, indicated, Resident 1 was found unresponsive, slanting in the wheelchair in Resident 2's room. Resident 1 was sent urgently to local hospital for further care. Review of Resident 1's "Drug Test, General Tox" (a urine test for drug screen), dated 7/22/21 at 8:50 PM, indicated the following compounds were detected in the Resident 1's body: Fentanyl (fentanyl a very strong opioid drug with potential for abuse and harm) and amphetamine (a mood elevating substance, used illegally or via prescription as a stimulant). Review of Resident 1's "Drugs of Abuse Screen" (a urine test for illicit substances), dated 7/23/21 00:54 AM, indicated presence of amphetamines, THC or Marijuana active ingredient (a plant-based cannabis that has mind altering recreational use) and benzodiazepines (or "benzo" a drug or substance with anti-anxiety	F 689		

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F 689	Continued From page 4 property). Review of Resident 1's prescribed medication list, titled "Current Scheduled Medications" dated 7/23/21, the prescribed medication list did not include the prescription form of the illicit substances (fentanyl and benzos) found in the Resident 1's urine test. Review of the Resident 1's discharge summary (a medical summary report when released from the hospital), titled "History and Physical" (H&P- a detailed history of medical condition), dated 8/20/21, indicated the urine test was "positive for benzo, amphetamine and fentanyl". The document under "Assessment" section, indicated "Patient was found to have seizures (uncontrolled brain activity that may cause body or brain injury), likely due to fentanyl exposure". According to the National Institute of Drug Abuse (NIDA) accessed on 11/14/21, at https://www.drugabuse.gov/publications/drugfacts/fentanyl, " ...Fentanyl's effects include extreme happiness, drowsiness, nausea, confusion, constipation, sedation, problems breathing, unconsciousness ..." In an interview with Resident 2, in his room on 8/12/21, at 11:41 AM, Resident 2 stated that Resident 1 was in smoking area prior to coming to his room and requested a cigarette then started laughing inappropriately; moments later he was falling from his wheelchair with head down. In an interview with Nurse Manager (NM) 2, in the Pavilion Mezzanine unit, on 9/13/21, at 4 PM, NM 2 stated Resident 2 denied sharing illicit drug with Resident 1 and stated, "you know who the	F 689		

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supplier was."

In an interview with Resident 1, in his room, on 9/9/21, at 3:07 PM, accompanied by Patient Care Assistant (PCA) 1 as translator, Resident 1 stated he could not recall when he became unconscious and was transferred to hospital.

In an interview with PCA 1 in the Pavilion Mezzanine, on 9/9/21, at 3:29 PM, PCA 1 stated, Resident 1 had to re-start his rehabilitation process from square one upon return from hospital. PCA 1 stated prior to hospitalization Resident 1 was more independent, mobile, and could communicate his needs clearly.

a2. Review of Resident 3's "Progress Notes", dated 7/17/21 at 7:12 AM, indicated, Resident 3 was "lethargic and very difficult to arouse. Pt (Resident 3) has h/o IVDU [means has history of intravenous (into the vein) drug use]. Friends visited last week."

Review of Resident 3's "Resident Care Team Meeting Note" (a document that mapped specific nursing care and steps to help with resident's medical problems), dated 7/17/21 at 9:50 AM and marked as "Special Review", indicated, "Patient was found hard to arouse and altered mental status. [MD 1] came to see the resident and decided to send her out for follow up and further evaluation ... was accepted in [local hospital emergency room] ..."

Review of Resident 3's "Discharge Summary", dated 7/17/21 at 12:00 PM, indicated, "When [Resident 3] admitted to the ED (hospital's Emergency Department) on July 17, the patient was noted to have respiratory failure (breathing

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problem)... most likely from opiate (substances used for pain relief) use, and patient required emergent intubation (put on a breathing machine to help her breath) ... patient did have a Utox [urine testing for illicit substances or prescription drugs in the body] which was positive for amphetamines, methamphetamines [or known as "Meth" a dangerous street drug that one can smoke, snort, swallow, or inject], and fentanyl."

According to the National Institute of Drug Abuse (NIDA) accessed on 11/14/21, at https://www.drugabuse.gov/drug-topics/commonly-used-drugs-charts#methamphetamine, the following are possible health effects of methamphetamine: increased wakefulness and physical activity; decreased appetite; increased breathing, heart rate, blood pressure, temperature; irregular heartbeat; anxiety; confusion; insomnia; mood problems; violent behavior, paranoia; hallucinations, delusions; weight loss, severe dental problems ("meth mouth"); and intense itching leading to skin sores from scratching.

Review of Resident 3's "Toxicology Screen, Urine Test" (urine test for drugs), dated 7/17/21, the test results confirmed presence of amphetamines, methamphetamines, and fentanyl in Resident 3's body upon admission to the hospital.

Review of Resident 3's "Medication Administration Record" (or MAR- a drug chart and a report that serves as a legal record of the drugs administered to a resident at a facility) last updated on 7/17/21, indicated Resident 3 was not on any prescription form of drugs found in the urine testing.

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F 689	Continued From page 7 Review of Resident 3's "History and Physical" (H&P- a detailed history of medical condition), dated 5/4/21, indicated Resident 3 "reports current drug use. Drugs: Amphetamines and Marijuana (a mind alerting substance in the form of dried leaves)." The document further indicated "will refer to Behavioral Medicine (a type of mental health specialty) for assessment related to h/o (history of) substance use." Review of Resident 3's Care Plan (document that mapped specific nursing care and steps to help with resident's medical problems) titled "Nursing Monthly Summary Form" dated 7/7/21, the Care Plan did not show any nursing intervention or planning to address history of illicit drug abuse. In an interview with NM 2, in the Pavilion Mezzanine unit, on 8/5/21 at 2:30 PM, NM 2 stated Resident 3 was noted to be sluggish and sleepy despite withholding the prescribed opioid pain medications in the early morning hours of 7/17/21. NM 2 stated, Resident 3 had refused urine test for ruling out illicit drug use in previous weeks. NM 2 further stated Resident 3 had one male visitor on 7/9/21 and days after that nursing staff noticed behavior changes including refusing to go to bed, hallucinating (perception of something not present) as if the bed was on fire or scratching her face harshly. In an interview with NM 2 in the Pavilion Mezzanine unit, on 8/5/21 at 4:07 PM, NM 2 stated seven days after Resident 3 was discharged from the facility, Resident 3's personal belonging had to be gathered for storage. A bag was found that contained syringes, needles, tiny Ziploc bags containing white powdery substances, small cotton balls and big syringes	F 689		

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that contained a clear liquid. NM 2 stated the items were photographed and given to sheriff on site. NM 2 stated the facility did not have any resources to test the recovered white substances.

In an interview with Licensed Social Worker (LCSW) 1, in the Pavilion Mezzanine unit, on 8/12/21, at 11:45 AM, LCSW 1 stated, she suspected a recent male visitor may have brought the illicit substances for Resident 3 to use in the facility.

In an interview via telephone with Resident 3, who was still in the hospital, on 8/12/21 at 1:17 PM, Resident 3 stated that her ex-husband visited her in the nursing home facility once. Resident 3 acknowledged that she had some illicit drug on her when she resided at the nursing facility and she snorted (inhaled through the nose) the powder at times.

In an interview with RN 6, in the Pavilion Mezzanine unit, on 9/23/21 at 2:27 PM, RN 6 recalled caring for Resident 3 during the daytime work shifts. RN 6 stated, Resident 3 was in bed most of the time and was not socializing with other residents. RN 6 recalled a report finding a syringe in Resident 3's room.

Review of facility's Adverse Drug Reporting (or ADR, a harmful or unpleasant reaction, resulting from the use of a product, which predicts hazard from future use) titled "Suspected Adverse Drug Reaction: Substance Use", dated 7/17/21, the ADR described the event as "major" and noted "Patient was found in altered mental status and hard to arouse"; "Resident was transferred to [local hospital] for further evaluation. Utox (Urine test for drugs) on 7/17/21 was positive for

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amphetamine and fentanyl..."

a3. Review of Resident 4's "Progress Notes", dated 7/31/21 at 9:50 PM, indicated, "(Resident 4) reported having ingested a "cupful of edibles (means illicit substance laced snacks)." Resident is sleepy and lethargic. Sent to ... [a local hospital emergency room] for evaluation."

Review of Resident 4's "Comprehensive Urine Drug test", dated 8/3/21 and 8/6/21, the record on both dates indicated presence of a non-prescribed substances called "THC" (active form of marijuana- mood altering substance) and methamphetamine (or "Meth" a mind alerting substance) respectively.

Review of Resident 4's "Nursing Notes", dated 8/6/21 at 10:38 AM, indicated another resident "gave her (Resident 4) crystal meth (illicit drug) which was placed in a pipe and she took "one hit" (means snorted or inhaled the substance)."

Review of Resident 4's "Care Plan Details" dated 8/27/21 at 1:26 PM, indicated a goal of "none or minimizing use of nonprescribed substances" for Resident 4. The document further noted the following:
"2/26/20: Resident had an empty 50 ml ("ml" was a unit of measure) bottle of (alcoholic beverage) and half of a marijuana joint in her laundry."
"5/16/21: Male Resident reported that she bought $70 worth of cannabis from him."
"7/18/21: Resident reportedly rolling marijuana joint in the Great Room."

In an interview with RN 8, who frequently cared for Resident 4, on 9/9/21, at 12:11 PM, RN 8 stated Resident 4 had an ongoing nausea issues

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and acted out irrationally when she was suspected of illicit drug use.

In a telephone interview with Resident 4's Conservator (someone who assumed legal guardianship over an adult), on 9/27/21, at 10 AM, the Conservator stated she had concerns with ongoing issues related to availability of illicit drugs in the facility. Conservator added, she had noticed Resident 4's behavior changed with substance use.

a4. Review of Resident 27's "Nursing Note", dated 8/16/21, at 8:04 AM, indicated, "...saw a pipe and a lighter on top of his (Resident 27) chest all soaked with liquid (from the pipe)". RN 11 note further indicated Resident 27 was in state of deep sleep and mumbling speech during the morning care.

Review of Resident 27's "Progress Notes: Psychiatrist", dated 8/25/21, indicated, "...per PCP (Primary Care Physician), patient noted to have AMS (Altered Mental Status, when resident is not mentally alert) ... and found to have pipe. Utox found to be positive for ...methamphetamine..."

a5. Review of Resident 2's "Toxicology Screen, Urine" dated 1/18/21, indicated fentanyl as a substance present in the body via the urine test.

Review of Resident 2's "Medication Administration Record" (MAR- a drug chart and a report that serves as a legal record of the drugs administered to a resident) for prescribed medication list did not show Resident 2 was

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prescribed any form of the fentanyl for pain management in the past 10 months (December 2020 through September 2021).

Review of the Resident 2's "Care Plan: Opioid Use Disorder", dated 6/2/21, indicated, Resident 2 received a "7-11" (Seven-Eleven, the name of a food store) food delivery bag that contained rolled aluminum foils along with four small Ziploc bags with white rock like substances.

Review of Resident 2's "Progress Notes", dated 6/14/21, at 4:24 PM, indicated, "...Per staff, patient has had recent incidents of ordering food delivery, but packages found to have unknown contraband (a banned or illegal item) ... Client did not consent to urine toxicology ... Patient acknowledges attempting to use what he believed is fentanyl but could not use it "because they (hospital) take it away...".

Review of Resident 2's "Progress Note", dated 6/23/21, at 1:25 PM, indicated, "...continue to have issues being found with contraband" ..." acknowledges cravings for opioids (fentanyl) ...Not interested in changing use patterns or seeking help ..."

In an interview with Resident 2, in his room, on 8/12/21, at 11:03 AM, Resident 2 stated he had done drugs like "crystal Meth and heroin" (illicit drugs) recently. Resident 2 did not disclose how the illicit drugs was acquired.

In an interview with Licensed Vocational Nurse (LVN) 2, in the Pavilion Mezzanine unit, on 9/13/21, at 2:02 PM, LVN 2 stated he had seen lighter, burned aluminum foil and brown plastic straws (paraphernalia used to smoke heroin) in

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Resident 2's room on multiple occasions.

In an interview with RN 4 in the Pavilion Mezzanine unit, on 9/13/21, at 2:35 PM, RN 4 stated that she cared for Resident 2 frequently and had been involved with clinical searches in the unit. RN 4 stated that "we found burned straw on top of his bedside table".

In another interview with NM 2, in the Pavilion Mezzanine unit, on 9/13/21, at 4 PM, NM 2 stated Resident 2 denied sharing illicit drug with Resident 1, when Resident 1 was found unconscious in Resident 2's room. NM 2 added, they had no resources to test or identify the items or residues found in Resident 2's room. NM 2 acknowledged the burned foil or brown straws could indicate igniter use and may pose fire hazard inside a resident's room.

a6. Review of Resident 32's "Resident Care Team Meeting Note" dated 9/15/21, at 11 AM, indicated, "...Resident fell twice on 9/9/21 and that is when the alcohol was discovered...Urine toxicology test was conducted on 9/10/21 and methadone was detected. Resident is not on methadone..."

Review of Resident 32's Physician's Progress Note, dated 9/15/21, at 10:25 AM, indicated, "Last weekend (Resident 32) had two falls - luckily he was not badly hurt...He specifically denied getting hold of any extracurricular drugs, aside from 'the booze', from (name redacted) or from anyone else..." Further review of the progress notes under A/P (Assessment and Planning) indicated, "1. Substance use...I am not sure what to say about the methadone - I guess we just watch him closely after visits with (name redacted) ..."

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a7. Review of Resident 11's "Progress Note", dated 1/6/21, indicated the nursing staff found unknown substance, which Resident 11 stated to be heroin (illicit substance). The PD 1 progress note stated the urine test for drug showed presence of morphine (opioid pain medication) which is a byproduct of heroin in the body. The PD 1 progress notes further indicated resident's "behavior would be classified as a 'unhealthy practice' ... has been referred to counseling".

Review of Resident 11's "Toxicology Screen: Urine", dated 1/4/21, 3/8/21, 3/22/21, and 8/27/21, indicated presence of non-prescribed opioid substances like morphine (opioid pain medication). Additionally, the record on 5/17/21 indicated presence of another non-prescribed substance called EDDP (which was a byproduct of methadone, an opioid medication).

a8. Review of Resident 18's "Toxicology screen, urine" dated 3/15/21, 5/5/21, 6/18/21, indicated, presence of non-prescribed substance called amphetamine in the resident's urine test.

Review of Resident 18's "Nursing Notes" dated 3/30/21, at 3:13 PM, indicated, "Resident with bizarre behavior throughout morning. Observed to be sitting on the edge of the bed without pants and making on and off giggling and moaning sounds...Notified RCT of positive meth (Methamphetamine) results from utox screen this morning..."

Review of Resident 18's Care Plan for "Resident uses nonprescribed substance" with start date of 12/17/19, indicated the following description: 3/30/21: Resident with positive urine toxicology

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screen result. Resident with pressured speech, increased irritability, rocking in chair.
5/5/21: Resident with positive urine toxicology screen after ordered on 5/4/21 due to hyperverbal and hyperactive.
6/19/21: Resident with positive urine toxicology screen after ordered on 6/17/21 due to behavioral changes..."Preliminary Positive...90% of preliminary positive for amphetamines are confirmed positive for amphetamines, methamphetamine, MDMA (ecstasy) or MDA."
8/5/21: Resident trades marijuana with another resident in the unit.

a9. Review of Resident 24's urine toxicology, dated 7/7/21 and 7/22/21, indicated, presence of non-prescribed substance called amphetamine in the resident's urine test.

Review of Resident 24's Psychiatrist Note, dated 8/21/21, indicated, "...7/28/21 ...Notified by team of recent urine toxicology positive for methamphetamine twice in July. Has had some short- term increased paranoia about PCP/verbally abusive towards PCP and endorsed delusional statements... Possible that brief increase in verbal irritability/psychosis maybe related to stimulant use..."

a10. Review of Resident 29's Nursing Note, dated 7/27/21, at 10 AM, indicated, "...Physician ordered urine tox for resident 7/27 due to increase in paranoid behavior..."

Review of Resident 29's "Toxicology screen, urine" dated 7/27/21, indicated, presence of non-prescribed substance called methamphetamine and amphetamine in the resident's urine test.

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a11. In an interview with Resident 7, on 9/9/21 at 2:35 PM, in the North 4 Unit, Resident 7 acknowledged use of non-prescribed substances a while ago and denied doing it again.

Review of Resident 7's "Urine Toxicology Screen", dated 1/31/20 and 2/5/20, indicated presence of a non-prescribed opiates (a class of drugs that include legal and illegal drugs) with morphine (a pain medication) as the substance in Resident 7's body.

Review of Resident 7's MAR with a date range of 1/2/20 to 2/10/20, the MAR indicated Resident 7 was not on any prescription form of drug found in the urine testing.

Review of Resident 7's "Nursing Notes", dated 2/5/20, at 4:01 PM, indicated, "...Resident (Resident 7) admitted that he took "something" last week, cannot exactly recall the date given to him by a visitor. Resident (Resident 7) would not specify who was the person and go no further details..."

Review of Resident 7's "Progress Notes: Physician", dated 2/6/20, indicated, "...educated him on potential drug interaction of currently prescribed medications and illicit drug use..." The note furthermore in the "assessment" section indicated that incident was an uncomplicated (without adverse outcome) opioid abuse and Resident 7 was not interested in optimizing his medication that help with his addiction issue.

Review of Resident 7's "Progress Notes: Behavioral Health", dated 2/12/20, indicated, "...Resident 7 has relapsed on 1/31/2020 ... urine

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test positive for Morphine." Resident 7 "admits that he took substances when somebody gave him but denies any craving."

Review of Resident 7's "Care Plan", dated 5/14/2020 at 5:34 PM, indicated Resident 7's use of non-prescribed substances as a problem for the facility to monitor since 9/27/2019 when urine test showed positive for cocaine (illicit substance). The interventions listed in the document included a 15-point plan including "discuss LHH (name of the facility) harm reduction and campus policy with resident"; "Restarted Suboxone (a medication to help with addition craving) as prescribed by Psych (mental health) doctor".

a12. Review of Resident 28's "Pertinent Diagnostic Studies" (same as blood or urine testing), dated 10/24/20, indicated presence of non-prescribed substance called methamphetamine in the resident's urine test.

Review of Resident 28's "History and Physical", dated 1/29/21, indicated, Resident 28 was "notable for intermittent suspected and confirmed drug use." The record under substance use section indicated, "...most significantly methamphetamine use, which he freely endorses that he continues to use at LHH ..."

Review of Resident 28's "Toxicology Screen: Urine", dated 6/3/21, indicated presence of non-prescribed substance called methamphetamine, in the resident's urine test.

Review of Resident 28's "Progress Notes" dated 7/6/21 indicated, "...openly endorses using methamphetamines, remains firmly

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pre-contemplative (means no intention to change behavior in the foreseeable future) about changing his behavior and continues to defer substance use services referrals..."

a13. Review of Resident 31's "Toxicology screen, urine" dated 8/2/21, indicated, presence of non-prescribed substance called amphetamine in the resident's urine test.

Review of Resident 31's Physician's Progress Note, dated 8/4/21, at 1:41 PM, indicated, "...Pt (Resident 31) has been going out more frequently than usual and I am concerned about his drug use while he is out on pass...Unfortunately it dd {sic} come back positive for Amphetamine..."

In an interview with Chief Medical Officer (CMO) on 10/13/21 at 1:56 PM, the CMO stated mental health consultant were notified of illicit substance use or possession as all residents with history of substance abuse were automatically enrolled and /or offered the program to help them overcome the addiction issues. CMO expected that both medical doctors and mental health doctors work together to help residents with substance abuse problems. CMO stated, when a resident was found to be under influence of illicit substance or not in their usual state of mind, the medical doctors asked for a urine drug test, if refused, the hospital monitored them or send them to hospital for immediate care. CMO stated the facility's harm reduction program is helping prevent overdose of harmful substances with use of reversal medications (antidote medication) or engaging residents to bring awareness for healthier lifestyle.

In an interview with Chief Executive Officer (CEO)

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on 10/14/21 at 2:15 PM, the CEO stated the facility's goal is to reduce harm from illicit drug use and be selective in admitting residents that may play a role in contraband drug use and distribution.

In an interview with Chief Operation Officer (COO) on 10/14/21 at 2:40 PM, the COO stated the facility had a large resident population and only a handful violated the safety rules. COO added, "We can't violate everyone's rights." The COO added, the facility's goal is not to prejudge residents with a goal of providing equitable care.

Review of facility's policy #75-05, titled "Illicit or Diverted Drugs and /or Paraphernalia Possession/use by Residents or Visitors", last revised on 9/10/19, indicated "...As in the greater community, the use, possession, solicitation and/or distribution of illicit or diverted drugs and/or paraphernalia at Laguna Honda Hospital (LHH) ... is prohibited." The policy further indicated, "...RCT (Resident Care Team- a team of facility's staff) team members shall orient the residents to LHH safety rules, and address issues related to substance use through the care planning process. Clinical interventions may include limiting access to medications and/or illicit drugs (Passes, access, visitors, etc.)" The Policy, additionally indicated "If resident refuse testing and is competent to refuse, (a) the refusal shall be considered the same as a positive result, and (b) further hospitalization may be conditional upon the resident's desire to comply with LHH policy." Furthermore, the policy on section 4 of the Procedures, indicated "LHH staff may request the SFSD (San Francisco Sheriff Department) to consider a legal search ... The SFSD shall seize all contrabands found during a legal search and

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shall proceed with appropriate and legal disposition. Any resident or visitor in possession of illegal substances is subject to detention and possible citation or physical arrest by the SFPD..."

b1. Review of Resident 14's "History and Physical", dated 10/28/20, indicated Resident 14 was sent to emergency room after return from dialysis (a procedure when kidney not able to clean the blood) and was found to have "3 (three) bottles of Alcohol and some marijuana in his possession".

Review of Resident 14's "Social Worker Consult", dated 1/28/21, indicated Resident 14 had a history of going out of the facility to buy or engage in illicit substance exchange which may have posed a safety risk to him and other vulnerable residents.

Review of Resident 14's "Resident Care Team Meeting Notes", dated 3/23/21, indicated the care team was concerned about Resident 14's "being in possession of contraband such as marijuana, and marijuana edibles and lighters".

Review of Resident's 14's "Nursing Notes", indicated the following:
On 1/28/21, at 12:03 PM, approximately 17 saran wrapped dark greenish dried buds (smell like marijuana) in one of his sweaters hanging in his closet and a red cigarette lighter.
On 4/5/21, at 6:05 PM, found 2 pieces of buds of marijuana.
On 6/2/21, at 5:44 PM, 1 block of cannabis infused chocolate inside in underpants and a lighter.
On 6/11/21, at 9:49 PM, a half of infused cannabis chocolate bar, in the sling.

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F 689	Continued From page 20 On 7/9/21, at 5:47 PM, unopened package of cannabis in his sweat-shirt right sleeve. On 7/30/21, at 6:05 PM, 4 buds (like dime size) of marijuana were found inside cigarette box. During an interview on 10/12/21, at 1 PM, in the facility's South 6 unit, RN 20 stated, Resident 14 had multiple clinical searches done. RN 20 added, "We're doing it (clinical search) almost on regular basis. Whenever he goes out on dialysis. We confiscated gummy bear, chocolate infused cannabis and a lot more." b2. In an interview with NM 2 in the Pavilion Mezzanine, on 8/5/21 at 4:07 PM, NM 2 stated seven days after Resident 3 was discharged from the facility, Resident 3's personal belonging had to be gathered for storage; during the search a bag was found that contained syringes, needles, tiny Ziploc bags containing white powdery substances, small cotton balls and big syringes that contained a clear liquid. NM 2 stated the paraphernalia items were photographed and given to sheriff on site. In an interview via telephone with Resident 3, who was still in the hospital on 8/12/21 at 1:17 PM, Resident 3 acknowledged she had some illicit drug on her when she resided at the nursing facility and snorted (inhaled through the nose) the powder at times. In an interview with RN 6 in the Pavilion Mezzanine unit, on 9/23/21 at 2:27 PM, RN 6 recalled caring for Resident 3 during the daytime work shifts. RN 6 stated, Resident 3 was in bed most of the time and was not socializing with other residents. RN 6 could recall a report finding a syringe in her room.	F 689		

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b3. Review of Resident 4's "Care Plan Details", dated 8/27/21 at 1:26 PM, with a goal of "minimizing use of nonprescribed substances" indicated the following:
On 2/26/20, "Resident had an empty 50 ml ("milliliter" unit of measure) bottle of (alcoholic beverage) and half of a marijuana joint in her laundry."
On 5/16/21, "Male Resident reported that she bought $70 worth of cannabis from him."
On 7/18/21, "Resident reportedly rolling marijuana joint in the Great Room."

Review of Resident 4's "Nursing Notes" indicated the following:
On 8/6/21 at 10:38 AM, another resident "gave her [Resident 4] crystal meth (illicit drug) which was placed in a pipe and she took "one hit [means snorted or inhaled the substance]."
On 9/21/21, at 11:11 PM, indicated, "...Clinical search done ... found a rolled paper burned halfway with some residue and smelled weed ..."
On 9/23/21, at 2:15 PM, indicated, "... she (Resident 4) saw some of the resident that she knows and asked them for money and cigarette {sic} ... She ended up meeting one of the resident from North 1 named (name redacted). I saw them exchanged money with cigarets {sic} and a joint (weed). Both smoked the weed, location "Betty Sutro Meadow"..."
On 9/29/21, at 6:38 PM, indicated, "... (Resident 4) had smoked MJ (marijuana) but clarified with coach how did he know it's MJ. He said it smelled/reeked of MJ and she smoked a rolled paper... Upon opening diaper, I noted a rolled paper fell down... I examined the rolled paper about 1.5 cm (centimeter) long and already burned the other side and reeked of MJ..."

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F 689	Continued From page 22 On 9/30/21, at 11:56 AM, indicated, "...Resident smoked weed at 11:45... The coach reported to LN (Licensed Nurse) that resident smoke weed second time at 12:10 (PM)... The coach saw the resident received weed (a roll paper with weed) from another resident ..." On 9/30/21, at 3:13 PM, indicated, "Relieved Coach, received the resident while actively rolling MJ with another resident that is from another Unit, resident smoked the MJ..." On 10/5/21, at 4:40 PM, indicated, "...Resident was observed exchanging money with "Weed" (in a rolled paper) with another resident near the nursing office at 1330 (1:30 PM) this afternoon ..." On 10/9/21, at 2:10 PM, indicated, "At 14:00 (2 PM), " ...Resident smoked "weed" in the farm ... The coach said that resident received the weed from another resident..." During an interview on 10/12/21, at 3:54 PM, RN 19 stated, Resident 4 had multiple clinical searched done. The most recent contraband confiscated was a "weed rolled in paper and brand-new cigarette." RN 19 added, "It's MJ (marijuana) because it has a distinct smell, skunk like but bearable." b4. Review of the Resident 5's "Care Plan: Opioid Use Disorder", dated 6/2/21, indicated Resident 5 received a "7-11" (or Seven-Eleven, the name of a food store) food delivery bag that contained rolled aluminum foils along with four small Ziploc bags with white rock like substances. During a concurrent observation and an interview, in the Pavilion Mezzanine unit, on 8/5/21 at 3:59 PM, NM 2 stated, Resident 5 was found to have illicit drugs in his purse. Resident 5 was observed	F 689		

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waiting next to the elevator and stated, "that was a one-time deal (he meant the illicit drug in his possession), it won't happen again."
In an interview with Security Staff 1, on 8/5/21, at 5:37 PM, the Security Staff 1 described the illicit drug in possession of Resident 5 as "clear crystal rock/powder in a Ziploc bag." The Security Staff 1 explained that he sealed it with a written report and gave it to security chief but did not test the substances for identification. Security Staff 1 was not sure how the illicit drugs were disposed. The Security Staff 1 added they (Security Officers) were not required to question the residents on how they acquired illicit substances.

Review of Resident 5's "Nursing Notes", dated 8/5/20 at 6 PM, indicated Resident 5 "grabbed" his bag from another resident in facility's South 2 Unit. Clinical search was requested due to "high suspicion of possession and distribution of illegal substances." Resident 5 initially refused the search "however, one small bag of a rock white substance was surrendered to sheriff."

In an interview with Resident 5, in his room, on 8/12/21 at 4:36 PM, Resident 5 stated his bag was "stolen" and he did not want to talk about the contents found in the bag.

In an interview with NM 1, on 9/13/21, at 11:28 AM, in South 2 Unit, NM 1 stated she first noticed the illicit substances in a Ziploc bag belonged to Resident 5 on 8/5/21. NM 1 stated, "The material looked like a clear rock." NM 1 stated, she was grateful that they had a sheriff in the facility, however, they needed to have a more proactive role in dealing with illicit drugs and its destruction.

b5. Review of Resident 2's "Progress Notes",

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F 689	Continued From page 24 dated 6/14/21, at 4:24 PM, indicated, "...Per staff, patient has had recent incidents of ordering food delivery, but packages found to have unknown contraband..." Review of facility document titled, "Clinical Searches with Items Found" received on 10/13/21, at 3:15 PM, for Resident 2 indicated the following: On 6/2/21, at 10:45 PM, "Found highly suspicious item in a 7/11 delivery bag; a rolled Reynolds aluminum foil with x4 small tiny zip lock bags with white rocks substance...found a silent pouch bag w/ (with) crushed white med residue inside..." On 6/6/21, at 10:45 PM, "White rock substance inside 1 of 3 soft taco & 6 folded aluminum foil inside the other tacos..." On 6/9/21, at 5:30 AM. "...with burned blackened substance in an aluminum foil paper straws stuck in res' mouth...a cigarette lighter was also found and confiscated..." Review of daily progress notes for Resident 2, dated 8/10/21, at 5:20 AM, indicated, "...Resident seen awake up on his wheelchair holding on to a cigarette lighter & noted a burned aluminum foil with burned substance on top of the table..." RN 3's progress note further indicated a "clinical search" was initiated ... on 8/10/21 at 6:25 AM and "found a pocketknife at bedside drawer." b6. Review of Resident 27's "Nursing Note", dated 8/16/21, at 8:04 AM, indicated, "...saw a pipe and a lighter on top of (Resident 27) chest all soaked with liquid (from the pipe) ..." Review of Resident 27's "Nursing Note", dated 8/16/21, at 5 PM, indicated "...clinical search was	F 689		

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F 689	Continued From page 25 done ... 2 (two) empty bottles of butine [sic] (a fuel for cigarette lighters) for lighter refill" was discovered. b7. Review of Resident 11's care plan for "Substance Use/Abuse" dated 7/31/20, indicated, "...clinical search done today and found what look like heroin (illicit substance) in Resident 11's pocket. We think (another resident) ... was involved in buying the contraband (heroin?) for Resident 11 in the ... parking lot when out (on medical pass) ... Her escort saw exchange of packages during this interaction ..." Under "Intervention and Recommendation" indicated, "Highly recommend... moving (two residents) ... off this unit as Resident 11 is using them to pay and bring in drugs." Review of Resident 11's Physician's Progress Notes, dated 1/3/21, at 8:13 PM, indicated, "Nursing staff discovered unknown substance in eye drop bottle, confiscated. Patient admits "contraband" but denies knowing the type of drug. Says used today...Says it helps him relax..." Review of Resident 11's "Nursing Note", dated 1/3/21, at 10:38 PM, indicated, "...Clinical search was performed ... Found eye drop vial (with blackish liquid) wrapped in white towel. Resident in the beginning stated it was for his "cake"..." Review of Resident 11's "Nursing Note", dated 1/4/21, at 8:37 AM, indicated, "Unit manager interviewed resident and he admitted that is was [sic] "drugs" when asked what type? "Heroine"..." b8. Review of Resident 17's progress notes indicated the following: On 4/20/21, "marijuana" was found on Resident	F 689		

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F 689	Continued From page 26 17's drawer. On 5/1/21, found "two lighters (igniters) and one tin can "altoid container" with marijuana." Review of Resident 17's "Nursing Note" indicated the following: On 5/5/21, at 8:56 PM, " ...Smoke patrol reported that he saw this resident smoking marijuana in the area ...Staff noticed the joint was in his hands and grabbed it immediately..." On 6/9/21, at 7:25 PM, "...Resident almost fell down but was supported and assisted to sit in the chair. While in the chair, it was noticed that he had a joint in his hand. When asked to surrender the joint, resident put it in his mouth and ate it..." b9. Review of Resident 13's "Nursing Note", dated 1/24/21, indicated, " ...Clinical search done ...found a small amount of dry, green loose leaves, some are shaped like a ball in one of the paper bag ... I was holding the bag and explaining to him that I need to confiscate it then he suddenly grab it from me. Tried to take it back but keep insisting that he doesn't need to give it back that he is allowed to smoke it..." b10. Review of Resident 15's "Nursing Note" dated 3/11/21, indicated, "... clinical search done... Able to find a nickel size green leaves with some loose leaves inside his cigarette box...Substance confiscated..." b11. Review of Resident 16's "Nursing Notes" dated 3/29/21, at 12:36 PM, indicated, "...Clinical search conducted after resident observed with possession of marijuana..." Review of Resident 16's "Nursing Notes" indicated the following:	F 689		

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F 689	Continued From page 27 On 3/29/21, at 3:40 PM, "...Resident was seen on the first floor hallway near North Tower with marijuana in his possession rolling joint out in public ..." On 9/10/21, at 5:05 PM, "...During the conversation a small marijuana box was noticed inside resident's jacket pocket ...inside were two marijuana joints and a cigarette butt..." On 9/10/21, at 5:18 PM, "...Clinical search conducted in resident's room...In the bedside table found an empty package of "Pacific Stone" marijuana..." b12. Review of Resident 23's "Nursing Note" dated 7/30/21, at 5:38 PM, indicated, "S2 (South 2) unit-wide clinical search conducted. Found: three unopened jars of CBD (Cannabidiol an active ingredients of marijuana) supplement products and small sharp scissors." b13. Review of Resident 20's "Nursing Note" indicated the following: On 5/16/21, at 1:45 PM, "Resident admitted that he sold cannabis to co-resident with stolen money on 5/15/2021. He also informed the coach that the co-resident spent $70 dollars worth cannabis which brought him to suspicion when the roommate of the co-resident reported that she lost her wallet." b14. Review of Resident 26's "Nursing Note" dated 5/16/21, at 1:45 PM, indicated, " ... Clinical searched done...Resident gave his box of cigarette and found small burned bud of marijuana and lighter..." b15. Review of Resident 21's "Nursing Note" dated 7/27/21, at 2:45 PM indicated, "Found marijuana cigarette on floor of resident's bedroom	F 689		

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just beyond [sic] doorway..."

b16. Review of Resident 19's "Nursing Note" dated 5/15/21, at 2:45 PM, indicated Resident 19 went out on pass (OOP) on 5/15/21 at 11:05 by himself.

Review of Resident 19's "Nursing Note" dated 5/15/21, at 5:11 PM, indicated, "Resident returned from OOP at 1645 (4:45 PM). CN conducted the protocol for resident returning from OOP. Resident voluntarily surrendered the lighter and joint..."

b17. Review of Resident 25's "Nursing Note" dated 8/27/21, at 8:42 PM, indicated, "Found rolled of used "JOINTS" in the bathroom floor..."

b18. Review of Resident 32's Physician's Progress Note, dated 9/15/21, at 10:25 AM, indicated, "Last weekend (Resident 32) had two falls - luckily he was not badly hurt. Then it turned out that he had two empty whiskey bottles. Later transpired that his sister (name redacted) had send them to him..."

Review of Resident 32's "Resident Care Team Meeting Note" dated 9/15/21, at 11 AM, indicated, "...Team met to discuss incident of resident receiving alcohol in the mail and consuming half a bottle of whiskey. Resident fell twice on 9/9/21 and that is when the alcohol was discovered..."

b19. Review of Resident 12's "Nursing Note" dated 1/28/21, at 1:19 PM, indicated, " ... Clinical search with charge nurse on (Resident 12) uncovered a rolled joint of marijuana under her waist band...Resident received a package from Sonoma today...We found more contrabands.

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F 689	Continued From page 29 Two 50g (grams) tin container of cannabis infused caramel bites, 50g zip lock container of cannabis infused mango, and a Vape pen..." Review of Resident 12's care plan for "Substance Use/Abuse" with start date of 12/27/20 and expected end date of 10/14/21, indicated on 1/9/21, " ...found contraband 2 small plastic wrapped of Marijuana.1(one) is almost empty and another one still intact. Contraband found inside her drawer while PCA cleaning her drawer...Staff found contrabands in her possession. One rolled joint and Marijuana edibles in a mailed package...5/28/21 Family member send a 3 big bag packages. During clinical search found a bottle of HEMP SEED OIL 118 ml (Cannabis Sativa seed oil with Vitamin E) ...6/23/21 Incident: Found narcotic (a substance used to treat moderate or severe pain) pill under her laptop on bed..." b20. Review of facility document titled, "Clinical Searches with Items Found" received on 10/13/21, at 3:15 PM, for Resident 18, indicated, on 8/5/21 at 3:40 PM, "Clinical safety search done; found an ICP (Intermittent Catheterization Procedure) kit small plastic container with one white pill; pharmacy was not able to ID (identify) the pill as the markings were not legible..." Review of Resident 18's "Resident Care Team Meeting Note" dated 8/10/21, at 9:30 AM, indicated, "...Team met to discuss the report of resident trading marijuana on the unit on 8/5/21 and subsequent clinical search where marijuana was found..." b21. Review of Resident 33's "Nursing Note" dated 7/30/21, at 5:45 PM, indicated, "S2 (South	F 689		

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F 689	Continued From page 30 2) unit-wide clinical search conducted. Found: small pink container with dozens small ends of marijuana joints..." b22. Review of Resident 10's "Nursing Note" indicated the following: On 1/3/21, at 2:40 PM, indicated, "PCA reported that found a bottle of 375 ml (of alcohol) in resident's top drawer...Noted the seal of the bottle of alcohol is broken and has 90% of the alcohol left in the bottle. Resident admitted that he drank the alcohol. When asked resident how he obtained the alcohol, resident stated, "Somebody from outside gave that to me" and refused to provide any detail..." On 3/7/21, at 3:21 PM, " ... PCA (name redacted) ... found a bottle of alcohol ... in resident's 2nd drawer of dresser... A bottle of alcohol total 200 ml and opened it, left in a bottle of alcohol is 3/4 bottle..." b23. Review of facility document titled, "Clinical Searches with Items Found" received on 10/13/21, at 3:15 PM, indicated, on 8/5/21 at 3:40 PM, Resident 24 was witnessed by the coach "hand rolling paper and one small dry bud." Lighter was also found during clinical search. b24. Review of facility document titled, "Clinical Searches with Items Found" received on 10/13/21, at 3:15 PM, indicated, on 7/28/21, at 1 PM, in the North 1 unit, "3 empty bottles of whiskey found in the garbage can in the unit balcony." In a joint interview with ND (Nursing Director) 1 and NM 1, on 9/13/21, at 11:30 AM, in the North 3 unit, they both acknowledged the multiple responsibilities nursing staff had to have to keep	F 689		

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the residents safe and at the same time respect the resident's privacy and rights regarding illicit substance use. "We can't open mail or deliveries, search resident's rooms and search visitors without their consent". NM 1 added, nurses needed to maintain a therapeutic relationship with residents to hold the trust and care they needed to provide.

In an interview with NM 1, on 9/13/21, at 12:12 PM, in the South 2 unit, NM 1 stated, they could not control what visitors brought in, could not search the visitors, open resident's mail, or packages without resident's consent.

Review of the facility's policy number 75-05, titled "Illicit or Diverted Drugs and/or Paraphernalia Possession/Use by Residents or Visitors" dated 5/19/20, indicated, "Policy: 1. As in greater community, the use, possession, solicitation and/or distribution of illicit or diverted drugs and/or paraphernalia...is prohibited...2. Staff shall take steps to prevent illicit or diverted drugs and/or paraphernalia use or access, and shall promote and support resident efforts to minimize the health consequences of illicit or diverted drugs and/or paraphernalia use ..."

Review of the facility's policy number 35-02, titled "Sales, Distribution of Free Items, And Solicitation On The Campus" dated 3/12/19, indicated, "...5. Illegal and Harmful Items a. Sale(s) or exchange(s) of illicit or prohibited drugs, paraphernalia, alcohol, tobacco products, products that emit smoke, or any lighted, heated, ignited, electronic, or any other device that delivers nicotine or other substances to the user, weapons, and illegal items, are prohibited..."

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Review of the facility's policy number 22-02, titled "Resident Alcohol Consumption" dated 10/13/20, indicated, "Policy: 1. The use of alcoholic beverages by (name of the facility) residents requires a physician order...Procedure...5. Unapproved use of alcohol by residents shall be reported by the observing party to nurse manager or charge nurse...may refer the resident for Substance Abuse Treatment Services. 6. Resident specific alcohol shall be stored in medication room..."

Review of the facility's policy number 22-12, titled "Clinical Search Protocol", last revised on 9/10/19, indicated, "Policy...2. Active substance use, drug dealing, unsafe smoking and use of dangerous objects endangers the safety of residents and staff and does not promote a resident's well-being...When there is a potential risk and/or reasonable suspicion that a resident possesses contraband, staff shall conduct searches of the resident, a resident's room, and personal belonging, as well as property and packages brought by visitors ..."

Review of the facility's policy titled "Mail Room Procedure" last updated in August 2016, the policy indicated "The Environmental Services Department will staff the mail room ..." The policy's "Delivery Procedure" indicated "Resident's packages (large packages) delivered to the nurse's station in neighborhood"; "Resident parcels and packages received from the United States Postal Services (USPS) delivered to the Laguna Honda Hospital mailroom will be sorted and delivered to the perspective nurse's station for distributions."

c1. During an observation, on 10/14/21, at 11:03

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F 689	Continued From page 33 AM, Resident 34 was smoking in the unsupervised smoking area outside the unit's great room. Resident 34 was holding a purple lighter in his left hand. During an interview, on 10/14/21, at 11:07 AM, Resident 34 stated, "This is for my personal use when I need to light my cigarette. The staff knows I have a lighter." During concurrent observation and an interview, on 10/14/21, at 11:18, RN 17 stated, "He might have bought the lighter while he was out on pass. The lighters are kept in the nurse station." RN 17 proceed to open the unlock overhead cabinet in the unit's nurse's station 1 and showed two purple lighters inside the cabinet. During an interview, on 10/14/21, at 11:42 AM, RN 17 stated Resident 34's "recent smoking assessment, summary/evaluation, requires 1:1 supervision." Review of Resident 34's "Safety Adult-Smoker" care plan with start date of 10/7/21 and expected end date: 1/5/22, under interventions, indicated, "... 8. If safe smoker: collect all matches, lighters, igniters, e-cigarettes..." Further review of the care plan indicated, on 10/13/21, Resident 34 was "handling lighter." c2. In an interview with NM 2, in the Pavilion Mezzanine unit, on 8/5/21, at 1:55 PM, NM 2 stated, although no illicit drugs were found in Resident 2's room during the clinical searches, the staff had reported presence of burned aluminum foil, used straw and igniters in his room on the bedside counter that may indicate substance use.	F 689		

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F 689	Continued From page 34 In an interview with RN 4 in the Pavilion Mezzanine unit, on 9/13/21, at 2:35 PM, RN 4 stated that she cared for Resident 2 frequently and had been involved with clinical searches in the unit. RN 4 stated that "we found burned straw on top of his bedside table." In another interview with NM 2, in the Pavilion Mezzanine unit, on 9/13/21, at 4 PM, NM 2 stated they had no resources to test or identify the items or residues found in Resident 2's room. NM 2 acknowledged the burned foil or brown straws could indicate igniter use and may pose fire hazard inside a resident's room. Review of Resident 2's "Daily Progress Notes" indicated the following: On 8/3/21 at 6:25 AM, "...during rounds found burned foil at his bedside..." On 8/5/21, at 4:08 AM, "...notice again and found burned aluminum foil in his table and straw on his mouth ..." On 8/6/21, at 4:20 AM, "Resident seen asleep up on his wheelchair with burned aluminum foil on top of bedside table..." On 8/7/21, at 11:15 PM, "...noted burned aluminum foil on top of his over-bed table..." On 8/10/21, at 5:20 AM, "...Resident seen awake up on his wheelchair holding on to a cigarette lighter & noted a burned aluminum foil with burned substance on top of the table..." On 9/23/21, at 12:05 AM, "...Resident seen in bed awake with burnt aluminum foil on his lap..." Review of Resident 2's "Safety Adult - Smoker" care plan with start date of 2/26/20 with expected end date of 10/25/21, indicated, "...4/4/21 Code	F 689		

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F 689	Continued From page 35 Red activated, resident ...admitted smoking cigarette @ (at) bedside with him...Educated Resident on safe smoking that includes...Residents are not allowed to smoke inside the hospital...Resident are NOT allowed to keep lighters, matches, and/or e-cigarettes...Smoking is PROHIBITED when you are on Oxygen..." c3. Review of Resident 27's "Nursing Note" indicated the following: On 8/16/21, at 8:04 AM, "...saw a pipe and a lighter on top of his (Resident 27) chest all soaked with liquid (from the pipe)". On dated 8/16/21, at 5 PM, "... 2 (two) empty bottles of butine [sic] (fuel for cigarette lighters) for lighter refill was discovered ..." Review of Resident 27's "Safety Adult - Smoker" care plan with start date of 8/10/19 and expected end date of 12/16/21, indicated, "...Resident is an unsafe smoker. He declines to wear fire-resistant apron. Resident also has multiple history of possessing igniters at bedside or in his person..." c4. Review of Resident 17's progress notes, dated 5/1/21, indicated, at 3 PM, LN 1 found two lighters (igniters) and one tin can "altoid container" with marijuana. Review of Resident 17's "Safety Adult - Smoker" care plan with start date of 3/10/20 and expected end date of 11/6/21, indicated, "...Interventions...8. If safe smoker: collect all matches, lighters, igniters, e-cigarettes..." Further review of the care plan indicated, on 5/25/21 Resident 17 was seen with 2 lighters. c5. Review of Resident 18's "Nursing Note"	F 689		

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F 689	Continued From page 36 dated 3/30/21, at 4:27 PM, indicated, "Resident had urine toxicology test was positive for meth (Methamphetamine). Clinical search conducted...Lighters found (4); all but one were [sic] empty..." Review of Resident 18's "Safety Adult-Smoker" care plan with start date of 11/4/19 expected end date: 11/12/21, under interventions, indicated, "... 8. If safe smoker: collect all matches, lighters, igniters, e-cigarettes..." c6. Review of Resident 20's "Nursing Note" dated 7/30/21, at 5:11 PM, indicated, "S2 unit-wide clinical search conducted. Found: small torch lighter blue and Cali Heights empty e-cigarette..." Review of Resident 20's "Safety Adult-Smoker" care plan dated 2/4/21, indicated, "At around 0845 AM, (name redacted), the assigned Zone manager for the smoking area reported that she saw (Resident 20) lighting his own cigarette. I approached (Resident 20) in the smoking area and instructed to surrender the lighter. He got upset..." Under interventions, indicated, "...9. Educate resident about policy regarding no lighters, igniters, or matches..." c7. Review of Resident 26's "Nursing Note" dated 5/16/21, at 1:45 PM, indicated, "...Resident gave his box of cigarette and found small burned bud of marijuana and lighter..." Review of Resident 26's "Safety Adult-Smoker" care plan with start date of 2/19/21, under interventions, indicated, "...6. Inform residents smoking is only permitted at designated areas. 7. Prohibit any open flame or cigarette within 5 feet of a resident receiving oxygen. 8. If safe smoker:	F 689		

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collect all matches, lighters, igniters, e-cigarettes...9. If unsafe smoker...a. May not smoke unsupervised b. Prohibited from carrying ALL smoking materials..."

c8. Review of Resident 14's "Smoking Assessment" dated 8/11/21, at 9:45 AM, indicated, "...Current smoker or uses smoking or smokeless products...History of past accidents/incidents with smoking materials...Observed to be sharing or selling cigarettes to other residents..."

Review of Resident 14's "Safety Adult-Smoker" care plan printed on 10/14/21, under interventions, indicated, "... 8. If safe smoker: collect all matches, lighters, igniters, e-cigarettes...9. If unsafe smoker...a. May not smoke unsupervised b. Prohibited from carrying ALL smoking materials..."

c9. Review of Resident 25's "Nursing Note" dated 8/27/21, at 8:42 PM, indicated, "Found rolled of used "JOINTS" in the bathroom floor..."

Review of Resident 25's "Safety Adult-Smoker" care plan with start date of 6/13/21 and expected end date of 10/14/21, indicated, "Problem: Safety Adult- Unsafe Smoker_ seen by staff smoking in the bathroom happened on 6/13/21... Interventions...6. Inform resident smoking is only permitted at designated areas...9. If unsafe smoker...a. May not smoke unsupervised b. Prohibited from carrying ALL smoking materials..."

c10. Review of facility document titled, "Clinical Searches with Items Found" received on 10/13/21, at 3:15 PM, indicated, on 8/5/21 at 3:40

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PM, Resident 24 was witnessed by the coach "hand rolling paper and one small dry bud." Lighter was also found during clinical search.

c11. Review of Resident 19's "Nursing Note" dated 5/15/21, at 5:11 PM, indicated, "Resident returned from OOP at 1645 (4:45 PM). CN conducted the protocol for resident returning from OOP. Resident voluntarily surrendered the lighter and joint..."

d. During an interview on 10/12/21, at 11:21 AM, QM (Quality Manager) 1 stated, lighters/igniters should be kept for safekeeping in the social worker's office. QM 1 further stated the nursing station is not a safe place to store the lighters/igniters.

During an interview, on 10/13/21, at 2:02 PM, in the South 4 unit, NM 7 stated, "Lighter go to Administration. That is where we used to send them."

During an observation and concurrent interview, with RN 15 and NM 7 on 10/13/21, at 2:04 PM, in the South 4 unit, RN 15 stated that lighters are kept in the nursing station. RN 15 opened the unlocked cabinet in the nursing station beside where the clerk is seating and showed the lighter.

During a concurrent observation and interview, on 10/13/21, at 2:34 PM, in South 4 nursing station, RN 4 stated the resident's lighters/igniters are stored in the unit clerk's office supply drawer. RN 4 opened the unlocked drawer by the unit clerk's desk which contained several lighters/igniters.

During a concurrent observation and interview, on 10/14/21, at 11:05 AM, with RN 5, in South 5

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conference room behind the nursing station, two lighters were found inside an open square-shaped white basket lined with light green cloth on the table. RN 5 stated the cigarettes are kept by the resident while the lighters are kept in the conference room and sometimes in nurse manager's office for safekeeping.

During a concurrent observation and interview with RN 6, on 10/14/21, at 11:19 AM, in South 6 nursing station, RN 6 went inside the medication room and showed a red plastic basket that contained several items including two lighters, a remote control, a charger, a pager, a thermometer, and two lanyards. RN 6 stated the lighters are kept in the treatment/medication room for safekeeping while the cigarettes are kept by the residents.

During an interview with ND 4, on 10/14/21, at 11:31 AM, the ND 4 stated, "Igniters should not be in the bedside, or with residents, or cabinets in the conference room. It should not be in the unit for safety."

During an interview, on 10/14/21, at 11:45 AM, NM 3 stated, "The lighters are kept in the nurse's station in all units." ND 2 agreed that the lighters are kept in the nurse's station in all units.

During an interview with Chief Quality Officer (CQO), on 10/14/21, at 2:30 PM, CQO stated all confiscated igniters should be stored "off nursing units" for safety purposes.

During an interview on 10/14/21, at 4:17 PM, the Director of Nursing Operations (DNO) stated, confiscated lighters/igniters should be stored in the social services office for safekeeping while

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F 689	Continued From page 40 the lighters/igniters used in the unit are kept in the nurse manager's office and only given to the assigned staff when resident wanted to smoke. Review of facility's policy 76-02, titled "Smoke and Tobacco Free Environment", dated 10/13/20, indicated, "...3. Lighters, matches, electronic cigarettes (e-cigarettes), and other devices that ignite, light, or fuel a flame are not permitted and shall be collected from residents by staff for safekeeping...7. Residents may only smoke in the designated smoking area...Smoking or ingesting cannabis is not permitted in the designated smoking area..." Review of facility's policy #24-25, titled "Harm Reduction", last revised on 7/9/19, the policy in the Definition section described examples of "Unsafe Practices" as "a resident attempts to smoke inside their room" ... and the "Imminently Dangerous Behavior" example as " A resident attempts to smoke, or use lighters, matches, e-cigarettes, and/or devices that ignite or fuel a flame, in the presence of or near devices that deliver oxygen to persons." The policy, furthermore, in the Interventions section, indicated "Clinical interventions shall be individualized based on the safety risk assessment, differentiating approaches for unhealthy practices and unsafe practices." e1. Review of Resident 17's progress notes indicated the following: On 4/20/21, at 8:54 AM, Licensed Nurse (LN)1 found "marijuana" on Resident 17's drawer. LN1 confiscated and gave the "marijuana" to the Charge Nurse (CN). Then, at 1:07 PM, CN gave the "marijuana" to NM 1. On 5/1/21, at 3 PM, LN 1 found two lighters	F 689		

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F 689	Continued From page 41 (igniters) and one tin can "altoid container" with marijuana. During an interview on 10/13/21, at 4:45 AM, NM 1 stated she disposed the marijuana that was given to her, by putting it inside the "cactus bin" located in South 2 floor, in front of the pharmacy department. NM 1 acknowledged she was by herself and did not have second staff to witness the disposal of confiscated marijuana. e2. During an observation and concurrent interview with NM 1, on 10/14/21, at 11:05 AM, NM 1 stated she kept all confiscated contrabands inside the North 3 Nurse Manager's office. During a concurrent observation in NM 1's office, NM 1 presented an unlabeled brown carton box. NM 1 explained, she kept all the confiscated contrabands during clinical searches of residents inside the box. The following items were found inside the brown carton box: i. A plastic bag containing one red igniter, and one black electronic cigarette, labeled with Resident 37's name. ii. A plastic bag containing one black igniter, one 4-inch nail, labeled with Resident 35's name. iii. A plastic bag containing two blue igniters, labeled with Resident 36's name. NM1 stated confiscated contrabands were kept in the Nurse Manager's office if the contrabands had sentimental value to the resident involved. NM 1 stated the facility will return the contrabands to the resident or family member when resident discharged or expired. NM 1 stated Resident 37 passed away years ago and acknowledged the contraband should have been given to Resident 37's responsible party (RP).	F 689		

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F 689	Continued From page 42 e3. Review of Resident 13's Nursing Note, dated 1/24/21, indicated, "...Clinical search done with another license and found a small amount of dry, green loose leaves, some are shaped like a ball in one of the paper bag ... I was holding the bag and explaining to him that I need to confiscate it then he suddenly grab it from me. Tried to take it back but keep insisting that he doesn't need to give it back that he is allowed to smoke it..." During an interview, on 10/14/21, at 11:49 AM, NM 3 stated, "There is no documentation, no log on what happened to it (referring to Resident 13's confiscated green loose leaves). There is no monitoring." e4. Review of Resident 15's Nursing Note, dated 3/11/21, indicated, "... clinical search done... Able to find a nickel size green leaves with some loose leaves inside his cigarette box... Substance confiscated..." No further documentation of the disposition of the confiscated item. e5. Review of Resident 23's "Resident Care Team Meeting Note" dated 8/4/21, at 9:30 AM, indicated, "... clinical search on 7/30/21. Three unopened jars of CBD supplements were confiscated and a small pair of sharp scissors. Resident may give the supplements to a friend to take home and the scissors posed safety risk..." No further documentation of the disposition of the confiscated item. e6. Review of Resident 19's "Nursing Note" dated 5/15/21, at 5:11 PM, indicated, " ... CN conducted the protocol for resident returning from OOP. Resident voluntarily surrendered the lighter and joint...Informed resident that the lighter was	F 689		

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F 689	Continued From page 43 labeled with his name and will keep at the nurse's station for him to use when he lights his cigarette..." e7. Review of Resident 11's Physician's Progress Notes, dated 1/3/21, at 8:13 PM, indicated, "Nursing staff discovered unknown substance in eye drop bottle, confiscated. Patient admits "contraband" but denies knowing the type of drug ...Says it helps him relax..." Review of Resident 11's "Nursing Note" indicated the following: On 1/3/21, at 10:38 PM, "...Clinical search was performed along with primary LN. Found eye drop vial (with blackish liquid) wrapped in white towel. Resident in the beginning stated it was for his "cake"...Possession was put aside, will endorse next shift to give to manager tomorrow..." On 1/4/21, at 8:37 AM, "Unit manager interviewed resident and he admitted that is was [sic] "drugs" when asked what type? "Heroine"...Called made to sheriff department...to come pick up the substance..." e8. Review of Resident 25's "Nursing Note" dated 8/27/21, at 8:42 PM, indicated, "Found rolled of used "JOINTS" in the bathroom floor..." Review of Resident 25's "Nursing Note" from 8/27/21 to 9/1/21 did not indicate documentation of disposal and/or disposition of confiscated "rolled of used joints." e9. Review of Resident 12's "Nursing Note" dated 1/28/21, at 1:19 PM, indicated, "...Clinical search with charge nurse on (Resident 12) uncovered a rolled joint of marijuana under her waist band...Resident received a package from	F 689		

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F 689	Continued From page 44 Sonoma today...We found more contrabands. Two 50g (grams) tin container of cannabis infused caramel bites, 50g zip lock container of cannabis infused mango, and a Vape pen..." During concurrent interview with ND 4 and record review of Resident 12's electronic record, on 10/13/21, at 4:52 PM, ND 4 acknowledged no documentation of disposal or disposition of the confiscated marijuana on 1/28/21. ND 4 added, "It could end up to someone else." e10. Review of Resident 4's "Nursing Note" indicated the following: On 9/21/21, at 11:11 PM, indicated, "...Clinical search done ...found a rolled paper burned halfway with some residue and smelled weed and showed it to Cadet (name redacted) and instructed me to flushed in the toilet..." On 9/30/21, at 11:56 AM, "... resident smoked weed at 11:45 at designated area with another resident. The coach reported to LN (Licensed Nurse) that resident smoke weed second time at 12:10 (PM)...The coach saw the resident received weed (a roll paper with weed) from another resident. Per coach, resident refused to give to the sheriff..." During an interview on 10/12/21, at 3:54 PM, RN 19 stated, Resident 4 had multiple clinical searched done. The most recent contraband confiscated was a "weeds rolled in paper and brand new cigarette. It's MJ (marijuana) because it has a distinct smell, skunk like but bearable." RN 19 explained that she put the confiscated "weeds" in a "Ziploc" and endorsed it to the night shift to show the Nurse Manager "as an evidence." The confiscated item was kept in "Charge Nurse box/bin" in the staff charting room	F 689		

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located at the back of Nursing station. where all staff has access. RN 19 also shared that there was an incident that she "flushed (the MJ) in the toilet as instructed by the Sheriff."

During an observation and concurrent interview, with RN 19, NM 5 and ND 3, on 10/12/21, at 3:54 PM, in the South 6 staff charting room, NM 5 showed the "charge nurse bin" on the table where RN 19 kept Resident 4's confiscated weeds. The uncovered bin had multiple items in a Ziploc such as lighter and phone charger. RN 19, NM 5 and ND 3 confirmed that all staff has access in the charting room and items can be taken without the knowledge of any staff. There was no log indicating items inside the charge nurse bin.

e11. Review of Resident 10's "Nursing Note" dated 1/3/21, at 2:40 PM, indicated, "PCA reported that found a bottle of 375 ml (alcohol) in resident's top drawer...When asked resident how he obtained the alcohol, resident stated, "Somebody from outside gave that to me"...Nursing supervisor instructed to place the bottle of alcohol in the medication room 2 and stated she will have the PM nursing supervisor to pick it up..."

Review of Resident 10's "Nursing Note" dated 1/3/21, at 11:02 PM, indicated, "Nursing supervisor came to the unit at 1800 (6 PM) and took the bottle of (alcohol) and locked it in Nurse managers office."

e12. Review of Resident 21's "Nursing Note" dated 7/27/21, at 2:45 PM, indicated, "Found marijuana cigarette on floor of resident's bedroom just beyond doorway..."

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F 689	Continued From page 46 During concurrent interview with NM 3 and record review of Resident 21's electronic record, on 10/12/21, at 1:05 PM, NM 3 stated, Resident 21 was on weekly clinical search as part of Pavilion Mezzanine intervention. NM 3 acknowledged no documentation of disposal or disposition of the confiscated marijuana on 7/27/21. e13. During an observation, on 10/14/21, at 11:03 AM, Resident 34 was smoking in the unsupervised smoking area outside the unit's great room. Resident 34 was holding a purple lighter in his left hand. During an interview, on 10/14/21, at 11:18, RN 17 stated, "He might have bought the lighter while he was out on pass. The lighters are kept in the nurse station." RN 17 opened the unlock overhead cabinet in the unit's nurse's station 1 and showed two purple lighters inside the cabinet. During an interview, on 10/14/21, at 11:45 AM, NM 3 stated, "The lighters are kept in the nurse's station in all units." ND 2 agreed that the lighters are kept in the nurse's station in all units. e14. Review of facility document titled, "Clinical Searches with Items Found" received on 10/13/21, at 3:15 PM, indicated, on 6/2/21, at 10:45 PM, for Resident 2, "Found highly suspicious item in a 7/11 delivery bag; a rolled aluminum foil with x4 small tiny zip lock bags with white rocks substance...found a silent pouch bag w/ (with) crushed white med residue inside; staff took items for safekeeping." e15. Review of facility document titled, "Clinical Searches with Items Found" received on 10/13/21, at 3:15 PM, for Resident 18, indicated,	F 689		

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F 689	Continued From page 47 on 8/5/21 at 3:40 PM, "Clinical safety search done; found an ICP (Intermittent Catheterization Procedure) kit small plastic container with one white pill; pharmacy was not able to ID the pill as the markings were not legible..." During an interview, on 10/14/21, at 1200 NN, ND 4 acknowledged no documentation of the disposition of the confiscated "white pill" from Resident 18. During an interview on 10/12/21, at 1:05 PM, NM 1 stated any sharp objects, unprescribed medications, and smoking paraphernalia found in resident's possession during clinical search will be confiscated. NM 1 added, "substances (referring to unprescribed medications)" will be given to the Sheriff for safe keeping. During an interview on 10/12/21, at 1:32 PM, RN 1 stated the Sheriff will be notified when a resident refused clinical search. RN 1 added, confiscated items during clinical search are given to the Quality Management Department for safekeeping. During an interview with Chief Nursing Officer (CNO), on 10/13/21 at 10:32 AM, the CNO stated there are no tracking system to check the packages received by the residents. CNO stated, for clinical searches, she expected nursing staff to call the onsite sheriff for observation and follow basic safety procedures; CNO stated the process for disposition, handling and itemizing contraband by nursing staff had not been standardized. CNO acknowledged the current facility's policy on illicit contraband substances and searches needed to be updated along with a more robust nursing education.	F 689		

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F 689	Continued From page 48 During an interview on 10/13/21, at 4:50 PM, NM 1 stated LN 1 found the contraband Saturday afternoon. NM 1 stated LN 1 gave the confiscated contraband to the Nurse Supervisor (NS) that weekend. Then, the NS will keep the confiscated igniter and cannabis inside NM 1's office. NM 1 stated she disposed the cannabis when she returned to work the following Monday. NM 1 acknowledged she was by herself and did not have second staff witnessed her disposing the cannabis. NM 1 stated she did not complete a log of the items she disposed in the "cactus bin". During an interview on 10/14/21, at 11:10 AM, NM 2 stated in cases cannabis is found in resident's possession, it will be confiscated and discarded in the "cactus smart sink (a "green" waste solution that automatically secures and renders controlled substance waste unusable and non-recoverable)" by the pharmacy on the second floor. NM 2 added, two licensed nurses should be present during disposal. During an interview on 10/14/21, at 11:56 AM, NM 3 stated, "The confiscated cannabis are disposed in the pharmacy. The confiscated illicit drugs are surrendered to the sheriff. There is no documentation of the handling and disposition of confiscated cannabis and illicit drugs." During an interview with QM 1, on 10/14/21, at 2:55 PM, QM 1 stated cannabis should be disposed in the "cactus smart sink" by two persons while the illicit drugs or unidentified pills are taken by the Sheriff for destruction. During an interview with Chief Quality Officer (CQO), on 10/14/21, at 4 PM, the CQO stated the	F 689		

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behavioral and substance abuse team (a team that helped residents with addiction and emotional issues) were not part of facility's staff and they had to work with facility's doctors and nurses to coordinate care. CQO added the coordination between facility's clinical team and substance abuse team may not be perfect as the facility had no control over behavioral and substance abuse. CQO stated the data on unusual occurrences such as illicit substance use or possessions were categorized, reviewed, and trended regularly by leadership and safety team. CQO added, there was no requirement to have double signature to dispose illicit marijuana substances. CQO acknowledged the sheriff staff were at times reluctant to process or dispose the illicit contraband substances found in resident's possessions.

Review of facility policy and procedure, titled "Clinical Search Protocol", revised 9/10/19, indicated "...2. Search Procedures...h. Whenever a search is conducted the following information shall be documented in the resident's medical record:...iii. Items found and seized; and Disposition of items found and seized... After the Search i. All confiscated contraband shall be catalogued by the staff member that conducts the clinical search, disposed of in the manner described below, and documented in the resident's medical record. Confiscated cannabis from a resident with or without a valid cannabis card shall be disposed of by 2 (two) staff members (including one supervising nurse) using the smart sink in the supplemental drug room... E-cigarettes, lighters, matches, and other devices that ignite, light, or fuel a flame shall be bagged, labeled by nursing staff and secured by Social Services for safekeeping... Dangerous objects or

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F 689	Continued From page 50 illicit or illegal drugs shall be confiscated by SFSD (San Francisco Sheriff's Department at the direction of LHH staff, catalogued by LHH staff, and transported by SFSD for proper destruction..."	F 689		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		

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F 726	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure Licensed Nurses (LN) and Certified Nurse Assistants (CNA) had the specific competencies and skill sets necessary to perform "clinical search" as identified through resident assessments and described in the plan of care. Clinical search means search of residents' room or properties to help locate harmful objects or illicit substances with resident's consent. This failure may pose safety risk to residents and caregivers. Findings: Review of Resident 2's "Care Plan: Opioid Use Disorder" (Care Plan is a document that mapped specific nursing care and steps to help with resident's medical problems) indicated, on 6/2/21, Resident 2 received a "7-11" (name of a store) food delivery which facility's nursing staff discovered a rolled aluminum foils and four small Ziploc bags with white rock substances inside. Review of Resident 2's "Daily Progress Notes" indicated the following: On 8/7/21 at 11:15 PM, " ...noted burned aluminum foil on top of his overbed table. Resident refused to give the material to the writer ..." On 8/10/21 at 5:20 AM, " ...Resident seen awake up on his wheelchair holding on to a cigarette lighter & noted a burned aluminum foil with burned substance on top of the table. Resident refused to comply when writer attempted to	F 726		

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retrieve the igniters & burned aluminum foil ... "clinical search" was initiated in the presence of Sheriff on 8/10/21 at 6:25 AM and "found a pocketknife at bedside drawer."

During an interview with Licensed Vocational Nurse (LVN) 2 in the PMS unit, on 9/13/21 at 2:02 PM, LVN 2 stated, he had seen lighter, burned aluminum foil and brown plastic straws in Resident 2's room on multiple occasions. LVN 2 stated he never questioned Resident 2 on the findings and his job was to clean the counter tops and bedside tables when Resident 2 allowed him to do so. LVN 2 stated that he reported his observation to the covering nurses. LVN 2 additionally stated, he had not received any training on how to handle cleaning of the possible illicit drugs or unknown items and "used my common sense". LVN 2 acknowledged that "we need training" on how to handle the illicit drug paraphernalia.

During an interview with Registered Nurse (RN) 4 in the PMS unit, on 9/13/21 at 2:35 PM, RN 4 stated during recent clinical searches "we found burned straw on top of Resident 2's bedside table". RN 4 acknowledged she did not have specialized training on how to do the clinical searches. RN 4 stated she was instructed if they discovered anything unusual, show it to the Manager or to the Sheriff, if they were present. RN 4 stated as a nurse she was not trained how to handle or monitor illicit drug use and at times had to cross professional boundaries since Sheriff had limitation to address issues in the facility and was not present all the times.

During an interview with Nurse Manager (NM) 2, in the PMS unit on 8/5/21 at 4:07 PM, NM 2

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stated seven days after Resident 3 was discharged from the facility, Resident 3's personal belonging had to be gathered for storage. During the search a half-open makeup bag was found that contained syringes, needles, tiny Ziploc bags with white powdery substances, small cotton balls and big syringes that contained a clear liquid. NM 2 stated the illicit paraphernalia were photographed and were given to Sheriff on site.

During a concurrent observation and interview with NM 2, in the facility's PMS unit, on 8/5/21 at 3:59 PM, NM 2 stated Resident 5 was found to have illicit drugs in his purse.

During an interview with Security Staff 1 in the facility, on 8/5/21 at 5:37 PM, Security Staff 1 stated, in general, they were not required to question the residents on how they acquired these illicit substances. Security Staff 1 described the illicit drug in possession of Resident 5 was a clear crystal rock/powder in a Ziploc bag. Security Staff 1 was not sure how the illicit drugs were disposed. He noted they followed state and local rules.

Review of Resident 5's "Nursing Notes", dated 8/5/20 at 6 PM, indicated Resident 5 "grabbed" his bag from another resident in facility's South 2 Unit. A clinical search was requested due to "high suspicion of possession and distribution of illegal substances." One small bag of a rock white substance was surrendered to sheriff..."

During an interview with NM 1, on 9/13/21 at 11:28 AM, in the South 2 Unit, NM 1 stated she first noticed the illicit substances in a Ziploc bag belonged to Resident 5 on 8/5/21. NM 1 stated, "The material looked like a clear rock". NM 1

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stated, she was grateful that they had a Sheriff in the facility, however, they needed to have a more proactive role in dealing with illicit drugs and its destruction. NM 1 stated, if Sheriff refused to take the illicit drugs, then the nursing had to destroy the illicit drugs in the "Cactus Sink" (a container with a substance that rendered medication waste and illicit material unusable/non-recoverable).

Review of Resident's 14's "Nursing Notes", indicated the following:
On 1/28/21, at 12:03 PM, approximately 17 saran wrapped dark greenish dried buds (smell like marijuana) in one of his sweaters hanging in his closet and a red cigarette lighter.
On 4/5/21, at 6:05 PM, found 2 pieces of buds of marijuana.
On 6/2/21, at 5:44 PM, 1 block of cannabis infused chocolate inside in underpants and a lighter.
On 6/11/21, at 9:49 PM, a half of infused cannabis chocolate bar, in the sling.
On 7/9/21, at 5:47 PM, unopened package of cannabis in his sweat-shirt right sleeve.
On 7/30/21, at 6:05 PM, 4 buds (like dime size) of marijuana were found inside cigarette box.

During an interview on 10/12/21, at 1 PM, in the facility's South 6 unit, RN 20 stated, Resident 14 had multiple clinical searches done. RN 20 added, "We're doing it (clinical search) almost on regular basis. Whenever he goes out on dialysis. We confiscated gummy bear, chocolate infused cannabis and a lot more

Review of Resident 4's "Nursing Note" dated 9/21/21, at 11:11 PM, indicated, "...Clinical search done ...with the Supervision of Cadet (name redacted) and found a rolled paper burned

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halfway with some residue and smelled weed and showed it to Cadet (name redacted) and instructed me to flushed in the toilet..."

During an interview on 10/12/21, at 3:54 PM, RN 19 stated, Resident 4 had multiple clinical searched done. RN 19 added, the most recent contraband confiscated was a "weeds rolled in paper and brand new cigarette. It's MJ (marijuana) because it has a distinct smell, skunk like but bearable." RN 19 explained that she put the confiscated "weeds" in a "Ziploc" and endorsed it to the night shift to show the Nurse Manager "as an evidence." RN 19 shared that there was an incident that she "flushed (the MJ) in the toilet as instructed by the Sheriff." RN 19 further stated she did not received training to do clinical search. RN 19 added, "I'm not comfortable doing it (clinical search). I'm scared especially if the residents are aggressive. They can hit us. The Sheriff doesn't even help. They're just watching."

Review of Resident 11's "Nursing Note", dated 1/3/21, at 10:38 PM, indicated, "...Clinical search was performed along with primary LN. Found eye drop vial (with blackish liquid) wrapped in white towel. Resident in the beginning stated it was for his "cake"...Possession was put aside, will endorse next shift to give to manager tomorrow..."

Review of Resident 11's "Nursing Note", dated 1/4/21, at 8:37 AM, indicated, "Unit manager interviewed resident and he admitted that is was {sic} "drugs" when asked what type? "Heroine"..."

Review of Resident 13's "Nursing Note", dated 1/24/21, indicated, " ...Clinical search done with

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F 726	Continued From page 56 another license and found a small amount of dry, green loose leaves, some are shaped like a ball in one of the paper bag ... I was holding the bag and explaining to him that I need to confiscate it then he suddenly grab it from me. Tried to take it back but keep insisting that he doesn't need to give it back that he is allowed to smoke it..." Review of Resident 15's "Nursing Note" dated 3/11/21, indicated, "... clinical search done... Able to find a nickel size green leaves with some loose leaves inside his cigarette box...Substance confiscated..." Review of Resident 16's "Nursing Notes" dated 3/29/21, at 12:36 PM, indicated, "...Clinical search conducted after resident observed with possession of marijuana..." Review of Resident 16's "Nursing Notes" dated 9/10/21, at 5:18 PM, indicated, "...Clinical search conducted in resident's room...In the bedside table found an empty package of "Pacific Stone" marijuana..." Review of Resident 23's "Nursing Note" dated 7/30/21, at 5:38 PM, indicated, "S2 (South 2) unit-wide clinical search conducted. Found: three unopened jars of CBD supplement products and small sharp scissors." Review of Resident 12's "Nursing Note" dated 1/28/21, at 1:19 PM, indicated, " ...Clinical search with charge nurse on (Resident 12) uncovered a rolled joint of marijuana under her waist band...Resident received a package from Sonoma today...We found more contrabands. Two 50g (grams) tin container of cannabis	F 726		

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F 726	Continued From page 57 infused caramel bites, 50g zip lock container of cannabis infused mango, and a Vape pen..." Review of facility document titled, "Clinical Searches with Items Found" received on 10/13/21, at 3:15 PM, for Resident 18, indicated, on 8/5/21 at 3:40 PM, "Clinical safety search done; found an ICP (Intermittent Catheterization Procedure) kit small plastic container with one white pill; pharmacy was not able to ID the pill as the markings were not legible..." During an interview, on 10/14/21, at 1200 NN, ND 4 acknowledged no documentation of the disposition of the confiscated "white pill" from Resident 18. Review of Resident 33's "Nursing Note" dated 7/30/21, at 5:45 PM, indicated, "S2 (South 2) unit-wide clinical search conducted. Found: small pink container with dozens small ends of marijuana joints..." Review of facility document titled, "Clinical Searches with Items Found" received on 10/13/21, at 3:15 PM, indicated the following: On 7/28/21, at 1 PM, in the North 1 unit, "3 empty bottles of whiskey found in the garbage can in the unit balcony." On 8/5/21 at 3:40 PM, Resident 24 was witnessed by the coach "hand rolling paper and one small dry bud." Lighter was also found during clinical search. During an interview with Quality Management (QM) 1 on 9/9/21, at 5:43 PM, in facility's conference room, QM 1 stated the last nursing safety education on handling contraband substances was in 2017 and there was one slide	F 726		

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on the document related to "Clinical Searches."

In a joint interview with ND 1 and NM 1, on 9/13/21, at 11:30 AM, in the North 3 unit, they both acknowledged the multiple responsibilities nursing staff had to have to keep the residents safe and at the same time respect the resident's privacy and rights regarding illicit substance use. NM 1 added, nurses needed to maintain a therapeutic relationship with residents to hold the trust and care they needed to provide.

During an interview on 10/12/21, at 12:39 PM, Licensed Vocational Nurse (LVN) 1 stated she received verbal training for clinical search in the unit by the Nurse Manager. LVN 1 explained a clinical search is completed when a resident return to the facility from an appointment but not with dialysis appointment.

During an interview on 10/12/21, at 12:40 PM, NM 6 stated, "I have no formal training or hands on training to do clinical search."

During an interview on 10/12/21, at 12:42 PM, RN 20 explained that she is not comfortable doing clinical search. RN 20 added, "It depends if resident resist. It's scary coz it's a safety issue. Sometimes Social Worker and doctors are doing it too (clinical search)." RN 20 could not recall when she received an in-service for clinical search and stated, "around 2013."

During an interview on 10/12/21, at 12:43 PM, Certified Nurse Assistant (CNA) 8 stated, "I am not comfortable doing clinical search but I have to do it. I know it's not in our job description."

During an interview on 10/12/21, at 12:45 PM, RN

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F 726	Continued From page 59 17 stated, "I do not have a training to do clinical search." During an interview on 10/12/21, at 1:10 PM, PCA 2 stated "I do not have a training to do clinical search. It would be nice to have one." During an interview on 10/12/21, at 1:15 PM, PCA 3 stated, " I do not remember having a training to do clinical search." During an interview on 10/12/21, at 1:33 PM, PCA 4 stated, "I do not remember if we had a training to do clinical search. I participated on a clinical search. We found scissors and screwdriver in the resident's room." During an interview on 10/12/21, at 1:35 PM, PCA 5 stated, "I do not remember having a training on clinical search." During an interview on 10/12/21, at 3:05 PM, PCA 6 stated, "I do not remember having a training on clinical search. During an interview on 10/12/21, at 3:30 PM, CNA1 stated she perform clinical search of residents and their rooms, if needed. CNA1 acknowledged she did not receive any training on how to perform clinical search. CNA1 stated she was not familiar what illicit drugs (cannabis, fentanyl, amphetamine) and drug paraphernalia looks like. During an interview on 10/12/21, at 3:38 PM, CNA 2 acknowledged he has no training related to clinical search and that he was not aware of what clinical search is.	F 726		

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F 726	Continued From page 60 During an interview on 10/12/21, at 3:45 PM, PCA 7 stated "We did not have a training on clinical search." During an interview on 10/12/21, at 3:46 PM, RN 2 stated she has no experience nor training related to clinical search. During an interview on 10/12/21, at 3:50 PM, RN 3 acknowledged she has no recent training on clinical search and the latest training she had was in 2019. During an interview on 10/12/21, at 3:55 PM, RN 18 stated "I have done a lot of clinical search. We have found cannabis. We dropped it off at the pharmacy. I did not have a training in clinical search." During an interview on 10/12/21, at 4:26 PM, CNA 9 stated he experienced helping in clinical search. CNA 9 added that he did not received training how to do clinical search safely. During an interview with Chief Nursing Officer (CNO) on 10/13/21 at 10:32 AM, the CNO stated, clinical searches were not a community standard and the peace officers through sheriff staff could not do the search for illicit substances. CNO stated "I cannot teach them do the clinical searches". CNO stated, for clinical searches, she expected nursing staff to call the onsite sheriff for observation and follow basic safety procedures. CNO stated the process for disposition, handling and itemizing contraband by nursing staff had not been standardized. CNO acknowledged the current facility's policy on illicit contraband substances and searches needed to be updated along with a more robust nursing education.	F 726		

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F 726	Continued From page 61 During an interview on 10/13/21, at 4:55 PM, NM1 stated she perform clinical search in her nursing unit if needed. NM1 acknowledged she did not have any training on how to perform clinical searches. Review of the facility's document titled "2017 SMART; Nursing Education" dated 2017, the document's Clinical Searches' slide, indicated " ...To maintain a safe milieu throughout the facility for residents, staff, volunteers, & visitors; When resident is suspected to have contraband or paraphernalia staff may search the room & property; admission; return late from OOP [Out On Pass, means going out of facility]; ... A minimum of two staff should be present at all times; Universal Precautions; ... Optional to contact the Sheriff (recommended if resident is agitated); All confiscated substances shall be cataloged then turned into SFSD [San Francisco Sheriff Department] except: Cannabis ..., Alcohol; cigarettes ..." Review of the facility's policy 22-12, titled "Clinical Search Protocol", last revised on 9/10/19, under Policy section indicated, " ...Active substance use, drug dealing, unsafe smoking and use of dangerous objects endangers the safety of residents and staff and does not promote a resident's well-being ... When there is a potential risk and/or reasonable suspicion that a resident possesses contraband, staff shall conduct searches of the resident, a resident's room, and personal belonging, as well as property and packages brought by visitors ..." Under Search Procedure section, indicated " ...Staff shall take Universal Precautions [a standard set of guidelines to prevent the transmission and	F 726		

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F 726	Continued From page 62 exposure to blood and other potentially infectious materials] such as wearing double gloves when handling resident belongings or suspected contraband. Staff shall avoid reaching into any pockets. Instead, staff shall pour out the contents of bags, boxes, packages, or other personal belongings, ask the resident to empty their pockets, and/or gentle patting ..." Review of the facility's policy 80-05, titled "Staff Education Program", last revised on 2/9/21, under Section 1 indicated, " ...a variety of initial and annual health and safety classes shall be provided to specific classifications of employees in compliance with CAL OSHA (a regulatory agency with focus on preventing work related injuries) regulations ..." Under Section 5 indicated, " ...Educational activities are documented to meet minimum requirements of the State Department of Health Services and California Board of Registered Nurses or other pertinent regulatory bodies..." Review of guidelines from Institute for Occupational Safety and Health (or NIOSH a federal government entity responsible for making recommendations for the prevention of work-related injury and illness) titled, "Preventing Occupational Exposure to Fentanyl: Preventing Occupational Exposure to Healthcare Personnel in Hospital and Clinic Settings" last accessed on 9/15/21 via https://www.cdc.gov/niosh/topics/fentanyl/healthcareprevention.html dated April 23, 2018, indicated " ...Illicit fentanyl and its analogues (for the purpose of this document, referred to as illicit fentanyl) pose a potential hazard to healthcare personnel who could come into contact with these drugs in the course of their work in hospital and	F 726		

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F 726	Continued From page 63 clinic settings. This potential risk, which is related to external sources of fentanyl (i.e., originating in the community), is distinct from the hazards posed by diversion of pharmaceutical fentanyl". The guidelines further indicated " ...Healthcare personnel who could potentially be exposed to illicit fentanyl include nurses, nursing assistants ... clerical, dietary, environmental services, laundry, security, engineering, and facilities management, administrative, billing, and volunteer personnel ... Healthcare personnel might be exposed when the patient or their personal items are contaminated with illicit fentanyl, which may be present in powder, tablet, or liquid forms." The NIOSH guideline further provided guidance on staff training, Personal Protective Equipment (PPE) use and specific decontamination practices for the areas such as surfaces and the laundry materials.	F 726		

EXHIBIT 4

State of California-Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Rcvd Laguna Honda Hosp Admin
2022 FEB 16 PM2:00

February 15, 2022

Letter 8

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Michael Phillips, Administrator
Laguna Honda Hospital & Rehabilitation Ctr D/P SNF
375 Laguna Honda Blvd.
San Francisco, CA 94116-1411

Dear Mr. Phillips:

On January 21, 2022 a revisit for an abbreviated survey for facility reported incident nos. CA00675386, CA00744774, CA00745390, CA00747134 and CA00746900 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency or "CDPH"), to verify if your facility achieved and maintained compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. However, based on CDPH's revisit conducted on , your facility is not in substantial compliance with the following participation requirement(s):

F689

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)

A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS- 2567. Failure to submit an acceptable POC by the due date may result in termination of your provider agreement or imposition of alternate remedies by the CMS and/or State Medicaid.**

Providers may now submit their plan of correction (POC) as a separate document attachment or may continue to document the POC on the right side of the CMS Form 2567- "Statement of Deficiencies and Plan of Correction" and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State Agency.

Recommended Remedies
The recommended remedies for imposition include the following:

[X] A civil money penalty will be recommended to CMS Regional Office if substantial compliance has not been achieved. (§488.430)

[X] Termination effective April 14, 2022. (§488.456)

Denial of Payment for New Admissions (DPNA)
Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective January 14, 2022. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

FILING AN APPEAL
If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program

(NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user.sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit. The CMS Regional Office may impose revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies, to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have any questions concerning this letter, please contact Pinky Suriben, District Administrator at (415) 330-6353.

Sincerely,

P. Suriben HFDM I for:

Diana Marana, R.N.
District Manager
Licensing and Certification

Enclosure *(CMS 2567)*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	R-C 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a first revisit for an Abbreviated Standard Survey on January 20, 2022 through January 21, 2022. Facility reported incident: CA00744774 Facility reported incident:: CA00745390 Facility reported incident: CA00747134 Facility reported incident: CA00746900 Facility reported incident: CA00675386 Inspection was limited to the revisit, and does not represent the findings of a full inspection of the facility. The census at the beginning of the survey was 697. The sample size was 10. The highest scope and severity was E. For Facility Reported Incident nos. CA00744774, CA745390, CA747134, CA746900 and CA675386, the federal deficiency (F689) was not corrected. Representing the California Department of Public Health: 39421, Health Facilities Evaluator Nurse 40009, Health Facilities Evaluator Nurse 44576, Health Facilities Evaluator Nurse 45439, Health Facilities Evaluator Nurse	{F 000}		
{F 689} SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	{F 689}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 689}	Continued From page 1 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, for three of 10 sampled residents (Resident 2, Resident 14 and Resident 31), the facility failed to ensure safe environment when: 1. Three of 10 sampled residents (Resident 2, Resident 14 and Resident 31) were found in possession of contraband during clinical search. 2. The "two empty baggies with small amount of white residue" were stored inside the medication storage room after confiscation on 12/6/21 until 1/21/22 (total of 46 days). 3. The confiscated contraband was not disposed in accordance to the facility policy. 4. The staff did not complete the transfer of contraband form for items confiscated from Resident 31. This failure had the potential for diversion, misuse or uncontrolled redistribution of confiscated contraband and further harm to residents, staff, and visitors. Findings: 1a. Review of Resident 2's "Transfer Form for Suspected Illicit Substances, Paraphernalia, Prohibited Drugs" indicated the following: On 11/13/21, "white powder found in a silent night pouch" and "Form uneven shape tablet like a half	{F 689}		

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{F 689}	Continued From page 2 tablet" were confiscated. Review of Resident 2's "Transfer Form for Contraband Items" indicated the following were confiscated: On 11/24/21, "2 pieces of foil 3x5 inches...Burnt foil with black residue." On 11/25/21, "Black residue on foil x 3." On 11/27/21, (i) "5 in (inch) x 2 in foil (with) black residue", (ii) "Pen casing 7 in long (with) black residue throughout", (iii) "1.5 in x 1.5 in clear baggies (with) white residue", (iv) "Silver foil (with) black residue." On 12/2/21, (i) "3 pieces of foil (with) black residue", (ii) "White paper straw (burned), (iii) "Bic lighter", (iv) "Capsule (with) whitish-brown powder", (v) "5 roll of foil." On 12/4/21, (i) "Burned foil (with) white burned straw." On 12/7/21, (i) "Round neon rainbow colored pill case (with) white powder inside + (plus) 2 white rocks. 1.25" x 1.25" round", (ii) "Clear baggies (with) white powder wrapped in silver foil", (iii) "Foil (with) black & brown substance", (iv) "Black lighter." 1b. Review of Resident 14's "Transfer Form for Contraband Items" indicated the following were confiscated: On 1/3/22, "Weed inside clear tube, like a size of cigarette." On 1/17/22, "Round, green dried leaves. Dime size" On 1/19/22, "Roll of marijuana. 3.2 cm (centimeter) x 1 cm." 1c. Review of Resident 31's progress notes dated 12/6/21, at 11:23 AM, indicated "Clinical search done... Collected two empty baggies with small	{F 689}		

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{F 689}	Continued From page 3 amount of white residue..." Review of Resident 31's "Transfer Form for Contraband Items", indicated on 12/6/21 the following were confiscated: Description of Substance: "Unknown Substance" Form and Color: "White Powdered Residue" Approximate Amount: "2 small bags" Further review of the form indicated the contraband was found by Registered Nurse (RN) 21 on 12/6/21. Under "Other Comments" indicated, the "2 Powdered (white) residue bags given to ND [Nurse Director] on 1/21/22." The sections under "Transfer to Nurse Manager" and "Transfer to Nursing Operations Supervisor" were left blank. During an interview with ND 5, on 1/21/22, at 3 PM, ND 5 acknowledged RN 21 did not complete the Transfer Form for Contraband Items on 12/6/21. ND 5 stated RN 21 stored the confiscated items inside the Pavilion Mezzanine Medication Storage. ND 5 stated RN 21 gave the confiscated items to ND 5 on 1/21/22. ND 5 stated he destroyed the confiscated items in the medication waste bin in the Pavilion Mezzanine medication room and was witnessed by RN 21 on 1/21/22. Review of Resident 31's progress notes, dated 1/21/22, at 4:11 PM, indicated "Received confiscated contraband from CN (Charge Nurse) [RN 21] that contained two bags with white residue noted. Disposed of in medication bin. Witnessed by [RN 21]." During an interview with Quality Management (QM) 1 on 1/21/22, at 3:15 PM, QM 1 stated RN 21 should have completed the Transfer Form for	{F 689}		

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{F 689}	Continued From page 4	{F 689}		

Contraband Items, within the same shift the contraband was found. QM 1 added the confiscated item should have been given to a Sheriff Deputy for proper disposal in accordance to the Standard Work for "Contraband Item Handling, Storage & Disposal."

Review of facility document, titled "Standard Work Instructions... Title: Contraband Items Handling, Storage & Disposal, dated 11/19/21, indicated "Purpose: To promote resident and staff safety on the units when handling contraband items removed from resident's possession... E. Handling & Disposal of Illicit or Prohibited Drug/ Drug Paraphernalia... 2. Transfer the bagged items to SFSD (San Francisco Sheriff Department) (sheriff) personnel within the shift the items were found... a. If a sheriff is not readily available, keep the contraband in a locked metal cabinet in the nursing office. b. The sheriff shall acknowledge receipt of the item(s) via the Transfer Form for Contraband Items, then store the item(s) off unit at the sheriff's office. c. Replace the copy of the Transfer Form for Contraband Items in the bag with an updated copy that includes the sheriff transfer acknowledgement. Place the old copy into the confidential recycle bin.

Review of facility's Plan of Correction, with completion date of 11/13/21, indicated "... 9. The San Francisco Department of Public Health has entered into a service agreement with the San Francisco Sheriff Office that deputies will take possession of any illicit substance, including cannabis, suspicious substances, contraband, or other prohibited items confiscated during clinical search activity.

EXHIBIT 5

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{F 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a second revisit for an Abbreviated Standard Survey on March 16, 2022 through March 28, 2022. Facility reported incident: CA00744774 Facility reported incident:: CA00745390 Facility reported incident: CA00747134 Facility reported incident: CA00746900 Facility reported incident: CA00675386 The inspection was limited to the revisit, and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 36814, Health Facilities Evaluator Manager I 38066, Health Facilities Evaluator Nurse 40009, Health Facilities Evaluator Nurse 41545, Health Facilities Evaluator Nurse 44478, Health Facilities Evaluator Nurse 45439, Health Facilities Evaluator Nurse 40903, Pharmaceutical Consultant The census at the beginning of the survey was 706. The sample size was 21. The highest scope and severity was K. For Facility Reported Incident: CA00744774, CA745390, CA747134, CA746900 and CA675386, the federal deficiency (F689) was not corrected. An immediate jeopardy (IJ) was declared on	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 3/22/22 at 4:22 PM in the presence of the Chief Executive Officer (CEO), Chief of Operations (COO), Chief Medical Officer (CMO), Chief Quality Officer (CQO), and Acting Chief Nursing Officer (CNO) for F689 - Free of Accident Hazards/Supervision/Devices because of the following: 1. Resident 44 on oxygen was in possession of a lighter. 2. Resident 45 was observed by staff smoking in the communal bathroom. 3. Ineffective system to eliminate source of contrabands inside the facility. Resident were found in possession of contraband on several occasions. 4. Resident 2 was freely smoking illicit substances in the presence of the provider. The IJ was removed on 3/27/22 at 5:41 PM with a Removal Plan of Action instituted by the facility and reviewed by the team.	{F 000}		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental	F 645		

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F 645	Continued From page 2 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual	F 645		

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F 645	Continued From page 3 is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete preadmission screening and resident review (PASRR, federal requirement to help ensure that individuals are not inappropriately placed in nursing homes) for one of seven residents reviewed (Resident 31). Failure to complete PASSR for Resident 31 could potentially result to unidentified needs and services. Findings: Review of Resident 31's clinical record, Resident 31 was admitted on 4/19/21 with diagnoses including stroke (occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts (or ruptures) and schizophrenia (serious mental disorder in which people interpret reality abnormally. Review of Resident 31's MDS (resident tool assesment) dated 7/13/22, indicated Resident 31 had significant change of status on 7/13/22.	F 645		

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F 645	Continued From page 4 However, there was no PASRR completed for Resident 31. During an interview on 3/28/22, at 2:22 PM, with Utilization Management Staff (UM), UM stated Resident 31 's PASRR was not done when it should have been completed. UM stated she did not receive notification from the MDS coordinator. The facility policy and procedure titled "PASRR", revised 9/10/2019, indicated, "4. Review by Resident Care Team (RCT) a. If there is a significant change of condition, the MDS coordinator notifies UM via the EHR (electronic health record) b. the UM Nurse completes status change PASRR Level I via DHCS 's (California Department of Health Care Services) PASRR web based system".	F 645		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		

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F 656	Continued From page 5 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a care plan to address Resident 42's going out-on-pass. This failure could potentially result to Resident 31's unmet physical, mental and psychosocial needs. Findings: Resident 42 was admitted on 2/18/2009 with diagnosis including quadriplegia (paralysis of all four limbs).	F 656		

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F 656	Continued From page 6 During a review of clinical record titled Minimum Data Set (MDS, a resident assessment tool), for Resident 42, dated 12/30/21, indicated a Brief Interview for Mental Status (BIMS, a brief assessment to help detect cognitive impairment) score of 15 indicating resident is cognitively intact. During a review of Resident 42's clinical records, the progress notes, dated 2/20/22, at 1:17 PM, indicated resident went out-on-pass (OOP) at around 11:30 AM and will be back at 5 PM. During an interview and concurrent record review with Quality Management (QM) 1, on 3/16/22, at 5: 15 PM, QM1 stated she could not find any documentation in progress notes to indicate when and what time Resident 42 came back from OOP. Review of Resident 42's clinical records did not indicate care plan to address Resident 42's going OOP. QM1 acknowledged the above findings and stated unit staff must complete the Out-on-Pass assessment form and document in progress notes Resident 42' return. Review of facility document, titled "Standard Work Instructions: Resident Returning from OOP (Day and Overnight) and Essential Appointment", dated 11/12/21, indicated "Purpose: To ensure resident are assessed upon return from OOP and essential appointments, and documented in Epic (electronic health record software)... To identify if an abuse and/or injury protocol is necessary upon residents return to LHH (Laguna Honda Hospital)... Major Steps... 2. Upon return of resident, the team leader or charge nurse will : a. For OOP - Completed the "Resident Returning from OOP Assessment" in Epic within 1 hour of return from OOP... 4. The Charge Nurse will	F 656		

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F 656	Continued From page 7 check the Team Leader if the "Resident Returning from OOP Assessment" in the flowsheet was completed during change of shift report... 7. Does the resident have any visible unexplained bruises, cuts or abrasions (or any signs potential signs of abuse)?". Review of facility policy and procedure, titled "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC), revised 7/9/19, indicated "2. the RCT, in conjunction with the resident, resident's family, or surrogate decision-maker, shall develop a comprehensive care plan, based on the care team disciplines' assessments, that includes measurable objectives and a time table to meet the resident's medical, nursing, and mental health needs."	F 656		
{F 689} SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure safe environment for all residents when the facility did not implement policies and procedures for the following practices: 1. Resident 44 who was on oxygen lighted	{F 689}		

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tobacco inside the room;
2. Resident 2 was freely smoking illicit substance in the presence of the provider;
3. Three residents (Resident 2, Resident 45 and Resident 48) were smoking in residents' care area;
4. Possession of igniters inside the resident care area for 17 of 38 residents (Resident 6 , Resident 50, Resident 11, Resident 38, Resident 48, Resident 2, Resident 14, Resident 22, Resident 56, Resident 7, Resident 17, Resident 53, Resident 18, Resident 4, Resident 39, and Resident 40).
Access to igniters posed a safety hazard that can cause combustion and fire in the building.

These failed practices placed all residents to an unsafe living environment and negative health outcomes.

Findings:

1. Resident 44 was admitted on 11/5/21. Review of Resident 44's Minimum Data Set (MDS - a resident assessment tool) dated 11/12/21 indicated, Resident 44 was cognitively intact, no impairment on upper and lower extremities, and required extensive assistance for activities of daily living. Resident 44 had active diagnoses that included but not limited to Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), Atrial Fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) and Nicotine Dependence (an addiction to tobacco products caused by the drug nicotine). Other health conditions included dyspnea (shortness of breath). Resident 44 was on oxygen therapy as part of respiratory

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treatment.

Review of Nursing Note dated 3/17/22 indicated, staff noted a smell of smoke at Resident 44's bedside. A 2-person clinical search was done and a rolled paper and lighter were found on resident's pocket. Nursing Note dated 3/18/22 indicated, Resident 44 remains on oxygen at 2 liters per minute (lpm) via nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help).

During an interview with Nurse Manager (NM)8 on 3/21/22 at 3:37 PM, NM8 stated, "Resident came with the lighter on admission on 11/5/21." NM8 said Resident 44 has COPD, a heavy smoker before and still has cravings to smoke. Furthermore, NM8 said that Resident 44 is oxygen dependent.

Review of Resident 44's clinical record titled "Active Order Sets" indicated, " ...Current Scheduled Medications ...Start 11/06/21 nicotine (Nicoderm CQ) 21 mg (milligram)/24 hr (hour) 1 patch transdermal (application of a medicine or drug through the skin), Daily ...Respiratory Orders: Start 2/15/22 ...Oxygen delivery/Respiratory support ...Simple Face Mask ...Rate in liters per minute: 6-10 lpm ...for comfort ...Continuous ..."

Review of facility document titled "Transfer Form for Contraband Items" indicated, a red lighter and three strips of torn brown paper were in Resident 44's pocket. These items were found and confiscated by staff member on 3/17/22.

During an observation and concurrent interview

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{F 689}	Continued From page 10 with Resident 44 on 3/22/22 at 2:08 PM, Resident 44 was in bed, with shortness of breath and on oxygen at 3lpm via nasal cannula delivered through a wall mounted oxygen flow regulator. Resident 44 acknowledged that he uses oxygen and stated, "Yes, all the time." Resident 44 said that he smoked for a long time before. Resident 44 admitted that while in bed and on oxygen, he lighted a piece of rolled paper, which the resident referred to as "tobacco". Resident 44 said that the nurse found about him lighting the tobacco "because they smelled it." Resident 44 understood the risk of smoking while oxygen is in use. Resident 44 stated, "It will blow up, it's scary." During an interview on 3/28/22 at 4:21 PM, NM5 acknowledged that a follow-up clinical search was done for Resident 44 on 3/23/22 at 7:30AM. One blue small lighter and four broken cigarettes were found in his possession. Review of facility policy titled "Smoke and Tobacco Free Environment" revised on October 13, 2020 indicated, "Policy: ...2. Smoking and tobacco products are prohibited on the LHH campus, with the exception of smoking in the designated smoking area ...3. Lighters ...and other devices that ignite, light, or fuel a flame are not permitted ...8. Residents with an oxygen tank or concentrator are prohibited from smoking ..." Review of facility policy titled "Oxygen Administration" revised on March 12, 2019 indicated, "...B. Safety measures for oxygen are to be followed. 1. Residents and visitors are to be informed of the risks of smoking when oxygen in use..."	{F 689}		

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{F 689}	Continued From page 11 2 .During review of the Resident 2's medical record titled "Nursing Notes", written by RN 3 on 2/9/22, at 3:45 PM, the note indicated "Received a call from Psychiatrist Doctor (PD 1) and reported during his session at bed side, resident did the actual burning of controlled substance using the aluminum foil and plastic pen body case". Review of Resident 2's medical record titled "Resident Care Team Meeting Note; Special Review", written by RN 3, on 2/9/22, at 6:04 PM, the record indicated a recommendation for monitoring by an "on sight coach (staff member that watched the resident all the time) for safety to monitor resident's whereabouts and activity" and for the "Staff to monitor resident for any S/SX (means sign and symptoms) of drug intoxication (bad reaction)". Review of Resident 2's medical record titled "Progress Notes" dated 2/9/22, written by PD 1, the note indicated during motivational interviewing (a type of talk therapy by skilled mental health providers), resident engaged in smoking an unknown substance out of foil. The PD 1's note indicated Resident 2 had a "history of Fentanyl/Opioid use disorder" (means addiction or use of unprescribed substances). The PD 1's note further indicated "After session, immediately called charge nurse to request monitoring of consciousness/RR (RR means Respiratory Rate or the breathing pattern) ... to ensure immediate medical safety". In an interview with the PD 1 on 3/18/21, at 10:15 AM, the PD 1 stated he had been conducting motivational interviewing as a tool to help the	{F 689}		

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resident with Substance Use Disorder (or SUD, means addicted to illicit or unprescribed substances) in addition to Medication-Assisted Treatment (or MAT which was the use of medications in combination with counseling for the treatment of addiction). PD 1 stated the level of mental health care provided in the facility was like a community clinic and Resident 2 needed a higher level of mental health interventions for his addiction. PD 1 stated the substance use by Resident 2, who shared a room with a bed bound resident, and the use of igniter was a safety issue.

3a. Review of the Resident 2's "Nursing Note" indicated the following:
On 2/9/22, at 3:45 PM, "(Resident 2) voluntarily handed the burnt aluminum foil, plastic pen body case burned on one end and a cigarette lighter that he's holding ...Resident even stated 'they know I'm doing this."
On 2/9/22, at 6:53 PM, " ...again found a burnt aluminum foil on top of the overhead table and resident handed the bottle of "Keto diet pill" with marijuana (plant-based mind altering substance) inside."
On 3/17/22, at 9:15 AM, (late entry 2/17/22) "Illicit substance found, see transfer form of contraband for listing items and disposition. Pt (patient) educated of danger and risks when taking unprescribed substances."
On 3/13/22, at 4:53 PM, "Staff ... found a burnt foil on the overbed table and resident was cleaning a plastic ink pen case when she walked in the room to give his roommate medication ... went to his room & found the burnt foil with black residue on it, apparently a brunt-controlled substance and a plastic ink pen case. Resident stated, 'take it, doctor know' ... lighter (blue and

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green) were also found on top of the overbed table ..."
On 3/24/22, at 3:30 PM, the staff found two cigarette lighters, burnt aluminum foil with black residue and multiple rock shaped marijuana leaves (mind altering substance) inside a pack of cigarette on top of Resident 2's overbed table. The note further indicated Resident 2 was upset and verbally abusive toward the nursing staff.
On 3/26/22, at 5 PM, staff reported the resident was holding on a cigarette lighter at bedside. RN 3s note, furthermore, indicated an empty lighter was retrieved and was "added to his list of personal belongings."

In an interview with Resident 2 on 3/16/22, at 10:47 AM in his room, Resident 2 stated he felt "F ...miserable" and the facility was not doing anything about the wound on his elbow. Resident 2 stated "they all know I do it (meant using or smoking illicit substances)" and added "it's my own choice, obviously, I am not dead." Resident 2 stated that his mother visited him last week.

In an interview with Licensed Vocational Nurse (LVN 2) on 3/21/22, at 10:45 AM, in the facility's Pavilion Mezzanine (PM) unit, LVN 2 stated Resident 2 had a sitter (a person who always watched and followed the resident), and he stayed in bed and slept until 2-2:30 PM on most days. LVN 2 stated Resident 2 stayed up until early morning hours and he was in and out of the unit throughout the evening and nighttime. LVN 2 added the day shift was mostly uneventful for him.

In an interview with Registered Nurse (RN) 23 in the PM unit, on 3/21/22, at 11:24 AM, RN 23 stated it was challenging to deal with substance

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{F 689}	Continued From page 14 abuse by few residents and at the same time keep everyone safe. RN 23 believed they could not control external factors and the contrabands kept showing up in the resident's rooms. In an interview with PM Unit's Clerk 1 (UC 1) on 3/21/22, at 11:50 AM, UC 1 stated she monitored visitors coming into the unit and help guided them to sign in the required logging document. UC 1 stated she facilitated residents' medical appointments or outside pass (permission to go outside facility) requests based on doctor's order. UC 1 stated she did not keep track of packages or deliveries for the residents. UC 1 stated that she received training on safety issues in the unit. In an interview with the Nursing Director (ND) 5 on 3/22/22, at 1:32 PM, the ND 5 stated we needed to address the root cause of how these substances and contrabands got in the hands of our residents and continued to flow into the facility. Our team have exhausted most options in helping eliminate or minimize the contraband and illicit substances into the unit. Review of the Resident 2's "Nursing Note" indicated the following: On 2/9/22, at 3:45 PM, "(Resident 2) voluntarily handed the burnt aluminum foil, plastic pen body case burned on one end and a cigarette lighter that he's holding ...Resident even stated 'they know I'm doing this." On 2/9/22, at 6:53 PM, " ...again found a burnt aluminum foil on top of the overhead table and resident handed the bottle of "Keto diet pill" with marijuana (plant-based mind altering substance) inside." On 3/17/22, at 9:15 AM, (late entry 2/17/22) "Illicit substance found, see transfer form of contraband	{F 689}		

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watched and followed the resident), and he stayed in bed and slept until 2-2:30 PM on most days. LVN 2 stated Resident 2 stayed up until early morning hours and he was in and out of the unit throughout the evening and nighttime. LVN 2 added the day shift was mostly uneventful for him.

In an interview with Registered Nurse (RN) 23 in the PM unit, on 3/21/22, at 11:24 AM, RN 23 stated it was challenging to deal with substance abuse by few residents and at the same time keep everyone safe. RN 23 believed they could not control external factors and the contrabands kept showing up in the resident's rooms.

In an interview with PM Unit's Clerk 1 (UC 1) on 3/21/22, at 11:50 AM, UC 1 stated she monitored visitors coming into the unit and help guided them to sign in the required logging document. UC 1 stated she facilitated residents' medical appointments or outside pass (permission to go outside facility) requests based on doctor's order. UC 1 stated she did not keep track of packages or deliveries for the residents. UC 1 stated that she received training on safety issues in the unit.

In an interview with the Nursing Director (ND) 5 on 3/22/22, at 1:32 PM, the ND 5 stated we needed to address the root cause of how these substances and contrabands got in the hands of our residents and continued to flow into the facility. Our team have exhausted most options in helping eliminate or minimize the contraband and illicit substances into the unit.

3b. Review of Resident 45's Minimum Data Set (MDS, a resident assessment tool) dated 1/8/22 indicated, Resident 45 had no cognitive

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impairment, no impairment on upper extremities, range of motion was impaired on both sides of lower extremities, and required supervision to extensive assistance with activities of daily living. Resident 45's active diagnoses included but were not limited to depression, vascular dementia (brain damage caused by multiple strokes), hemiplegia and hemiparesis (weakness and paralysis to one side of the body).

Review of Resident 45's H&P (History and Physical) Note dated 4/18/21 indicated, " ...Social History ... He started smoking about 55 years ago. He has a 27.50 pack-year smoking history. He has never used smokeless tobacco ..."

Review of facility document titled, "Transfer Form For Contraband Items", dated 3/19/22, indicated, two match book were found in Resident 45's left sock.

Review of Nursing Note dated 3/19/22 indicated, staff smelled some smoke in the communal bathroom of South 3 unit and found ashes inside. During an interview on 3/21/22, at 3:49 PM, Nurse Manager (NM) 8 stated the staff smelled cigarette smoke in the communal bathroom of South 3 unit on 3/19/22 after Resident 45 was seen using the communal bathroom. NM 8 added, Resident 45 was identified as the only smoker in the unit and tends to smoke in the bathroom without the staff's knowledge. NM 8 acknowledged Resident 45 should not be smoking in the unit but in the designated smoking area.

During a concurrent observation and interview on 3/22/22, at 2:05 PM, in South 3 unit, Registered Nurse (RN) 30 identified the area where the staff

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{F 689}	Continued From page 18 smelled the smoke on 3/19/22, referring to the communal bathroom by the entrance of the unit. RN 30 stated the bathroom was checked and found ashes inside. RN 30 further stated, Resident 45 was found using the communal bathroom after his niece brought cigarettes and match booklet on 3/19/22. Review of Nursing Note dated 3/24/22 indicated, Resident 45 was found to have one black lighter and book of matches in his possession. Review of Resident 45's "Smoking Assessment" dated 1/7/22 indicated, " ...Resident knows where the designated smoking area(s) are located. Smokes only in the designated area ... Resident was informed that smokable products will be kept by staff for safe keeping ..." 3c. Review of Resident 48's care plan for "Safety Adult - Smoker" with start date of 2/10/21, indicated the following: On 3/11/22, Resident 48 was found smoking his room. On 3/14/22, noted strong smell of cigarette coming from Resident 48's bathroom. On 3/22/22, found lighter at the bed side table. Under "Interventions" indicated, " ...Inform resident of smoking is only permitted at designated areas. Advised resident to ask for lighting the cigarette ... Provide written [Name of Facility] policy regarding smoking and how resident should not have any open flame or cigarette at the bedside ... Staffs to collect matches, lighters, igniters, e-cigarettes ... Remind resident we can assist him to light cigarettes when needed to smoke in the Balcony. Staff to do random "	{F 689}		

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{F 689}	Continued From page 19 Review of H&P Note dated 3/14/22 indicated, " ...He has been found to be apparently smoking in forbidden places (such as bathroom) but became upset & aggressive about being checked for smoking paraphernalia ... He has been exhibiting some unsafe smoking behavior ..." 4a. During an interview with the Nurse Manager (NM) 7, on 3/17/22, at 3:30 PM, in the South-6 unit, the NM 7 stated Resident 14 was escorted (meant a staff member accompanied the resident to outside appointments) to an outside dialysis center (a treatment for kidney disease) three times a week. NM 7 stated the escort was supposed to report to the nursing if the resident had any unusual events or cut short his dialysis hours. NM 7 stated upon return from dialysis, Resident 14 was monitored for behavior changes and staff completed a safety questionnaire to assess if he had any contrabands, lighter, or unprescribed substances. NM stated, Resident 14 was followed by behavioral health (doctors helping with emotional problems) services for addiction. Review of the Resident 14's "Nursing Notes" indicated the following: On 2/11/22, at 7:06 PM, discovery of a green package of cannabis (mind altering substance) upon resident's return from dialysis. On 2/14/22, at 9:30 PM, discovery of cannabis bar (mind altering substance) and rolling paper (special paper used to roll cannabis cigarette) upon return from dialysis. On 2/22/22, at 11 PM, Resident 14 was observed "approaching the balcony with his cigarette on his mouth ... and a lighter in his lap". On 2/28/22, at 9:40 AM, "EVS staff (housekeeper staff) found one brown rolling cigarette unknown	{F 689}		

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substance on the floor while ...cleaning room." The nurse manager talked to resident and discovered other contrabands such as lighter, cigarette rolling paper and additional rolling cigarette with unknown substance inside them.
On 3/23/22, at 2:56 PM, the staff discovered two lighters in the resident's room.
On 3/24/22, at 11:34 AM, "Unit clerk noted that resident is smoking in the balcony ... checked resident in the balcony and noted that resident hidden his cigarette and stop smoking. Noted smoke on the floor. Reminded resident that he is not allowed to smoke in the balcony. Confiscated his lighter, one lighter black in color". The note further indicated Resident 14 was verbally aggressive toward the staff.

In an interview with Home Health Aide 1 (HHA, an assistant who escorted resident to outside appointments) on 2/17/22, at 3:23 PM, in the South- 6 Unit, HHA1 stated during escort she followed Resident 14 to his dialysis appointments. HHA1 stated that she had observed Resident 14 cut short his dialysis session to go buy contraband substances sold in the stores near the dialysis center. HHA 1 stated when she confronted Resident 14, he became verbally and physically aggressive. HHA 1 stated she had observed Resident 14 buying contraband substances from other dialysis patients, and he was very creative on how to hide them prior to returning to the facility.

During an observation on 3/28/22, at 11:29 AM, in his room in South 6 unit, the door entrance to Resident 14's room and on top of his bed there was a sign indicating "No Smoking; Oxygen in Use; No Open Flames".

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{F 689}	Continued From page 21	{F 689}		

Review of facility document titled, "Contraband Disposition Log" dated 3/16/22 indicated, for Resident 14, a lighter was confiscated and transferred to the Sheriff on 2/28/22.

Review of an undated facility document titled, "Contraband Disposition Log" indicated, for Resident 14, a lighter was confiscated and transferred to the NM on 3/23/22. On 3/24/22, a lighter was confiscated and transferred to the NM.

Review of Resident 14's "Smoking Assessment" dated 2/2/22 indicated, "...Resident was informed that smokable products will be kept by staff for safe keeping ..."

Review of Resident 14's care plan for "Safety Adult-Smoker" with start date of 9/2/19 indicated, " ...Interventions: ...8 ...collect all matches, lighters, igniters ..."

4b. Review of Resident 6's "Toxicology Urine screen" (means urine test for prescribed or unprescribed drugs) indicated:
On 2/15/22, at 3:45 PM, the urine test indicated a positive result for presence of unprescribed fentanyl (a strong drug with high potential for abuse).
On 3/08/22 at 7:56 PM, the test results indicated a positive result for presence of unprescribed fentanyl.

Review of Resident 6's medical record titled "Medication List" dated 2/17/22, the list did not include fentanyl on his medication list.
Review of Resident 6's "Nursing Notes" indicated the following:
On 2/16/22, at 4:18 PM, "per resident he accidentally get contact into it ...He said, 'I walked

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into the room and I got contact with it accidentally' ... Writer further asked if the room that he is referring to is in the same unit, same floor and resident said 'where else, what are you talking about" ...'it's in a thin foil, rock but you know it is better if it's a powder' ... Resident will not elaborate further".
On 3/17/22, at 7:46 AM, the note was a late entry for 2/17/22, indicated the nursing staff discovered a "crumpled burnt foil with brown residue" in the resident's room.
On 2/24/22, at 7:16 PM, "per Psychiatrist Doctor 1 (PD-1) report, the resident has a lighter during his interview with the resident this morning. Staff came to resident to confiscate the lighter, the resident voluntarily gave the lighter to the staff".

Review of Resident 6's medical record titled "Weekly Behavior Summary" dated 3/9/22 at 10:36 PM, the record indicated the target behaviors as "Verbally abusive, sexually inappropriate behavior" and intervention was to have a coach one on one at all times to help monitor and for safety.

During an interview with the ND 5 on 3/22/22, at 1:32 PM, the ND 5 stated we needed to address the root cause of how these substances and contrabands got in the hands of our residents and continued to flow into the facility. Our team have exhausted most options in helping eliminate or minimize the contraband and illicit substances into the unit. ND 5 stated the nursing management team were working diligently to make sure residents and staff were safe.

During a concurrent record review and interview with RN 21 in the PM unit on 3/28/22, at 11:45 AM, RN 21 stated coach provided for Resident 6

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by a team of Home Health Care (HHC- nursing aides) and Certified Nurse Assistants (CNA) 24 hours per day. RN 21 stated the coaching staff covered each other when one needed to take a break. The coaches reported their observation to the licensed nurses or the unit's management.

During an interview with RN 29 on 3/26/22, at 2:46 PM in the PM unit, RN 29 stated Resident 6 had someone with him all the times for safety reasons and she was puzzled how the illicit substances and lighters got into the facility.

During an interview with Resident 6's PCA 1 (a staff member that watched the resident all the time) on 3/26/22 at 1:56 PM, PCA 1 stated he had been watching the resident on day and evening shifts as a coach and helped redirected him for safety reasons. PCA 1 stated if he noticed any unusual behavior or contrabands, he would notify the charge nurse.
4c. Review of facility document titled, "Contraband Disposition Log" dated 3/21/22 indicated, for Resident 2, two empty lighters were confiscated and transferred to the Sheriff on 3/13/22.

Review of an undated facility document titled, "Contraband Disposition Log" indicated, for Resident 2, two lighters were confiscated and transferred to the NM on 3/24/22.

Review of an undated facility document titled, "Contraband Disposition Log" indicated, for Resident 2, a lighter was confiscated and transferred to the NM on 3/26/22.

Review of Resident 2's care plan for "Safety Adult-Smoker" with start date of 2/26/20

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{F 689}	Continued From page 24 indicated, "...Interventions: ...8...collect all matches, lighters, igniters..." 4d. Review of facility document titled, "Contraband Disposition Log" dated 3/16/22 indicated, for Resident 22, a lighter was confiscated and transferred to the Sheriff on 3/1/22. Review of an undated facility document titled, "Contraband Disposition Log" indicated, for Resident 22, a lighter was confiscated and transferred to the Social Worker (SW) and Sheriff on 3/23/22. Review of Resident 22's care plan for "Safety Adult-Smoker" with start date of 7/11/21 indicated, " ...Interventions: ...8 ...collect all matches, lighters, igniters ..." 4e. Review of an undated facility document titled, "Contraband Disposition Log" indicated, for Resident 56, a lighter was confiscated and transferred to the NM on 3/22/22. Review of Resident 56's "Smoking Assessment" dated 3/23/22 indicated, " ...Resident was informed that smokable products will be kept by staff for safe keeping ..." Review of Resident 56's care plan for "Safety Adult-Smoker" with start date of 8/6/19 indicated, " ...Interventions: ...8 ...collect all matches, lighters, igniters ..." 4f. Review of an undated facility document titled, "Contraband Disposition Log" indicated, for Resident 7, on 3/22/22, a lighter was confiscated and transferred to the NM on two occasions.	{F 689}		

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{F 689}	Continued From page 25 Review of Resident 7's "Smoking Assessment" dated 3/23/22 indicated, " ...Resident was informed that smokable products will be kept by staff for safe keeping ..." Review of Resident 7's care plan for "Safety Adult-Smoker" with start date of 5/17/21 indicated, " ...Interventions: ...8 ...collect all matches, lighters, igniters ..." 4g. Review of an undated facility document titled, "Contraband Disposition Log" indicated, for Resident 17, on 3/23/22, lighters were confiscated and transferred to the Sheriff on two occasions. On 3/28/22, a lighter was confiscated and transferred to the NM. Review of Resident 17s "Smoking Assessment" dated 3/23/22 indicated, " ...Holds smoking materials ..." Review of Resident 17's care plan for "Safety Adult-Smoker" with start date of 8/20/19 indicated, " ...Interventions: ...8 ...collect all matches, lighters, igniters ..." 4h. Review of an undated facility document titled, "Contraband Disposition Log" indicated, for Resident 53, a lighter was confiscated and transferred to the NM on 3/23/22. Review of Resident 53's "Smoking Assessment" dated 3/25/22 indicated, " ...Resident was informed that smokable products will be kept by staff for safe keeping ..." Review of Resident 53's care plan for "Safety Adult-Smoker" with start date of 3/25/22	{F 689}		

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{F 689}	Continued From page 26 indicated, " ...Interventions: ...8 ...collect all matches, lighters, igniters ..." 4i. Review of an undated facility document titled, "Contraband Disposition Log" indicated, for Resident 18, a lighter was confiscated and transferred to the NM on 3/25/22. Review of Resident 18's "Smoking Assessment" dated 3/22/22 indicated, " ...Resident was informed that smokable products will be kept by staff for safe keeping ..." Review of Resident 18's care plan for "Safety Adult-Smoker" with start date of 11/4/19 indicated, " ...Interventions: ...8 ...collect all matches, lighters, igniters ..." 4j. Review of an undated facility document titled, "Contraband Disposition Log" indicated, for Resident 4, three lighters were confiscated and transferred to the SW on 3/23/22. Review of Resident 4's "Smoking Assessment" dated 3/24/22 indicated, " ...Holds smoking materials ...Resident was informed that smokable products will be kept by staff for safe keeping ..." Review of Resident 4's care plan for "Safety Adult-Smoker" with start date of 11/4/19 indicated, " ...Interventions: ...8 ...collect all matches, lighters, igniters ..." 3j. Review of an undated facility document titled "Contraband Disposition Log" indicated, for Resident 50, lighter was confiscated and transferred to the Nurse Manager (NM) on 3/22/22. Review of Nursing Note dated 3/22/22 indicated,	{F 689}		

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staff found "two empty blue cigarette lighter, one black empty lighter, one empty red lighter."

4k. Review of Resident 50's "Smoking Assessment" dated 3/25/22 indicated, " ...Resident knows where the designated smoking area(s) are located. Smokes only in the designated area ... Resident was informed that smokable products will be kept by staff for safe keeping ..."

Review of Resident 50's care plan for "Safety Adult - Smoker" with start date of 3/22/22 , indicated, "Interventions ... Inform resident of smoking is only permitted at designated areas ... collect matches, lighters, igniters, e-cigarettes ..."

4l. Review of an undated facility document titled "Contraband Disposition Log" indicated, for Resident 11, lighter was confiscated and transferred to the NM on 3/23/22.

Review of Resident 11's "Smoking Assessment" dated 3/25/22 indicated, " ...Resident knows where the designated smoking area(s) are located. Smokes only in the designated area; Holds smoking materials ..."

Review of Resident 11's care plan for "Safety Adult - Smoker" with start date of 6/19/21 , indicated, "3/23/22: Lighter found in resident's top drawer. Interventions ... Inform resident of smoking is only permitted at designated areas ... Resident is allowed to carry smoking materials ..."

4m. Review of an undated facility document titled "Contraband Disposition Log", indicated, for Resident 38, a lighter was confiscated and transferred to the NM on 3/28/22.

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{F 689}	Continued From page 28 Review of Resident 38's "Smoking Assessment" dated 3/23/22 indicated, " ...Resident knows where the designated smoking area(s) are located. Smokes only in the designated area; Holds smoking materials; Observed to be sharing or selling cigarettes to other residents ... requires 1:1 supervision while smoking ..." Review of Resident 38's care plan for "Safety Adult - Smoker" dated of 3/28/22, indicated, " ...Resident determined to be unsafe smoker due to holding onto contraband (e.g., lighters, etc.) Resident is not allowed to carry igniters which is against hospital policy. Coach reported that resident has lighter in his pocket." Under "Interventions" indicated, " ... Inform resident of smoking is only permitted at designated areas ... collect all matches, lighters, igniters, e-cigarettes ... a. May not smoke unsupervised ... b. Prohibited from carrying ALL smoking materials. Cigarettes and igniters will be confiscated ... Due to resident's TBI (traumatic brain injury) and cognitive impairment, resident will require continued reminders - reeducation about not being allowed to have igniters as these items are not allowed to be int eh possession of residents ... Provide notification and reminders to resident's mother that it is not allowed for her to bring or send him any contraband; lighters, pipes, etc." 4n. Review of facility document titled "Contraband Disposition Log" dated 3/21/22 indicated, for Resident 48, a red lighter was confiscated and transferred to the NM on 3/25/22. Review of Resident 48's "Smoking Assessment" dated 3/25/22 indicated, " ...Resident knows where the designated smoking area(s) are	{F 689}		

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{F 689}	Continued From page 29 located. Smokes only in the designated area; Holds smoking materials ..." Review of Resident 48's care plan for "Safety Adult - Smoker" with start date of 6/19/21 , indicated, "3/23/22: Lighter found in resident's top drawer. Interventions ... Inform resident of smoking is only permitted at designated areas ... Resident is allowed to carry smoking materials ..." 4o. Review of facility document titled "Contraband Disposition Log" dated 3/16/21 indicated, for Resident 39, a lighter was confiscated and transferred to the NM on 2/28/22. Review of Resident 39's "Smoking Assessment" dated 3/4/22 indicated, " ...Resident knows where the designated smoking area(s) are located ... Holds smoking materials. Found smoking in balcony on 2/28/22 ... Resident requires 1:1 supervision while smoking. Resident was informed that smokable products will be kept by staff for safe keeping ..." Review of Resident 39's care plan for "Safety Adult - Smoker" with start date of 4/6/20 , indicated, "2/28/22, staff witnessed resident was smoking a lighted cigarette at the N6 balcony." Under "Interventions" indicated, " ...Resident has been informed that as of 1/5/22 smoking has returned to Serenity Park - the designated smoking area. Smoking will not be permitted on the unit balconies or garden areas ..." 4p. Review of facility document titled "Contraband Disposition Log" dated 3/16/21 indicated, for Resident 40, a gray lighter was confiscated and transferred to the NM on 3/11/22.	{F 689}		

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{F 689}	Continued From page 30 Review of Resident 40's "Smoking Assessment" dated 3/11/22 indicated, "Current smoker... Found lighter on her ..." Review of Resident 40's care plan for "Safety Adult - Smoker" with start date of 3/11/22 , indicated, " ...3/11/22 Problem: resident had lighter... Interventions: ... Inform resident smoking is only permitted at designated areas... collect all matches, lighters, igniters, e-cigarettes ..." Review of facility's policy and procedure titled, "Smoke and Tobacco Free Environment", dated 10/13/20, indicated, " ...2. Smoking and tobacco products are prohibited on the [Name of Facility] campus, with the exception of smoking designated smoking area as described below. 3. Lighters, matches, electronic cigarettes (e-cigarettes), and other devices that ignite, light, or fuel a flame are not permitted and shall be collected from residents by staff for safekeeping. 4. This policy applies to any tobacco product, any product that emits smoke, or any lighted, heated, ignited, electronic, or any other device that delivers nicotine or other substances to the user, including nicotine and non-nicotine e-cigarettes, cigarettes, cigars, pipes, pipe tobacco, or chewing tobacco. 5. Buying and selling of tobacco products, products that emit smoke, or any lighted, heated, ignited, electronic, or any other device that delivers nicotine or other substances to the user, between any individuals is prohibited. 6. The prohibition of smoking on the [Name of Facility] campus applies to staff, vendors, volunteers, and visitors. 7. Residents may only smoke in the designated smoking area when on the [Name of Facility] campus, in accordance with their individual care plan. Smoking or ingesting	{F 689}		

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{F 689}	Continued From page 31 cannabis is not permitted int eh designated smoking area ..." Review of the facility's policy number 75-05, titled "Illicit or Diverted Drugs (means non prescribed medications) and/or Paraphernalia (means items or equipment's required to use illicit substances) Possession/Use by Residents or Visitors", last revised on 5/19/20, the policy indicated "As in the greater community, the use, possession, solicitation and/or distribution of illicit or diverted drugs and/or paraphernalia at Laguna Honda Hospital and Rehabilitation Center (LHH) is prohibited". The policy further indicated "Staff shall take steps to prevent illicit or diverted drugs and/or paraphernalia use or access and shall promote and support resident efforts to minimize the health consequences of illicit or diverted drug and/or paraphernalia use." An immediate jeopardy (IJ) was declared on 3/22/22 at 4:22 PM in the presence of the Chief Executive Officer (CEO), Chief of Operations (COO), Chief Medical Officer (CMO), Chief Quality Officer (CQO), and Acting Chief Nursing Officer (CNO) for F689 - Free of Accident Hazards/Supervision/Devices because of the following: 1. Resident 44 on oxygen was in possession of a lighter. 2. Resident 45 was observed by staff smoking in the communal bathroom. 3. Ineffective system to eliminate source of contrabands inside the facility. Resident were found in possession of contraband on several occasions. 4. Resident 2 was freely smoking illicit substances in the presence of the provider.	{F 689}		

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{F 689}	Continued From page 32 The IJ was removed on 3/27/22 at 5:41 PM after the facility presented an acceptable Plan of Correction (POC) and the survey team verified the implementation of the POC. The facility staff present were Chief Executive Officer (CEO), Chief of Operations (COO), Chief Medical Officer (CMO), Chief Quality Officer (CQO), and Acting Chief Nursing Officer (CNO) and Director of Regulatory Affairs. The IJ Removal Plan of Correction included the following: 1. A 1:1 coach has been assigned to Resident 2. The coach shall be present by the room to monitor movement and activity of Resident 2. Resident 2 is subject to random weekly clinical safety searches. Resident 2 has been processed through the Expedited Discharge Protocol due to the health and safety risk they pose on the facility, staff, and residents. Resident 2 will be discharged from the facility next week. 2. The provider who was with Resident 2 received re-education by participation in the in-service for all staff as part of this POA. All facility providers will be instructed to intervene when a resident is witnessed to be using illicit substances and/or paraphernalia on the premises. Providers will remind residents of the designated smoking area available on the campus for tobacco use only. 3. Effective 03/23/2022 visitors for residents will not be permitted to bring in personal belongings into the facility, such as purses, bags, backpacks, packages, etc. Items brought in for the resident shall be searched by Pavilion Lobby staff with Sherriff support prior to being provided to the resident. The search will be conducted in the Pavilion Lobby. Pavilion Lobby staff shall review	{F 689}		

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{F 689}	Continued From page 33 all contents for appropriateness to be provided to the resident. Any contraband, paraphernalia, and/or illicit substances shall be disposed of per facility protocol. 4. All packages for residents who are smokers, on oxygen, and those who have a diagnosis of substance use disorder shall be searched in the presence of the resident. Packages will be delivered to the unit and provided to unit staff. Packages will be checked if the receipt is a resident identified on the unit specific list of residents who are triggered to have all packages searched on the unit in the presence of the resident. A tracking list shall be developed - the unit Nurse Manager or designee shall document the date a package was searched and if items were identified as inappropriate. Any contraband, paraphernalia, and/or illicit substances shall be disposed of per facility protocol. Monthly audits of the tracking form will be completed, and data will be reported by the designated Nursing Director to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved. 5.A memo shall be sent to all visitors, family members and residents regarding the new safety measures for the facility. The memo shall discuss the new policy which prohibits visitors from bringing personal belongings into the facility. The memo shall discuss the need for all items being brought in by visitors for the residents to be searched in the Pavilion Lobby prior to being permitted to be given to the resident. 6. A memo shall be sent to all staff regarding the new safety measures for the facility. The memo	{F 689}		

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{F 689}	Continued From page 34	{F 689}		

shall discuss the new policy which prohibits visitors from bringing personal belongings into the facility. The memo shall discuss the need for all items being brought in by visitors for the residents to be searched in the Pavilion Lobby prior to being permitted to be given to the resident.
Resident Care Team (RCT) members (composed of nursing staff, physicians, social workers, activity therapists, and dietitians) shall be required to read and sign attesting they have understood the new safety measure being implemented. A unit-based in-service shall be provided during change of shift to review the following:
- Clinical Safety Search Standard Work
- Contraband Item Handling, Storing, Disposal Standard Work
- Contraband Transfer Form
- Out Pass Assessment Upon Return - Standard Work, Actual Assessment Form
- Smoking Assessment and Safety

The following departments shall receive the in-service: Nursing, Medicine, Psychiatry, Social Services, Activity Therapy, Clinical Dietitians, Pharmacy, Environmental Services
Respective Department Managers and Supervisors are responsible for monitoring staff completion of in-service. The Nursing Director for the Department of Education and Training and Department Managers and/or Supervisors are responsible for on-going improvement actions plans for RCT members competency in conducting clinical safety searches.
7. For residents who return from an out on pass and residents who are known to have deviated from outside clinic appointments, the team licensed nurse or unit charge nurse is responsible for assessing the resident after returning from an out on pass. A clinical safety search will be initiated if there is any reasonable suspicion of

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{F 689}	Continued From page 35 possession of illicit substances and/or contraband items. All contraband items confiscated are disposed of per facility protocol. Monthly audits for out on pass/return from appointment monitoring will be aggregated and reported by the designated Nursing Director to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved. 8. License nurses on all neighborhoods shall conduct a clinical safety searches per facility standard work of residents who are known smokers, on oxygen, and/or for those who have a diagnosis of substance use disorder. Any contraband, paraphernalia, and/or illicit substances shall be disposed of per facility protocol. The Quality Management Performance Improvement Team is responsible for aggregating and reporting of the monthly data of clinical searches and confiscated contraband items to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved. The LHH executive leadership team is responsible for on-going improvement of action plans for reducing and prevention of possession of contraband items. 9. Clinical safety searches shall be conducted per facility standard work in all resident rooms throughout the facility during the Day shifts over the next 48 hours. Any contraband, paraphernalia, and/or illicit substances shall be disposed of per facility protocol. The Quality Management Performance Improvement Team is responsible for aggregating	{F 689}		

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{F 689}	Continued From page 36 and reporting of the monthly data of clinical searches and confiscated contraband items to PIPS. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved. The LHH executive leadership team is responsible for on-going improvement of action plans for reducing and prevention of possession of contraband items. 10. All residents who are known smokers to the facility shall be re-assessed and determined if they are a safe or unsafe smoker, and a new or revised smoking care plan shall be developed and completed by Nurse Managers or their designee. Nurse Directors are responsible for monitoring compliance that resident smoking re-assessments and a new or revised resident care plan have been completed through quality audits (QAs). Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body until three consecutive months of 95% compliance or greater has been achieved. The LHH executive leadership team is responsible for on-going improvement of action plans for reducing and prevention of possession of contraband items.	{F 689}		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and	F 838		

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F 838	Continued From page 37 update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their	F 838		

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F 838	Continued From page 38 education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure facility assessment addressed resident profile for behavioral issues, including substance use disorder, and update a facility wide-assessment. The facility's failure to review the assessment within 12 months may result in the facility failing to identify a factor that would require a change to the assessment, thereby potentially placing the residents at risk for at least minimal harm. Findings: Review of facility document, titled "Laguna Honda Hospital and Rehabilitation Center Facility Assessment Report (FY 2020-2021", dated 8/20/21, indicated "reviewed by QAA/QAPI committee: 9/21/21. The facility assessment (FA) did not indicate resident behavioral diagnoses under resident profile. The facility assessment did not address residents with substance-use disorder (SUDs) under resident profile.	F 838		

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F 838	Continued From page 39 During an interview on 3/28/22, at 3:30 PM, with Chief Executive Officer (CEO), CEO acknowledged the above findings. CEO stated the facility's assessment is completed annually and is scheduled for review this April. During an interview on 3/28/22, at 3:35 PM, with interim Chief Nursing Officer (DNO), DNO acknowledged the facility assessment was last updated on 8/20/21. DNO stated facility updates the facility policies, standard works, in-service training to staff but not the facility assessment. DNO stated the resident profile on the facility assessment is not "all-inclusive" but only the most common diagnosis. DNO stated resident population with substance use disorder is around 10%. Review of facility document, dated 3/28/22, indicated list of resident with substance use disorders. It also indicated 86 out of 702 residents, or 12% of resident population are with substance use disorders.	F 838		

EXHIBIT 6

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{F 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a third revisit for an Abbreviated Standard Survey on 4/11/22 through 4/13/22. The inspection was limited to the revisit, and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 36814, Health Facilities Evaluator Manager I 38066, Health Facilities Evaluator Nurse 38612, Health Facilities Evaluator Nurse 40009, Health Facilities Evaluator Nurse 40454, Health Facilities Evaluator Nurse 41545, Health Facilities Evaluator Nurse 44478, Health Facilities Evaluator Nurse 45439, Health Facilities Evaluator Nurse 27000, Pharmaceutical Consultant II The census at the beginning of the survey was 699. The highest scope and severity was E.	{F 000}		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow medication policy for self-administration for one of three sampled residents (Resident 80) when Resident	F 554		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 554	Continued From page 1 80 was allowed to self administer numerous herbal medication and dietary supplements without a physicians order. These failure could potentially resulted Resident 80 to suffer from allergic and medication reactions. Findings: A review of physician notes dated 7/8/22, indicated Resident 80 was admitted with diagnoses including schizotypal personality disorder (a type of mental illness) and dementia (impaired ability to remember, think, or make decisions). During an observation on 4/12/22, at 7:40 AM, the following were found in a basin and around the bed, overbed table, open shelf cabinet and on a basin on the floor inside the resident's room: 1. Sulfur 8 medicated conditioner (anti-dandruff). 2. Essential enzymes (supplement that aids in digestion). 3. Baking soda 4. Vitamin C 5. Dermal repair complex (dietary supplement) 6. Glycine (dietary supplement) 7. Melatonin (helps promote sleep) 8. Silver oil (a probiotic Resident 80 uses on her teeth) 9. Citric Acid (dietary supplement) 10. Lemon powder 11. Carrot powder 12. Day 4 vitamins 13. A bottle containing multiple unidentified capsules in different colors and sizes 14. Baobab oil	F 554		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 2 15. Baja gold oil 16. Hemp seed oil 17. Silver Savior shampoo (antifungal, antibacterial used for skin disease) 18. Three bottles of apple cider vinegar. During a concurrent interview with Licensed Vocational Nurse (LVN) 7 and review of Resident 80's electronic medication administration record (eMAR) on 4/12/22, at 8 AM, LVN 7 stated, "She has no medications. We do not administer the supplements to her." During an interview on 4/12/22, at 11 AM, Registered Nurse (RN) 38 stated, "She (Resident 80) tells us what supplements she took and then we document it. She mixes the other supplements with her food." LVN 7 stated, Resident 80 "Has a lot of medications and supplements in the room. She takes 20-30 supplements a day." RN 37, RN 38, and LVN 7 stated that they do not know how many tablet or capsule of each supplements were taken by Resident 80." LVN 7 stated, "If resident is taking one or ten, we do not know." A review of the Other Nursing Orders dated 6/29/21, indicated under Nursing Communication, Resident 80 may self administer the following supplements at bedside: 1. Glycine (protein supplement). 2. Colostrum 30% IGG (dietary supplement). 3. X-INFX (supplement to prevent infection). 4. Blue green algae (supplement to treat high blood pressure). 5. Molecular Hydrogen (anti-oxidant). 6. Bio complete 3 (probiotics). 7. Quercetin with bromelian (anti-inflammatory). 8. Vegetable juice powder.	F 554		

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F 554	Continued From page 3 9. Sinus plus (herbal supplements that helps clear the sinus). 10. French maritime pine bark (anti-inflammatory). 11. Antarctic krill oyperil - omega 3 FA 200 mg/phospholipids 200 mg (fish oil supplement). 12. Dermal repair dietary supplement (supplement to reduce aging of skin). 13. Vita sprout (multi-vitamins and mineral supplements). 14. Lion's mane - (medicinal mushroom to strengthen the immune system, stimulate digestion, and protect against cancer). 15. arginine (supplement to lower blood pressure and nd treating erectile dysfunction due to a physical cause). 16. omega plus (helps to reduce the risk of heart disease). 17. astralugus (herbal supplement to enhance immune system). 18. liposomal vitamin C (anti-oxidant). 19. citric acid (Vitamin C supplement). 20. NAC 600 mg with selenium (helps improve fertility). 21. DHEA (anti-aging therapy and to improve physical performance). 22. Immune renew (support immune system). During a concurrent interview and review of Resident 80's Other Nursing orders on 4/12/22, at 11:20 AM, NM 12, RN 37, RN 38, and LVN 7 acknowledged there was no physician's order for the administration of the numerous herbal medications and dietary supplements found at the bedside and the ones indicated in the "Nursing Communication." NM 12 stated, "Resident orders her supplement online. No one assists her. She does it by herself." NM 12 also acknowledged the list of supplements in the "Nursing	F 554		

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F 554	Continued From page 4	F 554		

Communication" was not updated to account the herbal medications and dietary supplements found at the bedside.

During an interview on 4/12/22, at 11:35 AM, Medical Doctor (MD) 10 acknowledged there is no physicians orders for the administration of the numerous herbal medications and dietary supplements. MD 10 stated, "I have to revise the order, the pharmacist has to review it and psychiatrist (a doctor that specializes on treatment of mental illness) consultation for her (Resident 80) behavior."

A review of the facility Policy and Procedure, titled "Medication Administration" dated 9/14/21, indicated "Policy: Registered Nurses (RN) and Licensed Vocational Nurse (LVN) must demonstrate safe medication administration competency and are responsible for administering, monitoring, and documenting medications consistent with their scope of practice...2. All medications, including over-the-counter medications, require a physician's order which includes: a. medications name/agent, b. dose, c. frequency. d. route of administration, e. indication for use. If indication for use is not in the order, consult with the ordering physician...Self- administration and bedside medication...c. A resident may only self-administer medications and or herbal supplements after the appropriate orders have been placed. d. Orders will be entered in the Electronic Health Record (EHR) for medications and formulary supplements..."

A review of the facility Policy and Procedure For Bedside Storage of Medication, dated February 2019, indicated "...II. Only medications prescribed

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F 554	Continued From page 5 by physicians for bedside storage may be kept at bedside...V. The Pharmacy will label all bedside medications in appropriate lay-language...The registered nurse or LVN assigned to medication duty will supervise the use of self medications and chart the medications used on the medication and treatment record. 1. The medications used will be recorded in the resident's health record, based on observation of self-administration by nursing personnel and/or information supplied by the resident. 2.The quantity supplied for bedside storage will be recorded by nursing staff in the resident's health record each time the medicationis supplied." According to the National Institutes of Health (NIH) consumer health information titled, "Dietary Supplements: What You Need to Know" updated on 9/3/20, "...Safety and Risk Many supplements contain active ingredients that can have strong effects in the body. Always be alert to the possibility of a bad reaction, especially when taking a new product. You are most likely to have side effects from dietary supplements if you take them at high doses or instead of prescribed medicines, or if you take many different supplements. Some supplements can increase the risk of bleeding or, if taken before surgery, can change your response to anesthesia. Supplements can also interact with some medicines in ways that might cause problems. Here are a few examples: Vitamin K can reduce the ability of the blood thinner warfarin to prevent blood from clotting. St. John's wort can speed the breakdown of many medicines and reduce their effectiveness (including some antidepressants, birth control pills, heart medications, anti-HIV medications, and transplant drugs). Antioxidant supplements, such as vitamins C and E, might	F 554		

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F 554	Continued From page 6 reduce the effectiveness of some types of cancer chemotherapy. Manufacturers may add vitamins, minerals, and other supplement ingredients to foods you eat, especially breakfast cereals and beverages. As a result, you may get more of these ingredients than you think, and more might not be better. Taking more than you need costs more and might also raise your risk of side effects. For example, too much vitamin A can cause headaches and liver damage, reduce bone strength, and cause birth defects. Excess iron causes nausea and vomiting and may damage the liver and other organs...Keep in Mind Consult your healthcare provider before taking dietary supplements to treat a health condition. Get your healthcare provider's approval before taking dietary supplements in place of, or in combination with, prescribed medicines. If you are scheduled to have any type of surgical procedure, talk with mean safe. Some all-natural botanical products, for example, like comfrey and kava, can harm the liver. A dietyour healthcare provider about any supplements you take. Keep in mind the term "natural" doesn't always ary supplement's safety depends on many things, such as its chemical makeup, how it works in the body, how it is prepared, and the amount you take...Dietary supplements are products intended to supplement the diet. They are not medicines and are not intended to treat, diagnose, mitigate, prevent, or cure diseases..."	F 554		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		

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F 657	Continued From page 7 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a care plan that reflects current treatment and services for three of nine sampled residents (Resident 67, Resident 4, Resident 69) when the care plan for psychotropic drug (medications used to treat mental illnesses) use and pain were not revised. Failure to review and revise the comprehensive plan of care plan had the potential to result in inaccurate and inappropriate provision of care. Findings:	F 657		

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F 657	Continued From page 8 1. Resident 67 was admitted on 7/1/05 with diagnoses including traumatic brain injury (TBI - injury that causes damage to the brain); schizophrenia (a disorder that affects the ability to think, feel, and behave clearly) and cortical blindness (partial or total loss of vision caused by damage to the brain). Review of Resident 67's Minimum Data Set (MDS, a resident assessment tool) dated 3/18/22 indicated, moderate cognitive impairment. The mood and behavior assessment indicated presence of feeling down, verbal outbursts and delusions (misconception or beliefs that are firmly held, contrary to reality). Review of Resident 67's physician's orders for April 2022 indicated, Divalproex sprinkle (Depakote) capsule 750 mg (milligrams) oral, two times daily was ordered on 4/1/2022. Review of "Psychotropic Drug Use" care plan dated 7/21/21 indicated, " ...Target behavior symptoms: delusional preoccupations/psychosis; med noncompliance; verbal outburst, irritability ... 2. "I" Assess efficacy of drug therapy and monitor for potential side effects ... 9. "I" Administer Depakote (used to treat certain types of seizures) 250 mg q (every) 12 hrs (hours) as prescribed..." During an interview with Nurse Manager (NM) 8 on 4/12/22 at 11:01 AM, NM 8 acknowledged the current physician's order for Divalproex 750 mg did not reflect in the psychotropic drug use care plan. NM 8 stated, "It should reflect the current orders. It should have been updated (referring to the care plan)." 2. Resident 69 was admitted on 9/14/21 with diagnoses including adenocarcinoma of the colon	F 657		

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F 657	Continued From page 9 (type of cancer that starts in the large intestine) and chronic pain. Review of Resident 69's Minimum Data Set (MDS - a resident assessment tool) dated 3/10/22, under Section J indicated, Resident 69 had been on scheduled pain medication regimen and received PRN (as needed) pain medications. Review of Resident 69's care plan for pain, initiated on 9/22/21, under interventions indicated, " ... Administer analgesics based on type and severity of pain and evaluate response: with order of acetaminophen PRN q (every) 8 hours, norco 5-325 mg (milligram) Q 6 hours, lidoderm patch, ibuprofen 3x daily ..." Review of Resident 69's physician's orders indicated the following current PRN pain medications: Acetaminophen (TYLENOL) tablet 500 mg (milligram) oral, every 8 hours PRN for any pain ordered on 1/28/22. Tramadol (ULTRAM) tablet 50 mg, oral, every 12 hours PRN for moderate pain and severe 7-10 pain scale ordered on 1/17/22. During an interview with Nurse Manager (NM) 8 on 4/12/22 at 11:46 AM, NM 8 acknowledged the Norco 5-325 mg and Ibuprofen indicated in the care plan were not in the physician's orders and stated, "I don't see it." NM 8 also acknowledged that the care plan for pain was not updated and stated, "I agree. It should reflect the most current pain medication regimen." 3. Resident 4 was admitted on 3/29/19 with diagnoses including chronic pain syndrome (pain remains long after an illness or injury has healed),	F 657		

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F 657	Continued From page 10 nicotine dependence (an addiction to tobacco product) and multiple substance abuse. Review of Resident 4's physician's orders indicated, "...acetaminophen (TYLENOL) tablet 1,000 mg oral, Every 6 hours PRN ..." with a start date of 7/20/21. Review of Resident 4's pain care plan started on 2/27/20, under interventions, indicated, "...3. Medicate w/ pharmacological pain management as ordered by MD (Medical Doctor)... Chronic Pain. Scheduled dosing suboxone 2 mg SL (sublingual - applied under the tongue) daily ...Ibuprofen 600 mg q 8H (hours) PRN..." During an interview with NM 8 on 4/12/22 at 11:54 AM, NM8 acknowledged that Suboxone 2 mg SL and Ibuprofen 600 mg indicated in the care plan were not in the physician's orders and stated, "I don't see it." NM 8 further acknowledged that the care plan for pain was not revised and stated, "It should be updated." Review of facility policy titled, "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)" revised on 7/9/19 indicated, "Policy ...3. The Resident Care Plan (RCP) shall be person-centered, evaluated during weekly or monthly summaries, when indicated for short term problems, every quarter, and revised as needed to serve as an essential resource for improved resident outcomes ..." Review of facility policy titled, "Documentation of Resident Care/Status by the Licensed Nurse" revised on 3/12/19 indicated, "Policy ...The Licensed Nurse (LN) is responsible for documenting assessments findings, developing	F 657		

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F 657	Continued From page 11 care plans based on identified needs, implementing or supervising nursing interventions, and evaluating and revising the resident care plan ..."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide treatment in accordance with current professional standards when two of seven sampled residents (Residents 70 and 71) did not receive routine medications, as ordered: 1a. Resident 70 missed two doses of anti-diabetic medications (to lower blood glucose) on 3/17/22. 1b. Additionally, the glipizide (an anti-diabetic medication) for Resident 70 was not administered before a meal, as ordered and specified by the manufacturer, to optimize its therapeutic effect and to avoid drug-food interaction. 2. Resident 71 did not receive a dose of Keppra (anti-seizure medication) on 3/18/22. The facility staff failed to notify the pharmacy after confirming the medications were not available. The failure had the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions.	F 658		

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F 658	Continued From page 12 Findings: 1a. On 4/12/22, a review of Resident 70's clinical record with the Director of Pharmacy (DOP) reflected Resident 70 was admitted to the facility with diagnoses including diabetes. Her medication orders included: Glipizide 5 milligrams (mg, unit of measurement) and 10 mg (total 15 mg) two times daily "before meals", dated 2/2/22; and Metformin (an anti-diabetic medication) 1,000 mg two times daily with meals, dated 8/3/19. A review of Resident 70's March 2022 Medication Administration Record (MAR) indicated the facility scheduled the glipizide to be given daily at 8 AM and 6 PM. The MAR also indicated, on the morning of 3/17/22, the 8 AM dose of glipizide 5 mg and metformin were documented as "Not Given", with the reason of "Med Not Available" by registered nurse (RN) 28. During a concurrent interview and record review with RN 28 on 4/12/22 at 12:11 PM, he stated when he documented "med not available", it meant the medications were missing in the medication cart. He said he would normally send a note, through secure chat, to the pharmacy, and "when they send it, I give it." After reviewing Resident 70's clinical record, RN 28 confirmed he did not give the two medications on the morning of 3/17/22, and there was no documentation indicating he contacted the pharmacy to obtain the medications. During an interview with the Nurse Manager (NM)	F 658		

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F 658	Continued From page 13 3 and the DOP on 4/12/22 at 12:30 PM, NM 3 stated when medications were not available for administration, the nurse was to contact the pharmacy right away to get the medications. The DOP stated she looked up the pharmacy communication records, there was none related to the resident's metformin and glipizide on 3/17/22. A review of Lexi-Comp, a nationally recognized drug information resource, it indicated to administer glipizide "30 minutes before a meal (preferably before breakfast if once-daily dosing) to achieve greatest reduction in postprandial hyperglycemia [rise in blood sugar following a meal]." Lexi-Comp indicated glipizide works by stimulating the release of insulin (a hormone to lower blood glucose) from the pancreas, and "a delayed release of insulin may occur if glipizide is taken with food." b. During a concurrent interview and record review with RN 29 and the DOP on 4/12/22 at 11:45 AM, RN 29 stated Resident 70's glipizide doses were scheduled daily at 8 AM and 6 PM; and breakfast was scheduled daily at 8:30 AM and dinner at 6:30 PM. She stated the nursing staff had a 2-hour window (1 hour before and 1 hour after) for administering scheduled medications. This indicated the glipizide could be given before, during, or after a meal. After reviewing the clinical record, RN 29 stated Resident 70 received the glipizide at 9:17 AM on 4/11/22, and breakfast was documented at 8:36 AM; and at 10:21 AM while breakfast was documented at 8:33 AM on 4/12/22. The DOP stated the timing of medication administration may depend on the resident's preference, that sometimes residents want to take medications	F 658		

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F 658	Continued From page 14 with their meals. During an interview with RN 28 on 4/12/22 at 12:11 PM, he stated Resident 70 "doesn't care when to get her meds." On 4/12/22 at 2:15 PM, a review of Resident 70's 7-day MAR with the DOP indicated Resident 70 received the AM doses of glipizide 5 mg and 10 mg as follows: On 4/6/22 at 9:40 AM.; 4/7/22 at 9:41 AM; 4/8/22 at 9:33 AM; 4/11/22 at 9:17 AM; and on 4/12/22 at 10:22 AM. The DOP acknowledged the AM glipizide doses were most likely given during or after breakfast. On 4/12/22 at 12:20 PM, the DOP reviewed Lexi-Comp and confirmed it indicated to give glipizide 30 minutes before a meal for best postprandial outcome, and its absorption is "rapid and complete; delayed with food." During an interview with Resident 70 on 4/13/22 at 12:55 PM, she stated she had no preference when to take her medications and understood why certain medications had to be taken before meals. During an interview with licensed vocational nurse (LVN) 4 on 4/13/22 at 1:02 PM, she stated sometimes she asked Resident 70 if she wanted all her AM medications together, and she said yes. LVN 4 stated this morning she explained to the resident why the glipizide should be taken before meal "and she's okay." When asked whether there was any documentation Resident 70 prefered or required her medications to be given with or after meals, LVN 4 said, "No." A review of the facility's policy and procedures	F 658		

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F 658	Continued From page 15 (P&P) titled "Medication Administration", dated 9/14/21, indicated, "Medication administration times may be modified to accommodate clinical need or resident's preferences." 2. On 4/12/22, a review of Resident 71's clinical record indicated she was admitted to the facility with diagnoses including seizure (a sudden, uncontrolled electrical disturbance in the brain. It can cause changes in your behavior, movements or feelings, and in levels of consciousness). Her medication orders included levetiracetam (Keppra) 100 mg/milliliter (ml), 500 mg every 12 hours for seizure disorder, dated 3/25/21. It was scheduled to be given daily at 9 AM and 9 PM. A review of Resident 71's March 2022 MAR with the DOP on 4/12/22 indicated the AM dose of Keppra was documented as "Not Given" on 3/18/22 with the reason of "Med Not Available" by RN 30 on 3/18/22 at 10:23 AM. During an interview with RN 10 on 4/12/22 at 2:43 PM, she stated any time the medication was not available for administration, the nurse was to contact the pharmacy to obtain the medication, and had the option to document the late administration after the medication arrived and administered to the resident. During an interview with RN 30 in the presence of the DOP on 4/12/22 at 3:05 PM, RN 30 stated she remembered not being able to locate the Keppra in the medication cart so she talked to the pharmacy and was told Keppra was already sent twice. She stated she did not recall what happened next but she endorsed it to the next shift that she contacted the pharmacy. The DOP stated the pharmacy record showed a bottle of	F 658		

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F 658	Continued From page 16 Keppra solution was sent on 3/16 and another on 3/18/22. She explained, a new label for Keppra was printed on 3/18/22 at 10:51 AM, but the pharmacy did not keep records of when medications were delivered to the units. She stated, "It was probably sent to the unit with the noon run." During an interview with NM 9 on 4/12/22 at 3:20 PM, she stated when the medication was not available at the time of administration, the nurse should send a message the pharmacy and let the charge nurse know and follow up to get the medication. She added, the nurse "should also call the pharmacy and ask if the medication is ready; and if ready, ask someone to go pick up the medication from the pharmacy." NM 9 stated it was not acceptable that Resident 71 did not receive her Keppra dose because it was not available. A review of the facility's P&P titled "Medication Administration", dated 9/14/21, indicated the following under Missing Medications: "After confirming a medication that is due is missing, notify pharmacy for replacement." A review of the facility's P&P titled "Obtaining, Handling, and Storage of Medications", dated 5/15/2020, indicated, "The charge nurse or team leader is responsible to have a continuous supply of prescribed medications available 24 hours a day, seven days a week through Department of Pharmacy Services..." and "Medications needed prior to the next pharmacy delivery may be picked up at the pharmacy window by a licensed nurse or licensed psychiatric technician."	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility	F 688		

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F 688	Continued From page 17 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide preventive treatment and services to maintain and improve range of motion (ROM) for one of three residents (Resident 87) when the Restorative Nurse Assistant (RNA) program was not implemented in accordance with the physician's order. RNA is a program available in nursing homes that helps residents maintain any progress they've made during therapy treatments This deficient practice had the potential for further decline of ROM or possible development of contracture to Resident 87. Contracture is a condition of shortening and hardening of muscles, tendon or other tissue, often leading to deformity and rigidity of joints	F 688		

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F 688	Continued From page 18 which limit and interfere with daily functioning Findings: Resident 87 was admitted on 9/3/21 with diagnoses including quadriplegia (paralysis that results in the loss of movement and sensation in all four limbs) and chronic obstructive pulmonary disease (COPD - refers to a group of diseases that cause airflow blockage and breathing-related problems). During an observation on 4/13/22 at 12:57 PM with Quality Management Nurse (QM) 1, in the hallway of South 5, Resident 87 was propelling his electric wheelchair. Resident 87 showed how he smokes by lifting his left arm and fingers touching his lips. For the right arm, Resident 87 was able to lift up to the chest area. Both hands were contracted and had shaking movement as Resident 87 moved. During concurrent interview, Resident 87 stated, "I can smoke but I cannot use my right arm, only the left (arm). I'm paralyzed." A review of Resident 87's physician's order dated 9/3/21, with Nurse Manager (NM) 5 on 4/13/22 at 10:17 AM, indicated the following: i. Passive ROM (PROM) to bilateral lower extremities for "15 mins (minutes) each shift." PROM means the joint is moved by an external force or therapist. ii. Self ROM (SROM), Active ROM (AROM), and Active Assist ROM (AAROM) to bilateral upper extremities for "15 mins each shift." SROM is when the unaffected limb is used to help the affected limb with the range of motion exercise; AROM is when the patient performs the exercises without assistance and AAROM is a	F 688		

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F 688	Continued From page 19 movement of a joint or limb in which the patient provides some effort, but also receives some assist provided by others. Review of Resident 87's Minimum Data Set (MDS - an assessment tool) dated 2/18/22, under Section G indicated, the ROM on both sides of the upper and lower extremities was impaired. Under Section O: Restorative Nursing Program, indicated an entry of 0 (zero) for passive and active range of motion technique. An entry of zero means "none or less than 15 minutes daily" of restorative program was performed. Review of Resident 87's restorative care flowsheet for 2/24/22 through 4/12/22 indicated, AROM exercise for bilateral upper extremities was not performed for a total of 38 days and AROM for bilateral upper extremities was performed for less than 15 minutes for a total of 10 shifts. Review of Resident 87's restorative care flowsheet for 2/24/22 through 4/12/22, indicated, the PROM for bilateral lower extremities was not performed on 2/26/22 and 3/27/22 (total of two days) and PROM exercise was performed for less than 15 minutes for a total of 12 shifts. During an interview with NM 5 and review of Resident 87's ROM flowsheet for 2/24/22 through 4/12/22, on 4/13/22 at 10:26 AM, NM 5 explained that if there is no entry of minutes indicated in the flowsheet, it means that ROM activity or exercise was not provided. NM 5 also confirmed that the documentation indicated that PROM and AROM activity was provided to resident as early as 1:30 AM.	F 688		

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F 688	Continued From page 20 Review of Resident 87's care plan on ADL (Activities of Daily Living) Maintenance with a start date of 2/14/22 indicated, "Goal: Mobility/activity is maintained at optimum level for patient ...Interventions ...3. Perform active/passive ROM as tolerated/ordered by stabilizing the joint, moving slowly, gently and only to the point of slight resistance ...8. Perform restorative nursing activities as tolerated and/or ordered ..."	F 688		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a safe environment when three of three sampled residents (Resident 73, Resident 77, Resident 80) when a pair of scissors were found inside the room of Resident 73, Resident 77, and Resident 80. This facility failure has the potential to cause accident and harm when accessed by other residents. Findings: During an observation and concurrent interview	{F 689}		

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{F 689}	Continued From page 21 with the Nurse Manager (NM) 10 on 4/11/22, at 12:25 PM, four pair of scissors (three bandage scissors and one straight scissor) were observed in an open shelf cabinet inside Resident 73's room. NM 10 stated the scissors should be in the locked treatment cart inside the medication room. NM 10 added, "The concern is residents safety." During an observation concurrent interview with the NM 1 on 4/11/22, at 3 PM, a pair of pointed tip scissors was observed at the bedside of Resident 77. NM 1 stated that the scissors should not be in the resident's room. During an observation and concurrent interview of Resident 80 on 4/12/22, at 7:40 AM, a pair of bandage scissors was observed inside the room of Resident 80. Resident 80 stated, "I use this (referring to the scissors) to cut the parts of the diaper I am allergic to." Review of facility Standard Work Instruction titled, "Contraband Items Handling, Storage & Disposal" dated 3/4/22, indicated, "Purpose: To promote resident and staff safety when handling contraband items removed from resident's possession...C. HANDLING OF DANGEROUS OBJECTS (including but not limited to, box cutter, scissors, guns, or objects with blade regardless of length) CONFISCATED FROM A RESIDENT OR FOUND ON THE UNIT...1. While donning double gloves, bag, and label the confiscated item(s)...2. Complete Transfer Form for Contraband Items...3. Prior to transfer the items inside sip-lock [sic] bag, call the [City] Sheriff Deputy immediately...d. The sheriff shall acknowledge receipt of the item(s) off unit at the sheriff's office. **Note: Dangerous objects shall not be released to the resident, person identified	{F 689}		

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{F 689}	Continued From page 22 by the resident, resident's surrogate decision-maker, or personal representative if the attending physician or the SFSO reasonably determines that the person would be a safety threat to themselves or to others if the dangerous object was released to them..."	{F 689}		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide respiratory care and treatment for one of three sampled residents when the physician's order for oxygen administration was not followed for Resident 44. This failure had the potential to result in respiratory distress and decline in Resident 44's health condition. Findings: Review of Resident 44's Minimum Data Set (MDS - a resident assessment tool) dated 2/11/22 indicated, Resident 44 was cognitively intact and had active diagnoses that including Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it	F 695		

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F 695	Continued From page 23 difficult to breathe) and Atrial Fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). Other health conditions included dyspnea (shortness of breath). Resident 44 was on oxygen therapy as part of respiratory treatment. During an observation on 4/11/22, at 2:19 PM, Resident 44 was in bed, having shortness of breath and on oxygen via nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) The oxygen flow regulator was set at 2 liters per minute (L/min). Resident 44 acknowledged that he uses oxygen continuously and stated, "Yes, all the time. Always." During an observation and concurrent interview on 4/11/22 at 2:27 PM, Registered Nurse (RN) 31 verified that Resident 44 was on oxygen at 2 L/min and stated, "It's at 2 L/min." Review of Resident 44's oxygen therapy flowsheet indicated the following oxygen flow rate: On 3/28/22, oxygen was at 3 L/min. On 3/29/22 at 8 AM, oxygen was at 2 L/min; at 9:53 AM, oxygen was at 3 L/min; at 10:07 AM, oxygen was at 2 L/min. On 3/30/22, 3/31/22, 4/1/22, 4/2/22 and 4/3/22, was at 3 L/min. On 4/4/22 was at 4 L/min. On 4/5/22 at 7:52 AM, oxygen was at 2 L/min; at 9:27 AM, oxygen was at 3 L/min. On 4/6/22, 4/7/22, 4/8/22, 4/9/22, 4/10/22, 4/11/22 and 4/12/22, oxygen was at 3 L/min. Review of Resident 44's active physician's order dated 2/15/22 indicated an order for "continuous"	F 695		

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F 695	Continued From page 24 oxygen therapy via "Simple Face Mask" with a rate of "6 - 10" L/min. Review of Resident 44's respiratory care plan with a start date of 11/5/21 and expected end date of 6/16/22, under interventions indicated, " ... 6-10 L/min Oxygen supplementation at all times ..." Review of facility policy titled "Oxygen Administration" revised on 3/12/19 indicated, " ...G. Administration: ...2. Turn on the oxygen and adjust flow rates as prescribed ..." According to an Nursing 2022 Journal article titled, "How do I choose a supplemental oxygen delivery device?", " ...The nasal cannula is a low flow system that mixes oxygen with room air. The flow rates range from 1 to 6 liters/minute, providing 24% to 44% of inspired oxygen. Rates above 4 liters/minute can dry mucous membranes and cause discomfort and bleeding, so add humidification ...the face mask mixes oxygen with room air, but it can provide higher oxygen concentrations (35% to 60%) and higher flow rates (5 to 10 liters/minute)..." (https://journals.lww.com/nursing/Fulltext/2003/12000/How do I choose a supplemental oxygen delivery).	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		

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F 697	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure pain management regimen was consistently evaluated, monitored and revised as necessary for one of three sampled residents (Resident 67) when pain assessments were not completed before and after administration of pain medication. Failure to evaluate, monitor and revise the resident's pain management regimen had the potential for residents to not receive effective treatment for pain. Findings: Resident 67 was admitted on 7/1/05 with diagnoses including traumatic brain injury (TBI an injury that causes damage to the brain); schizophrenia (a disorder that affects the ability to think, feel, and behave clearly) and cortical blindness (a partial or total loss of vision caused by damage to the brain). Review of Resident 67's Minimum Data Set (MDS, a resident assessment tool) dated 3/18/22, under "Section J: Health Conditions" indicated, Resident 67 received PRN (as needed) pain medications for occasional presence of pain. During an interview with Certified Nursing Assistant (CNA) 21 on 4/12/22 at 6:38 AM, CNA 21 stated Resident 67 was always complaining of leg pain and easily get mad if pain medication is not given on time. Review of Resident 67's physician's orders for April 2022 indicated, Acetaminophen (Tylenol)	F 697		

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F 697	Continued From page 26 tablet 500 mg oral, every 6 hours PRN for any pain was ordered on 7/7/21. Review of Resident 67's Medication Administration Record (MAR) for April 2022 indicated, Resident 67 received Acetaminophen 500 mg on 4/1/22, 4/2/22, 4/3/22, 4/4/22, 4/5/22, 4/6/22, 4/7/22, 4/8/22, 4/9/22, 4/10/22, and 4/11/22. The MAR did not indicate an indication for the administration of pain medication. During an interview with Nurse Manager (NM) 8 on 4/12/22 at 11:05 AM, NM 8 stated Resident 67 was consistently receiving PRN Acetaminophen for chronic leg pain. Review of Resident 67's pain assessment flow sheet for April 2022 indicated, incomplete pain assessment information on the following: On 4/1/22 at 3:59 PM, no pain location was documented for a pain score of 3. On 4/2/22 at 4:09 AM, no pain location was documented for a pain score of 5. On 4/4/22 at 6:43 AM, no pain location was documented for a pain score of 10. On 4/4/22 at 10:18 PM, no pain location was documented for a pain score of 5. On 4/5/22 at 4:00 PM, no pain location was documented for a pain score of 3. On 4/6/22 at 12:56 AM, right leg was indicated under pain location but no pain score was documented. On 4/6/22 at 11:34 PM, no pain location and pain score were documented. On 4/7/22 at 10:20 PM, no pain location was documented for a pain score of 2. On 4/8/22 at 3:51 AM, no pain score was documented. On 4/10/22 at 6:25 AM, no pain location and pain	F 697		

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LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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F 697	Continued From page 27 score were documented. On 4/10/22 at 3:38 PM, no pain location was documented. On 4/10/22 at 11:44 PM, no pain location and pain score were documented. On 4/11/22 at 11:34 PM, no pain location and pain score were documented. Review of Resident 67's pain assessment flow sheet for April 2022 indicated, post pain assessments was not done after Acetaminophen 500 mg was administered on 4/3/22 at 12:07 AM; 4/4/22 at 6:43 AM; 4/6/22 at 4:19 PM; and 4/9/22 at 10:38 PM. During an interview with NM 8 on 4/12/22 at 11:06 AM, NM 8 stated, "Pain assessment is part of the vital signs. Pain assessment should be done before giving PRN medications. For oral PRN medications, reassess the resident within an hour." NM 8 acknowledged several pain assessments on 4/1/22 to 4/11/22 had incomplete pain assessment information. Post pain assessments were not completed on several occasions. Review of Resident 67's pain care plan dated 7/31/20 indicated, " ...Description: Assess and monitor patient's pain using appropriate pain scale. Collaborate with interdisciplinary team and initiate plan and interventions as ordered. Re-assess patient's pain level within 90 minutes after pain management intervention. Interventions: 1. "I" Nurse will assess pain level and provide Tylenol as needed ..." Review of the facility's policy for "Pain Assessment and Management" dated 9/14/21 indicated, "1. Residents have the right to	F 697		

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F 697	Continued From page 28 appropriate assessment and management of pain. 2. Pain is regularly (re)assessed as clinically indicated. 3. When pain is identified, a pain management plan is developed as part of the resident's care plan ... 4. Verbal Descriptor Scale is the preferred method for (re)assessing pain intensity for residents/patients able to self-report pain ... 2. Pain Reassessment ... c. reassess and document pain location and pain intensity before PRN, and record pain intensity only after each PRN medication administered ... 4. Documentation ... c. pain intensity is recorded with each set of vital signs except as noted in Pain Reassessment Section. d. pain intensity scores are documented in the EHR. e. Breakthrough pain scores are recorded on the MAR and include location and intensity (reason for PRN) and change in intensity (as response to PRN)... f. The nurse evaluates resident's response to pain management care plan side effects, analgesic use and other data and progress toward goals ... g. Pain care plan will include the location (or site) of pain, pain associated diagnoses, and the method use to reassess pain ..."	F 697		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		

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F 761	Continued From page 29 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility failed to ensure medication and biological's were kept in a locked storage for eight of eight sampled residents (Resident 73, Resident 74, Resident 75, Resident 76, Resident 77, Resident 78, Resident 79, Resident 80). This facility failure has the potential for the confused and unauthorized residents to access the medications and biological's that could result into harm. Findings: a 1. A review of History and Physical dated 11/30/21, indicated Resident 73 was admitted with diagnoses including traumatic brain injury. During an observation on 4/11/22, at 12:20 PM, with the Infection Control Nurse (ICN) 1 and Nurse Manager (NM) 10, a bottle of dakin's solution (an antimicrobial wound cleanser), a	F 761		

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F 761	Continued From page 30 bottle of anasept antimicrobial wound cleanser and a bottle of skintegrity wound cleanser was found inside Resident 73's room. NM 10 stated the wound cleansers should be kept in a locked cart inside the medication room. NM 10 stated, "The concerns are infection control and resident's safety. The resident might spray it on themselves or ingest it." a 2. A review of History and Physical 7/24/19, indicated Resident 74 was admitted with diagnoses including stroke. During an observation with Infection Control Nurse (ICN) 1 on 4/11/22, at 12:35 PM, a bottle of Skintegrity wound cleanser was found on the bedside table inside the Resident 74's room. a 3. A review of Active order set dated 3/2/22, under Admission, Transfer, Discharge Orders, indicated Resident 75 was admitted with diagnoses including dementia (decline in memory or other thinking skills). During an observation and concurrent interview with NM 1 on 4/11/22, at 2:40 PM, two bottles of Skintegrity wound cleansers were found on the bedside table inside the Resident 75's room. NM 1 stated, "The wound cleansers should be kept in the lock drawer in the resident's room." a 4. A review of Minimum Data Set (MDS, an assessment tool) dated 2/28/22 indicated Resident 76 was admitted with diagnoses including dementia. During an observation and concurrent interview with NM 1 on 4/11/21, at 2:55 PM, a bottle of Skintegrity wound cleanser was found inside the	F 761		

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F 761	Continued From page 31 resident's room. NM 1 stated, "It should not be in the resident's room." a5. A review of MDS dated 1/22/22, indicated Resident 77 was admitted with diagnoses including dementia. During an observation and concurrent interview with NM 1 on 4/11/22, at 3 PM, two bottles of Skintegrity wound cleansers were found inside the resident's room. NM 1 stated the medicated dressing and wound cleaners "should not be in the resident's room." a6. A review of Admission, Transfer, Discharge orders dated 9/10/21, indicated Resident 78 was admitted with diagnosis including paraplegia (weakness of both legs). During an observation and concurrent interview with NM 1, on 4/11/22, at 3:05 PM, a bottle of Skintegrity wound cleanser was found inside the resident's room. NM 1 stated the wound cleanser should not be inside the resident's room. b. During an observation with NM 1 on 4/11/22, at 3 PM, two bottles of iodoform packing strips (medicated dressing used for wound treatment), and three boxes of silver dressings (medicated dressing used for wound treatment) inside the room of Resident 77. NM 1 stated, "The medicated dressings should not be kept inside the resident's room." c. A review of Resident 79's MDS, dated 2/2/22 indicated a Brief Interview of Mental Status (BIMS, a brief memory test to help determine cognitive function) score of 3 which means Resident 79 has severe cognitive impairment.	F 761		

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F 761	Continued From page 32 During an observation on 4/11/22, at 10:50 AM three uncovered and unlabeled plastic medication cups with white cream were found at Resident 79's overbed table. During an interview on 4/11/21, at 10:55 AM, Registered Nurse (RN) 37 stated, "I brought the creams and put it on him. I forgot about them." RN 37 further stated, "Medications are not supposed to be left at the bedside. Other residents can get to them. It is a safety issue. It is not safe to other residents." During a review of the April 2022 Medication Administration Record (MAR) with RN 37 on 4/11/22, at 10:20 AM, the MAR indicated capsaicin 0.025 % cream (used as a pain reliever), lanolin alcohol (minerin, used to relieve dry skin), methyl salicylate-menthol cream (used as a pain reliever). d. During an observation with ICN 1 on 4/11/22, at 12:20 PM, a bottle of anti-itch lotion (Rugby brand) was found at the bedside of Resident 73's room. e. During an observation on 4/12/22, at 7:40 AM, the following were found on a basin and on and around different areas on the bed: 1. Sulfur 8 medicated conditioner (anti-dandruff). 2. Essential enzymes (supplement that aids in digestion). 3. Baking soda 4. Vitamin C 5. Dermal repair complex (dietary supplement) 6. Glycine (dietary supplement) 7. Melatonin (helps promote sleep)	F 761		

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F 761	Continued From page 33 8. Silver oil (a probiotic Resident 80 uses on her teeth) 9. Citric Acid (dietary supplement) 10. Lemon powder 11. Carrot powder 12. Day 4 vitamins 13. A bottle containing of multiple capsules in different colors and sizes 14. Baobab oil 15. Baja gold oil 16. Hemp seed oil (reduces cholesterol level) 17. Silver Savior shampoo (antifungal, antibacterial used for skin disease) 18. Three bottles of apple cider vinegar. During an concurrent interview with Licensed Vocational Nurse (LVN) 7 and review of Resident 80's electronic medication administration record (eMAR) on 4/12/22, at 8 AM, LVN 7 stated, "She has no medications. We do not administer the supplements to her." A review of the Nursing Communication dated 6/29/21 indicated, Resident 80 may self administer the following supplements at bedside: 1. Glycine (protein supplement). 2. Colostrum 30% IGG (dietary supplement). 3. X-INFX (supplement to prevent infection). 4. Blue green algae (supplement to treat high blood pressure). 5. Molecular Hydrogen (anti-oxidant). 6. Bio complete 3 (probiotics). 7. Quercetin with bromelian (anti-inflammatory). 8. Vegetable juice powder. 9. Sinus plus (herbal supplements that helps clear the sinus). 10. French maritime pine bark (anti-inflammatory). 11. Antarctic krill oyperil - omega 3 FA 200	F 761		

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F 761	Continued From page 34 mg/phospholipids 200 mg (fish oil supplement). 12. Dermal repair dietary supplement (supplement to reduce aging of skin). 13. Vita sprout (multi-vitamins and mineral supplements). 14. Lion's mane - (medicinal mushroom to strengthen the immune system, stimulate digestion, and protect against cancer). 15. arginine (supplement to lower blood pressure and treating erectile dysfunction due to a physical cause). 16. omega plus (helps to reduce the risk of heart disease). 17. astralugus (herbal supplement to enhance immune system). 18. liposomal vitamin C (anti-oxidant). 19. citric acid (Vitamin C supplement). 20. NAC 600 mg with selenium (helps improve fertility). 21. DHEA (anti-aging therapy and to improve physical performance). 22. Immune renew (support immune system). During an interview on 4/12/22, at 11 AM, Registered Nurse (RN) 38 stated, "She (Resident 80) tells us what supplements she took and then we document it. She mixes the other supplements with her food." LVN 7 stated, Resident 80 "Has a lot of medications and supplements in the room. She takes 20-30 supplements a day." RN 37, RN 38, and LVN 7 stated that they do not know how many tablet or capsule of each supplements were taken by Resident 80." LVN 7 stated, "If resident is taking one or ten, we do not know." During concurrent interview and review of Resident 80's Other Nursing Orders on 4/12/22, at 11:20 AM, NM 12, RN 37, RN 38 and LVN 7,	F 761		

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F 761	Continued From page 35 acknowledged there was no physician's order for the administration of the medications and supplements indicated in the "Nursing Communication." NM 12 stated, "Resident orders her supplement on line. No one assists her. She do it by herself." NM 12 also acknowledged the list of medications and supplements in the "Nursing Communication" was not updated. During an interview on 4/12/22, at 11:35 AM, Medical Doctor (MD) 10 acknowledged there is no physicians orders for the administration of the 33 supplements. MD 10 stated, "I have to revise the order, the pharmacist has to review it and psychiatrist consultation for her (Resident 80) behavior." A review of the facility Policy and Procedure For Bedside Storage of Medication, dated February 2019, indicated "...I. Prior to placing medications at the bedside, the interdisciplinary team shall determine that the resident can safely self-administer medications and an appropriate plan of care shall be written. II. Only medications prescribed by physicians for bedside storage may be kept at bedside...V. The Pharmacy will label all bedside medications in appropriate lay-language...The registered nurse or LVN assigned to medication duty will supervise the use of self medications and chart the medications used...2. The quantity supplied for bedside storage will be recorded by nursing staff in the resident's health record each time the medicationis supplied." According to the National Institutes of Health (NIH) consumer health information titled, "Dietary Supplements: What You Need to Know" updated on 9/3/20, "...Safety and Risk Many supplements	F 761		

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F 761	Continued From page 36	F 761		

contain active ingredients that can have strong effects in the body. Always be alert to the possibility of a bad reaction, especially when taking a new product. You are most likely to have side effects from dietary supplements if you take them at high doses or instead of prescribed medicines, or if you take many different supplements. Some supplements can increase the risk of bleeding or, if taken before surgery, can change your response to anesthesia. Supplements can also interact with some medicines in ways that might cause problems. Here are a few examples: Vitamin K can reduce the ability of the blood thinner warfarin to prevent blood from clotting. St. John's wort can speed the breakdown of many medicines and reduce their effectiveness (including some antidepressants, birth control pills, heart medications, anti-HIV medications, and transplant drugs). Antioxidant supplements, such as vitamins C and E, might reduce the effectiveness of some types of cancer chemotherapy. Manufacturers may add vitamins, minerals, and other supplement ingredients to foods you eat, especially breakfast cereals and beverages. As a result, you may get more of these ingredients than you think, and more might not be better. Taking more than you need costs more and might also raise your risk of side effects. For example, too much vitamin A can cause headaches and liver damage, reduce bone strength, and cause birth defects. Excess iron causes nausea and vomiting and may damage the liver and other organs...Keep in Mind Consult your healthcare provider before taking dietary supplements to treat a health condition. Get your healthcare provider's approval before taking dietary supplements in place of, or in combination with, prescribed medicines. If you are scheduled to have any type of surgical procedure, talk with

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F 761	Continued From page 37 your healthcare provider about any supplements you take. Keep in mind the term "natural" doesn't always mean safe. Some all-natural botanical products, for example, like comfrey and kava, can harm the liver. A dietary supplement's safety depends on many things, such as its chemical makeup, how it works in the body, how it is prepared, and the amount you take...Dietary supplements are products intended to supplement the diet. They are not medicines and are not intended to treat, diagnose, mitigate, prevent, or cure diseases..."	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

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F 880	Continued From page 38 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 39 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement an effective infection control program in accordance with internal policies and procedures, nationally recognized infection control guidelines and regulations when: 1. Staff did not wear appropriate personal protective equipment (PPE) in resident care areas and while providing resident care; Staff did not wear respirators properly; Staff are wearing isolation gown and gloves outside the resident care area of North 1; PPE are equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses. 2. Extended use respirator and reusable eye protection equipment were not properly disinfected and stored; 3. Staff did not perform hand hygiene in between clean and dirty tasks; 4. Multiple open plastic bags containing exposed garbage and overflowing soiled linens were left unattended; and 5. An unvaccinated visitor gained access to the facility without a confirmation of a negative COVID-19 rapid test result. COVID 19 is a respiratory disease caused by a virus and transmitted from person to person. COVID 19 rapid test is used to detect COVID-19 infection with results that can be reported within 15 minutes. Failure to implement infection prevention practices may contribute to cross contamination	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40 of infection that can jeopardize the health and safety of residents, staff, and visitors. Findings: 1a. During an observation on 4/12/22 at 6:14 AM, two yellow-colored signage indicating "Amber Level" were posted on the entrance door of South 2. There were no signage for the type of transmission-based precautions (TBP) the facility is implementing and the specific type of PPE staff are required to use during provision of care to the residents. TBP are additional measures focused on a particular mode of transmission and are always in addition to standard precautions [basic level of infection control that should be used in the care of all patients all of the time]). A review of facility document titled, "LHH (Laguna Honda Hospital) COVID-19 Prevention and Management Protocol Neighborhood COVID-19 Outbreak Protocol (NCOP)," revised on 4/1/22, indicated that a neighborhood (a unit where residents reside) is placed on Amber Level status "... after a known neighborhood exposure to staff or resident with confirmed COVID-19..." During a concurrent observation and interview on 4/12/22 at 6:17 AM in South 2, Certified Nursing Assistant (CNA) 19 was wearing two surgical masks. CNA 19 was not wearing eye protection. CNA 19 stated he was supposed to wear N-95 respirator mask (a particulate filtering facepiece) and a face shield (a protective covering for all or part of the face that is commonly made of clear plastic and is worn to reduce the spread of transmissible diseases) while in the unit.	F 880		

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F 880	Continued From page 41 b. During a concurrent observation and interview on 4/12/22 at 6:30 AM in South 2, Licensed Vocational Nurse (LVN) 6 was standing in the hallway adjacent to Room 231. LVN 6 was not wearing eye protection. LVN 6 stated, "All of South 2" was placed on Amber Level status because staff and residents were exposed to either a staff or resident who was confirmed COVID-19 positive. c. During an observation in South 2 on 4/12/22 at 6:35 AM, CNA 17 was not wearing eye protection. In a concurrent interview, CNA 17 stated, "I have not been wearing face shield. I don't really know about that one (referring to use of face shield)." d. During an observation in South 2 on 4/12/22 at 6:46 AM, CNA 18 was using the computer located in the "Living Room." CNA 18 was not wearing eye protection. In a concurrent interview, CNA 18 stated, "We are on Amber. We need to put on N-95 and face shield the whole shift, even here (referring to the Living Room)." CNA 18 explained that staff wear yellow gowns when doing patient care "to protect ourselves (from COVID-19 infection) or else you're going to be sick." e. During an observation in South 2 on 4/12/22 at 6:53 AM, LVN 5 was seated at the nursing station. LVN 5 was not wearing an eye protection. In a concurrent interview, LVN 5 stated she wears a face shield "Only when we go to the patient. No gowns unless they (residents) are on contact precaution (procedures that reduce the risk of spread of infections through direct or indirect contact)." LVN 5 stated that staff are supposed to wear a face shield at the nursing station.	F 880		

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F 880	Continued From page 42 f. During an observation in South 2 on 4/12/22 at 7:06 AM, CNA 15 and CNA 20 entered Resident 81's room. CNA 15 was not wearing a gown (used to protect the wearer from the spread of infection or illness if the wearer comes in contact with potentially infectious liquid and solid material) and CNA 20 was not wearing eye protection and a gown inside Resident 81's room. At 7:09 AM, CNA 15 and CNA 20 exited Resident 81's room and entered Resident 82's room. During an interview on 4/12/22 at 7:11 AM, CNA 20 stated that staff do not need to wear a gown while providing care to the residents. g. During an observation in South 2 on 4/12/22 at 7:13 AM, CNA 15 entered Resident 81's room. At 7:16 AM, CNA 15 entered Resident 83's room. At 7:21 AM, CNA 15 entered Resident 85's room. At 7:24 AM, CNA 15 entered Resident 86's room. CNA 15 did not wear a gown while inside the aforementioned residents' rooms. During an interview on 4/12/22 at 7:29 AM, CNA 15 acknowledged not wearing a gown when she went inside the rooms of Resident 81, Resident 85, and Resident 86. CNA 15 stated she went inside the residents' rooms to check their blood pressure. h. During an observation on 4/12/22 at 7:18 AM, CNA 16 entered Resident 84's room wearing two surgical masks and a face shield. CNA 16 was not wearing a gown while inside Resident 84's room. During an interview on 4/12/22 at 7:30 AM, Nursing Director (ND) 4 stated that the type of PPE worn during patient care in a unit on Amber	F 880		

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F 880	Continued From page 43 Level status includes N-95 respirator, face shield, and gloves. During an interview on 4/12/22 at 7:34 AM, CNA 16 stated, "I took his (Resident 84) blood pressure, put on his pull up (disposable undergarment)." CNA added, "I wear double masks and face shield." CNA 16 explained she does not need to wear a gown inside the resident's room. During an interview on 4/12/22 at 8:34 AM with ND 1 and Nurse Manager (NM) 11, ND 1 stated, staff "need to wear goggles and N-95 if caring for residents. Everybody in the unit need to wear N-95 and goggles." ND 1 stated that staff could get exposed (to COVID-19) and expose others if staff do not wear a N-95 respirator and eye protection while in the unit. During an interview with Infection Control Nurse (ICN) 1 and ICN 2, accompanied by Quality Management Nurse (QM) 1, on 4/12/22 at 3:09 PM, ICN 1 stated that a unit is placed on Amber Level status when "...Floors (units) either have exposure or positive (for COVID-19 infection for either staff or resident)..." ICN 2 stated that for units on Amber Level status, staff are to wear "N-95, face shield or goggles...wear during entire shift." i. During an observation on 4/12/22, at 1:55 PM, a yellow colored signage indicating "AMBER LEVEL" was posted on the entrance door of North 1. At 1:56 PM, CNA 12 was walking around the great room wearing a yellow gown, a respirator over a cloth mask, and double gloves. During concurrent interview, CNA 12 stated she stores her respirator and eye protection in her	F 880		

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F 880	Continued From page 44 bag during her break. During an observation on 4/12/22, at 2:05 PM, CNA 13 was coming out of the resident's room wearing a respirator, a surgical mask on his neck, and eye protection on top of his head. During an observation on 4/12/22, at 2:07 PM, in North 1, a staff was not wearing gown inside the resident's room while providing care. During an observation on 4/12/22, at 2:10 PM, in North 1, a staff was wearing a respirator over a surgical mask, walking in the hallway with gloves, and eye protection on top of his head. j. During an observation on 4/12/22 at 1:54 PM, in the hallway of the Great Room of North 1, which is on "AMBER LEVEL", six staff were walking toward the nurse station wearing an N-95 respirator, a yellow gown, eye protection and gloves. During concurrent interview, CNA 12 stated, "I'm part of the clinical search team." CNA 12 explained that the team completed safety clinical search inside the residents room. Review of facility policy titled, "Standard Precautions" revised October 13, 2020 indicated, "...2. Personal Protective Equipment (PPE)...iv. Do not wear gloves or other PPE outside of resident care areas, including common areas unless under specific quarantine precautions..." Review of the NCOP indicated, "... Staff PPE used (COVID-19 PPE includes respirator, eye protection, gloves, gown) .... AMBER...Respirator and eye protection at all times on neighborhood...1...exposed residents: COVID-19 PPE.."	F 880		

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F 880	Continued From page 45 According to NIOSH "Eye Safety", accessed at https://www.cdc.gov/niosh/topics/eye/eye-infectious.html on 4/13/22, indicated, "... Eye protection should be removed by handling only the portion of this equipment that secures the device to the head (i.e., plastic temples, elasticized band, ties), as this is considered relatively "clean." The front and sides of the device (i.e., goggles, face shield) should not be touched, as these are the surfaces most likely to become contaminated by sprays, splashes, or droplets during patient care. Non-disposable eye protection should be placed in a designated receptacle for subsequent cleaning and disinfection. The sequence of PPE removal should follow a defined regimen that should be developed by infection control staff and take into consideration the need to remove other PPE (see donning and removing PPE) ... " 2a. During a concurrent observation of the staff break room in South 2 and interview with RN 33 on 4/12/22 at 12:10 PM, a N-95 respirator mask and a face shield were resting on a piece of paper towel on the dining table. RN 33 stated that the N-95 and face shield were used by and belong to RN 34 who was currently on break. RN 33 stated that when staff are on break, they should place their respirator and face shield in a brown paper bag "for protection" and "to keep it clean." During an interview on 4/12/22 at 3:45 PM, ICN 1 stated that during break, staff's N-95 respirator goes into a paper bag and stored in the break room. 2b. During an observation on 4/12/22 at 1:58 PM, Environmental Services Staff (EVS) 2 was sitting in the staff breakroom wearing an N-95 respirator	F 880		

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F 880	Continued From page 46 and a blue hair cover. On the dining table was a face shield placed on top of paper towels. During a concurrent interview, EVS 2 acknowledged that the face shield on the table was used and belonged to her. EVS 2 said that she wears the respirator in the breakroom, places it on the table on top of paper towels when eating. EVS 2 stated, "I wear it all the time." Review of facility policy titled, "Standard Precautions" revised October 13, 2020 indicated, "...2. Personal Protective Equipment (PPE)...iv. Do not wear gloves or other PPE outside of resident care areas, including common areas unless under specific quarantine precautions..." 2c. During an observation on 4/12/22, at 1:47 PM, Certified Nursing Assistant (CNA) 11 was walking at the hallway wearing eye protection on top of her head. During concurrent interview, CNA 11 stated she was coming from the "Amber" unit and going for her break. When asked where she stores her respirator and eye protection during her break, CNA 11 stated, "I put my N95 in my pocket. The goggles in my bag." CNA 11 added, she change her respirator and eye protection every shift. Review of facility policy titled, "Standard Precautions" revised October 13, 2020 indicated, "...2. Personal Protective Equipment (PPE)...iv. Do not wear gloves or other PPE outside of resident care areas, including common areas unless under specific quarantine precautions..." According to NIOSH "Eye Safety", accessed at https://www.cdc.gov/niosh/topics/eye/eye-infectious.html on 4/13/22, indicated, "...A labeled container for used (potentially contaminated) eye	F 880		

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F 880	Continued From page 47 protection should be available in the HCW change-out/locker room. Eye protection deposited here can be collected, disinfected, washed, and then reused ... Healthcare setting-specific procedures for cleaning and disinfecting used patient care equipment should be followed for reprocessing reusable eye protection devices. Manufacturers may be consulted for their guidance and experience in disinfecting their respective products. Contaminated eye protection devices should be reprocessed in an area where other soiled equipment is handled. Eye protection should be physically cleaned and disinfected with the designated hospital disinfectant, rinsed, and allowed to air dry. Gloves should be worn when cleaning and disinfecting these devices..." The "Cal/OSHA Interim Guidance on COVID-19 for Health Care Facilities: Severe Respirator Supply Shortages" dated 8/6/20 indicated, "...Acceptable Optimization Strategies to Extend Respirator Use: While there are still respirator shortages in some sectors, California health care providers are no longer experiencing an extreme respirator shortage. Manufacturers are increasing respirator production. Many manufacturers and distributors make respirators available to employers through allocation protocols. In addition, state and local governments are procuring respirators to support health care facilities. All employers should continue efforts to obtain a sufficient supply of NIOSH certified respirators through private supply chains. Non-NIOSH certified respirators must not be used where respirators are required to address the risk of occupational exposure to COVID-19...6.1 Extended use of respirators. Extended use occurs when health care employees use the same respirator during	F 880		

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F 880	Continued From page 48 encounters with several patients without removing the respirator between patient encounters. Employers must ensure that the respirators are kept clean, sanitary, and in good working order at all times. Extended use is practiced when multiple patients are infected with the same respiratory pathogen and patients are placed together in dedicated areas (cohorting). When patients are cohorted together: The maximum recommended respirator extended use period is 8 to 12 hours. Respirators should be removed and carefully stored in a clean paper bag before activities such as meals, restroom breaks, and other breaks and then re-donned and worn through the remainder of the shift. The respirator must be discarded if it any time it becomes contaminated or does not fit or function correctly..." 3a. During an observation on 4/12/22, at 2:30 PM, a yellow colored signage indicating "AMBER LEVEL" was posted on the entrance door of North 4. At 2:32 PM, Registered Nurse (RN) 35 was observed coming out of the galley with an empty cup and apple juice for a resident sitting in the great room. RN 35 donned a pair of gloves without performing hand hygiene and proceeded to assist the resident. RN 35 did not perform hand hygiene after removing and discarding his gloves. During concurrent interview, RN 35 acknowledged he did not perform hand hygiene before donning and after doffing his gloves. 3b. During an observation on 4/12/22, at 6:20 AM, at South 6, LVN 3 observed at the hallway by the resident room, LVN 3 did not perform hand hygiene after removing gloves, proceeded inside the resident room, took out his "Work Station On Wheels" (WOW) cart, went out of the resident room without doing hand hygiene and proceeded	F 880		

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F 880	Continued From page 49 to put on a new pair of gloves. During concurrent interview, LVN 3 stated, "After removing gloves, need to disinfect hands, wash or disinfect hands before going in or out of the room and before donning a new pair of gloves, not disinfecting hands can spread infection." During an interview on 4/12/22, at 4:10 PM, ICN 1 acknowledged, after removing gloves, staff should wash or disinfect hands and stated, "That practice is not acceptable, that's not per facility policy." 3c. During an observation on 4/12/22 at 1:57 PM, in the North 1 hallway by the Great Room, Patient Care Aide (PCA) 4 was walking towards the nurse station wearing an N-95 respirator, a yellow gown, eye protection and gloves. Inside the room behind the nurse station, PCA 4 removed her gown and gloves. PCA 4 did not perform hand hygiene after discarding gown and gloves. PCA 4 headed inside the nurse station and took her bag. During concurrent interview, PCA 4 acknowledged that hand hygiene was not performed after doffing and stated, "I didn't do it." Review of the facility policy and procedure titled, "Hand Hygiene," revised 10/13/20, indicated, "...Policy: (4.) Gloves are not a replacement for proper hand hygiene. Purpose: The purpose of this policy is to guide staff in the use of proper hand hygiene standards. Hand hygiene has been identified as the single most important factor in reducing the transfer of infectious disease to others. Procedure: (2.) Hand hygiene will be performed: (b.) Before and after direct resident contact, (c.) Before and after glove use..." 4a. During an observation on 4/12/22 at 6:24 AM, in South 6, a hamper with a plastic bag full of	F 880		

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F 880	Continued From page 50 soiled linen was in the residents' care area hallway. The dirty linen hamper had four trash bags tied on each side. Three of the four trash bags were full of soiled linen and trash, were left open and unattended. During an interview on 4/12/22, at 6:26 AM, CNA10 acknowledged that the trash bags should be closed to not attract germs which can spread infection. During an interview on 4/12/22, at 6:34 AM, ND 6 acknowledged and stated, "I think we just use one bag at a time. It is an infection control issue." 4b. During an observation on 4/12/22 at 6:40 AM, outside of the non-resident bathroom in South 3, there were two hampers, each with a plastic bag full of dirty linen/clothing. On top of one hamper was an untied plastic bag of dirty clothes. By the wall outside the adjacent Environmental Services (EVS) room, on the floor were four plastic bags of dirty linen/clothing. Outside the soiled utility room, located across the EVS room, was a hamper with a bag full of dirty linen/clothing. On top of the hamper were four plastic bags of dirty linen/clothing. During an interview on 4/12/22 at 6:44 AM, RN 32 acknowledged that the plastic bags were filled with dirty linen/clothing and stated, "It's soiled linens and clothes." RN 32 further said that the Home Care Aide comes to do the laundry in the laundry room. RN 32 stated, "We don't have special room for dirty laundry." During an interview on 4/12/22 at 6:57 AM, PCA 14 said that the plastic bags of dirty linen/clothing should not be overflowing. PCA 14 stated, "It's not	F 880		

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F 880	Continued From page 51 supposed to be there. It should be inside (hamper) and covered. That's not good. It's infection control." During an interview on 4/12/22 at 4:10 PM, ICN 1 said that hampers should not be full and stated, "Bad infection control, passing bloodborne pathogens (infectious microorganisms in human blood that can cause disease in humans) or HAIs (healthcare-associated infections). It's not appropriate." Review of facility policy titled, "Bed Stripping and Terminal Cleaning" revised on March 12, 2019 indicated, " ...4 ...d. Discard dirty linens into the dirty linen hamper ..." Review of Environmental Services policy titled, "XVII. Transport, Delivery, Time for Biohazard, Trash and Linen" effective June 2010 indicated, "...South Residence Building Soil linen - Staff shall collect soil linen from chute, wrap cart with plastic bag and transport to 2nd floor loading dock for pick up by vendor..." The Center for Disease Control and Prevention (CDC) Guidelines for Environmental Infection Control in Health-Care Facilities, last reviewed on 11/5/15, under "G. Laundry and Bedding" indicated, "...Contaminated textiles and fabrics often contain high numbers of microorganisms from body substances, including blood, skin, stool, urine, vomitus, and other body tissues and fluids...Disease transmission attributed to health-care laundry has involved contaminated fabrics that were handled inappropriately (i.e., the shaking of soiled linens)...OSHA [Occupational Safety and Health Administration] defines contaminated laundry as "laundry which has been	F 880		

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F 880	Continued From page 52 soiled with blood or other potentially infectious materials or may contain sharps." The purpose of the laundry portion of the standard is to protect the worker from exposure to potentially infectious materials during collection, handling, and sorting of contaminated textiles through the use of personal protective equipment, proper work practices, containment, labeling, hazard communication, and ergonomics...The laundry process starts with the removal of used or contaminated textiles, fabrics, and/or clothing from the areas where such contamination occurred, including but not limited to patients ' rooms, surgical/operating areas, and laboratories. Handling contaminated laundry with a minimum of agitation can help prevent the generation of potentially contaminated lint aerosols in patient-care areas. Sorting or rinsing contaminated laundry at the location where contamination occurred is prohibited by OSHA. Contaminated textiles and fabrics are placed into bags or other appropriate containment in this location; these bags are then securely tied or otherwise closed to prevent leakage..." (https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/laundry.html) 5. During an observation on 4/11/22, at 1:55 PM, in the facility main entrance lobby, Random Visitor (RV) 1 entered the facility. RV 1 was on wheelchair and was able to wheel himself. During an observation on 4/11/22, at 1:58 PM, PCA 3 assisted RV 1 with COVID-19 antigen rapid testing. Immediately after, RV 1 went to use the common bathroom in the main lobby located outside the testing site. Then RV 1 checked-in his personal belongings in the locker room accompanied by Security 3. Afterwards, RV1 wheeled self and waited for his COVID-19 rapid	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	R-C 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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F 880	Continued From page 53 antigen test result in the common waiting area, along with other visitors and staff. During an interview with PCA 3 on 4/11/22, at 2:30 PM, PCA 3 stated RV1 did not have a proof of COVID-19 vaccination. PCA 3 acknowledged the above findings and stated RV1 should have stayed in the testing area for 15 minutes while waiting for his COVID-19 rapid antigen test result. During an interview with ICN 1 on 4/12/22, at 3:22 PM, ICN 1 stated the visitor's COVID-19 testing area should be located outside the entrance of facility to minimize risk of spread of infection. ICN 1 stated RV1 should wait in the testing area for 15 minutes until the COVID-19 result is obtained. ICN 1 stated RV 1 should not go outside the testing area and go anywhere else in the facility without a confirmed negative COVID-19 rapid antigen test result. Review of facility document, titled "iHealth Antigen Rapid Test - Testing, Processing for Unvaccinated Visitors, dated 3/24/22, indicated "Laguna Honda Hospital will utilize the iHealth Covid-19 antigen rapid test for unvaccinated visitors... Screeners will ask visitors if they are vaccinated... If no, screener gives iHealth testing kit to unvaccinated visitor. Location of testing site will be across from screener, next to double doors to the farm... 6. Afer testing, the visitor will sit at table with testing kit on table. Leave undisturbed for 15-30 minutes... 7. Staff reads results 15 minutes after test is performed... Screener will send unvaccinated visitor to cadets for check in after proof of negative test. Review of facility document, titled "Employee Health Checkers Process (formerly Screeners),	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	R-C 04/13/2022

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F 880	Continued From page 54 dated 12/3/21, indicated "Purpose: Streamline process for daily staff symptom health check to safeguard resident/staff health and limit spread of COVID-19."	F 880		

EXHIBIT 7

State of California-Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Rcvd Laguna Honda Hosp Admin
2022 JAN 7 PM1:58

January 6, 2022

Letter 4

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Michael Phillips, Administrator
Laguna Honda Hospital & Rehabilitation Ctr D/P SNF
375 Laguna Honda Blvd.
San Francisco, CA 94116-1411

Dear Mr. Phillips:

On October 15, 2021 an abbreviated survey for facility reported incident no. CA00729480 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[X] Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (D).

[ ] A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (E).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)
Providers may now submit their plan of correction (POC) as a separate document attachment or may continue to document the POC on the right side of the CMS Form 2567- "Statement of Deficiencies and Plan of Correction".
A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS-2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or the State Medicaid Agency effective as soon as notice requirements are met.

Your POC must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by January 17, 2022.

Recommended Remedies
The remedies, which will be recommended if substantial compliance has not been achieved by **January 17, 2022,** include the following:

[X] A civil money penalty will be recommended to CMS Regional Office if substantial compliance has not been achieved (§488.430).

We are also recommending to the CMS Regional Office and/or the State Medicaid Agency that your provider agreement be terminated on April 14, 2022, if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)
Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA

effective January 14, 2022. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable POC and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial Compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your

appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon a subsequent revisit or by other means it is determined your facility has not achieved substantial compliance, we will recommend the remedies previously mentioned in this letter be imposed by the CMS Regional Office beginning on October 15, 2021, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose a revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an

opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact Raquel Larsen, Health Facilities Evaluator Supervisor, at (415) 330-6353.

Sincerely,

Raquel Larsen HFES
for

Diana Marana, R.N.
District Manager
Licensing and Certification

Enclosure *(CMS 2567)*

DM:cr

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	C 10/15/2021

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LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Facility Reported Incident: CA00729480 Representing the California Department of Public Health: ID 40454, Health Facilities Evaluator Nurse The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was written as a result of Facility Reported Incident CA00729480.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

M. Phillips | Chief Executive Officer | 01/13/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to treat one of three sampled residents (Resident 1) with respect and dignity when Resident 1 verbalized that she felt "less of a person" during the investigation of her stolen belongings. This facility failure had the potential to cause emotional stress to Resident 1. Resident 1 was admitted with diagnoses including cerebrovascular disease (stroke) and seizure disorder (epilepsy). Minimum data set (an assessment tool) dated 2/16/21 brief interview of mental status (a brief memory test to help	F 550		

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F 550	Continued From page 2	F 550		

determine cognitive function) score 15 indicated cognitively intact.

During an interview on 5/5/21, at 11:30 AM, with Resident 1, Resident 1 stated, "A friend of mine brought me a bag of lollipops, a pack of thank you cards and a pretty wedding congratulatory card. Someone stole them. I reported it to the staff. No one was interested with my concerns. I was put in an awkward position and made me feel guilty. That I was lying, that I don't remember, and that it was actually hard to believe that my things were stolen. I was told, you have misplaced it. They never found the bag of lollipops. It was not returned. It was not replaced. There was no apology. It was not a priority. My concern is not important. I was made to feel a bad person, that I should have taken care of my things. There is no resolution. Nobody talked to me about it. The Nurse Manager (NM) was accusatory. She made me feel it is all my fault. I stopped talking to her. She doesn't have intention to help. It is not important to her. I lost my respect for her. She made me feel less of a person. They were doubting me from the beginning. My stuff were fine until someone stole them. They should at least check the wanderers. I told them to ask their staff. No one has talk to me how to get my stuff back. There is no closure. I guess it's just a stupid candy."

Review of Resident 1's nurse's notes dated 3/16/21 indicated Resident 1 "... wanted to be reimbursed for her missing items...

Review of Resident 1's nurse's notes dated 3/17/21 indicated, "...Staff continued to search for her missing lollipops and thank you notes (cards) but were not found..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 3 Review of Resident 1's nurse's notes dated 3/18/21 indicated Resident 1, "...No verbalization about losing her lollipops..." Review of Resident 1's nurse's notes dated 3/19/21 indicated Resident 1, "...No verbalization of missing lollipops and thank you card..." Review of Resident 1's Social Services notes dated 3/16/21 indicated, "Informed by nursing that resident is alleging her lollipops and a thank you card were stolen from her. Staff have never seen these items and this writer has not had visitors drop anything off to her recently..." During an interview on 5/5/21, at 12 pm, with Certified Nurse Assistant (CNA, caregiver) stated, CNA "(name of Resident 1) uses one of the tables in the solarium as if it is part of her room. She has been in the unit for a while. She sits there during the day and do her activities. She was comfortable leaving her things there. It was suspected that it is Resident 4 who might have stolen her candies. She is a wanderer. They eventually knew that Resident 4 took her candies." During a concurrent interview on 5/5/21 with the Nurse Manager (NM) and Director of Nursing (DON), at 12:10 PM, NM stated, "(name of Resident 1) is alert, oriented and sometimes forgetful. A week before, she reported that she is missing some items. We do not know what it was. She couldn't find the pictures of the lollipops and the thank you cards on her cellphone. It was not followed up. It was not investigated. " DON stated, "I wander why it was not followed up." NM continue to state, "Then we learned from her	F 550		

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F 550	Continued From page 4 (Resident 1) that she was missing a bag of lollipops and a box of thank you cards. I have the bag of lollipops in my office. She doesn't know I have them. I didn't tell her. I did not return it because the bag is already open. It was found in Resident 4's room. The cards were not found. The lollipops and the cards were not replaced. I don't know how the lollipops can be reimbursed. The social worker is not involved in this incident, it's only us, nursing. I don't know how the facility can replace the lollipops. I haven't asked about it." Review of facility Policy and Procedure (P&P), "Handling Resident's Property and Prevention of Theft and Loss" dated 7/9/19, P&P indicated, "...7. Claims and Liability ...b. LHH is liable for damage or loss of the personal property of a resident, but only if negligence or willful wrongdoing on the part of LHH or its employee shown. LHH may also deny liability when reasonable efforts to safeguard the resident's personal property has been provided and the resident chooses to take other actions or the property is not listed on the residents Inventory of Resident's Property (IRP)..."	F 550		

EXHIBIT 8

State of California-Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Rcvd Laguna Honda Hosp Admin
2022 JAN 6 PM12:08

January 5, 2022

Letter 4

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Michael Phillips, Administrator
Laguna Honda Hospital & Rehabilitation Ctr D/P SNF
375 Laguna Honda Blvd.
San Francisco, CA 94116-1411

Dear Mr. Phillips:

On November 5, 2021 an abbreviated survey for facility reported incident no. CA00734547 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[X] Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (D).

[ ] A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (E).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

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A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS-2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or the State Medicaid Agency effective as soon as notice requirements are met.

Your POC must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by January 17, 2022.

Recommended Remedies
The remedies, which will be recommended if substantial compliance has not been achieved by **January 17, 2022,** include the following:

[X] A civil money penalty will be recommended to CMS Regional Office if substantial compliance has not been achieved (§488.430).

We are also recommending to the CMS Regional Office and/or the State Medicaid Agency that your provider agreement be terminated on April 14, 2022, if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)
Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective

January 14, 2022. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable POC and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial Compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be

considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon a subsequent revisit or by other means it is determined your facility has not achieved substantial compliance, we will recommend the remedies previously mentioned in this letter be imposed by the CMS Regional Office beginning on November 5, 2021, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose a revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies to Diana Marana, District Manager, California Department of Public Health, Licensing and

Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact Raquel Larsen, Health Facilities Evaluator Supervisor, at (415) 330-6353.

Sincerely,

Raquel Larsen HFES
for

Diana Marana, R.N.
District Manager
Licensing and Certification

Enclosure *(CMS 2567)*

DM:cr

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Facility Reported Incident: CA00734547 Representing the California Department of Public Health: ID 44477, Health Facilities Evaluator Nurse The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was written as a result of Facility Reported Incident CA00734547.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 1 law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to appropriate authorities within the required regulatory timeframe for one (Resident 1) of three residents when: Resident 1 had verbal altercation with another resident (Resident 2) on 4/22/21 at 6:00PM, but was not reported until 4/24/21 at 4:30PM. This failure had the potential to negatively impact the protection of residents from abuse. Findings: During an interview on 9/3/21, at 11:20AM, Staff 2 stated that Nursing Supervisor 1 (NS1) did not report the incident. Nursing Supervisor 2 (NS2) reported the incident two days later, on 4/24/21". During an interview on 9/3/21, at 4:05PM, Staff 2	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 2 stated, "It was a late report." During an interview on 10/29/21, at 4:28PM, Staff 1 stated, "I don't remember why it was not reported. I told my supervisor that day." NS1 told him to observe Resident 1 and Resident 2. Review of Resident 1's Nursing Note, dated 4/22/21, 4/23/21, 4/24/21, 4/25/21, 4/26/21, and 4/27/21 indicated, nurses observed Resident 1, and Resident 1 had no issues. Review of Resident 2's Nursing Note, dated 4/22/21, 4/23/21, 4/24/21, 4/25/21, 4/26/21, and 4/27/21 indicated, nurses observed Resident 2, and Resident 2 had no issues. During an interview on 10/29/21, at 4:46PM, with Nursing Supervisor 3 (NS3) stated, "Whoever taking care of resident, they are supposed to call Ombudsman and CDPH." During an interview on 11/1/21, at 11:56PM, with NS1 stated, "I cannot recall," when asked about the incident. NS1 stated, whoever witnessed the incident needed to report immediately to CDPH, Ombudsman per policy and procedure. Review of Resident 1's nursing note, dated 4/24/21 at 5:28PM indicated, NS2 left a message to CDPH (The California Department of Public Health) and Ombudsman at 4:30PM. The nursing	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 3 note also indicated, NS2 reported to Sheriff. During a review of Facility's Incident Interview Report, dated 4/28/21 indicated, "... called in to report... on 4/24/21 to CDPH, Ombudsman and SFSD(San Francisco Sheriff's Department)." During a review of the facility's policy and procedure(P&P), "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response," indicated on page 9 of 22, "... 6. Reporting Protocol a. All LHH(Laguna Honda Hospital and Rehabilitation Center) employees ... are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse. i. The mandated reporter shall immediately respond to and report observed or suspected incidents of abuse by contacting the following within 2-hours: · CDPH ... · Ombudsman ..."	F 609		

EXHIBIT 9

State of California-Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Rcvd Laguna Honda Hosp Admin
2022 JAN 7 PM 1:58

January 6, 2022

Letter 4

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Michael Phillips, Administrator
Laguna Honda Hospital & Rehabilitation Ctr D/P SNF
375 Laguna Honda Blvd.
San Francisco, CA 94116-1411

Dear Mr. Phillips:

On December 21, 2021 an abbreviated survey for complaint CA00745218 and facility reported incident nos. CA007386567 and CA00745216 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[ ] Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (D).

[X] A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (E).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)
Providers may now submit their plan of correction (POC) as a separate document attachment or may continue to document the POC on the right side of the CMS Form 2567- "Statement of Deficiencies and Plan of Correction".
A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS-2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or the State Medicaid Agency effective as soon as notice requirements are met.

Your POC must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by January 17, 2022.

Recommended Remedies
The remedies, which will be recommended if substantial compliance has not been achieved by **January 17, 2022,** include the following:

[X] A civil money penalty will be recommended to CMS Regional Office if substantial compliance has not been achieved (§488.430).

We are also recommending to the CMS Regional Office and/or the State Medicaid Agency that your provider agreement be terminated on April 14, 2022, if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)
Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA

effective January 14, 2022. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable POC and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial Compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

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The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your

appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005 . We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon a subsequent revisit or by other means it is determined your facility has not achieved substantial compliance, we will recommend the remedies previously mentioned in this letter be imposed by the CMS Regional Office beginning on , and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose a revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an

opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact Raquel Larsen, Health Facilities Evaluator Supervisor, at (415) 330-6353.

Sincerely,

Raquel Larsen HFES
gov

Diana Marana, R.N.
District Manager
Licensing and Certification

Enclosure *(CMS 2567)*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	C 12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an Abbreviated Standard Survey. Complaint: 745218 Facility reported incidents: 745216 and 738656 Representing the California Department of Public Health: 40009, Health Facilities Evaluator Nurse 42766, Health Facilities Evaluator Nurse The inspection was limited to the specific complaint and facility reported incidents investigated and does not represent the findings of a full inspection of the facility. Three (3) deficiencies were issued for complaint 745218 and facility reported incidents 745216 and 738656.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to complete accurate assessment for one of three sampled residents (Resident B); when coding on Section H of the Minimum Data Set (a resident assessment tool) did not reflect application of intermittent catheterization. Failure to complete accurate assessments may	F 641		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

M. Phillips | Chief Executive Officer | 01/14/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 1	F 641		

cause potential harm to residents by not providing needed care and services to maintain their highest level of functioning.

Findings:

Resident B was admitted on 6/12/18, with diagnoses including paraplegia (paralysis of the legs and lower body, and neurogenic bladder (lacking in bladder control due to a brain, spinal cord, or nerve condition).

Review of Resident B's Minimum Data Set (MDS, a resident assessment tool) dated 4/29/21, indicated, Resident B is cognitively intact. Resident B had impairment on both lower extremities that required two-person extensive assist with toileting.

Review of Resident B's physician orders dated 10/21/19, indicated, "... Nursing communication Pls. (Please) Do ICP (intermittent catheterization procedure) every(q) 12 hours(hrs) and record the volume of urine until discontinued..."

During an observation on 7/27/21, at 8:48 AM, in Resident B's room, Registered Nurse (RN 1) performed ICP to Resident B.

During an interview on 8/10/21, at 11:21 am with MDS Coordinator (MDSC) and concurrent review of Resident B's MDS, dated 4/29/21 stated, "I missed it" and added that she will submit a correction of Resident B's MDS assessment. The MDS, under "Section H" indicated, Intermittent catheterization was coded "No".

Review of facility policy and procedure (P&P), "Completion of Resident Assessment Instrument

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 2 /Minimum Data Set (RAI/MDS)", dated 7/9/19 indicated, "... Purpose:... To ensure accurate and timely completion of the Resident Assessment Instrument/Minimum Data Set... Background: The RAI/MDS is a tool used to identify resident problems, strengths, weaknesses and preferences and provides information for the development of an individualized plan of care..."	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	C 12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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F 656	Continued From page 3	F 656		

resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for two of three sampled residents (Resident A and Resident B) when the Activities of Daily Living (ADLs, routine activities which includes but not limited to eating, bathing, dressing, toileting, mobility and transfers) care plan was not individualized.

The deficient practice had the potential to result in Resident A and B not receiving the care and services to meet their needs.

Findings:

1a. Resident B was admitted on 6/12/18, with diagnoses including paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), Multiple Sclerosis (or MS, is a disease that can affect your brain and spinal cord) and neurogenic bladder (a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition).

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F 656	Continued From page 4 Review of Resident B's Minimum Data Set (MDS, an assessment tool) dated 4/29/21, indicated, Resident B is cognitively intact. MDS also indicated, Resident B had impairment on both lower extremities and required two-person extensive assist with toileting (including managing her catheter), one-person extensive assist with bed mobility. During an observation on 7/27/21, at 8:48 AM, in Resident B's room, Registered Nurse (RN) 1 performed intermittent catheterization procedure (ICP) to Resident B. Resident B was positioned supine (lying face upward). Resident B not able to move her lower extremities. RN 1 successfully inserted the catheter on the third attempt. RN 1 stated, normally she would not miss the first attempt. RN 1 further stated, the ICP would have been easier if there was another staff to help lift and reposition Resident B's legs. Review of Resident B's ADL care plan, dated 8/22/19, and concurrent staff interview on 7/27/21, at 9:15 AM, with RN 1, ADL care plan indicated, "...Interventions... 7. Provide cueing, supervision and/or appropriate level of assistance to promote ADL's/mobility/safety as needed...". RN 1 acknowledged the above findings and stated, Resident B's ADL care plan was not individualized. RN 1 also stated, the ADL care plan did not indicate how much assistance and staff support were needed for each ADL. During an interview on 7/27/21, at 9:20 AM, NM 1 stated all licensed staff are responsible for developing and implementing Resident B's comprehensive care plan. NM 1 acknowledged the above findings and stated, he will conduct an	F 656		

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F 656	Continued From page 5	F 656		

in-service to licensed staff to make the residents' ADL care plan person-centered.

1b. Resident A was admitted on 5/4/21, with diagnoses including paraplegia (paralysis of the legs and lower body), osteomyelitis (an infection in a bone) of vertebra of thoracic region and difficulty walking.

Review of Resident A's MDS, dated 5/10/21 indicated, Resident A is cognitively intact. Resident A had impairment on both lower extremities that required extensive assistance with one to two person-assist with bed mobility, dressing and toileting.

Review of Resident A's ADL care plan, dated 5/4/21, and concurrent interview on 7/27/21 at 12:15 AM, with Quality Management Nurse (QMN) 1, indicated "...Interventions... 7. Provide cueing, supervision and/or appropriate level of assistance to promote ADL's/mobility/safety as needed...". QMN 1 acknowledged the above findings and stated, the licensed nurses should develop the ADL care plan interventions specific and person-centered to Resident A.

Review of Resident A's Care Area Assessment (CAA) dated 5/13/21, indicated, "... CAA on ADL Function is triggered by 'Extensive assistance with Bed mobility, Dressing and toilet use; limited assist with personal hygiene, and supervision with eating." ..."

Review of facility P&P, "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)" dated 7/9/19, indicated, "Policy... 3. The Resident Care Plan (RCP) shall be person-centered, evaluated during weekly or

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F 656	Continued From page 6 monthly summaries, when indicated for short term problems, every quarter, and revised as needed to serve as an essential resource for improved resident outcomes...". It also indicated, "... Procedure... 4. Comprehensive Care Plan... a. LHH [Laguna Honda Hospital] shall develop and implement a comprehensive person-centered care plan within seven days of completion of the comprehensive assessment..." and "... 7. Developing Interventions... b. Interventions are specific, individualized and describes the team member(s) responsible for carrying it out and the frequency for conducting the interventions..."	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the Intermittent Catheterization Procedure (ICP) provided for one of three sampled residents (B), met professional standards of practice. Failure to follow standards of practice could potentially result in Resident B's negative outcome. Findings: 1. Resident B was admitted on 6/12/18, with diagnoses including paraplegia (paralysis of the legs and lower body, and neurogenic bladder	F 658		

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F 658	Continued From page 7 (lacking in bladder control due to a brain, spinal cord, or nerve condition). Review of Resident B's MDS dated 4/29/21, indicated, Resident B is cognitively intact. Resident B had impairment on both lower extremities that required two-person extensive assist with toileting. Review of Resident B's physician orders dated 10/21/19, indicated, "... Nursing communication Please (pls) Do ICP (intermittent catheterization procedure) q 12 hrs and record the volume of urine until discontinued..." During an observation on 7/27/21, at 8:48 AM, in Resident B's room, RN1 conducted the ICP to Resident B. Resident B was positioned supine. RN1 attempted to bend Resident B's knees but Resident B was not able to move her lower extremities. RN1 opened the sterile catheterization tray. RN1 placed sterile drape under Resident B's perineal area. RN1 did not use a flashlight or ask someone assist to hold a flashlight to visualize the urinary meatus. RN1 was unsuccessful on the first and second attempt. During an interview on 7/27/21, at 9:30 AM, RN 1 stated, normally she would not miss inserting the catheter during ICP. RN1 also stated, she had never used a flashlight during Resident B's ICP. RN 1 added the ICP would have been easier if there was another staff to help her lift and reposition Resident B's legs. Record review of facility document, "Foley Catheter Insertion Competency for Licensed Nurses", dated 9/21/20, and concurrent staff	F 658		

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F 658	Continued From page 8 interview with Director of Staff Development (DSD)1 and DSD2, the document indicated, "... Preparations Prior to Catheterization... Gathers and brings equipment needed for the procedure to the resident's bedside... Urinary Catheter... Flashlight (as needed)... 3. Procedure... A. Position resident as follows: Female: Dorsal recumbent position (on back with knees flexed), instruct resident to relax thighs. Alternate position: Sims' position: side-lying with upper leg flexed at knee and hip... Cover or drape resident with blanket so only perineum and genitals are exposed... Positions light to illuminate perineum or have someone assist in holding flashlight to visualize urinary meatus... B. Preparation of Equipment Needed:... Drape resident's perineum. For females, expose labia...". DSD 1 stated, staff should check Resident B's care plan to check what level of assistance is needed for him for toileting including ICP. DSD1 further stated, the licensed nurse should have asked for another nursing staff to assist with repositioning and holding the flashlight for best practice of ICP. DSD2 stated, the nursing staff could also use a support band to help hold the weight of Resident B's legs for repositioning for ICP.	F 658		

EXHIBIT 10

State of California-Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Rcvd Laguna Honda Hosp Admin
2022 JAN 7 PM1:58

January 6, 2022

Letter 6a

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Michael Phillips, Administrator
Laguna Honda Hospital & Rehabilitation Ctr D/P SNF
375 Laguna Honda Blvd.
San Francisco, CA 94116-1411

Dear Mr. Phillips:

On December 28, 2021 an abbreviated survey for facility reported incident no. CA00681059 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[ ] Widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (F).

[X] Isolated deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (G).

[ ] A pattern of deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (H).

[ ] Widespread deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form , whereby significant corrections are required (I).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal

Regulations (CFR).

Plan of Correction (POC)
A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS- 2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or State Medicaid Agency effective as soon as notice requirements are met.

Providers may now submit their plan of correction (POC) as a separate document attachment or may continue to document the POC on the right side of the CMS Form 2567- "Statement of Deficiencies and Plan of Correction" and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by January 17, 2022.

Recommended Remedies
The remedies which will be recommended include the following:

[X] A civil money penalty will be recommended to CMS Regional Office if substantial compliance has not been achieved. (§488.430)

[X] Termination effective April 14, 2022. (§488.456)

We are also recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on April 14, 2022 if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective January 14, 2022. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.)

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit. In such a case, neither the CMS Regional Office nor the State Medicaid

Agency will impose the previously recommended remedy(ies) at that time.
If, upon the subsequent revisit, it is determined your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter will be imposed by the CMS Regional Office beginning on December 28, 2021 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies, to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact Raquel Larsen, Health Facilites Evaluator Supervisor, at (415) 330-6353.

Sincerely,

Raquel Larsen HFES
for DV

Diana Marana, R.N.
District Manager
Licensing and Certification

Enclosure *(CMS 2567)*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS The following reflects the findings of California Department of Public Health during an abbreviated standard survey. Facility Reported Incident: CA00681059 Representing the Department: 39291, Health Facilities Evaluator Nurse The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was written as a result of facility reported incident number CA00681059.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure resident safety for one resident (Resident A) when Resident A's seatbelt was not fastened while transport vehicle was in motion. This failure resulted in Resident A falling out of her wheelchair inside the van and sustaining a fracture on her right tibia (shin bone) and fibula	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

M. Phillips | Chief Executive Officer | 01/13/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 (calf bone).	F 689		

Findings:

During a review of Resident A's physician notes (PN), dated 3/13/20, the PN indicated Resident A had diagnoses that included End-Stage Renal Disease, and Dementia (loss of cognitive functioning). PN also indicated, Resident A was completely unaware of her situation and cannot reliably state her needs.

During a review of the Minimum Data Set (MDS, an assessment tool) dated 3/2/20, the Brief Interview for Mental Status (BIMS) indicated, Resident A was unable to repeat three words, unable to report the correct year, month, and day of the week, and was unable to complete the interview. Resident A's functional status in MDS indicated, the resident was totally dependent on staff for bed mobility, transfers, locomotion on and off the unit, eating, toilet use and personal hygiene.

During a review of Resident A's Care Plan, (CP), dated 8/17/19, the CP indicated, " ...Problem: Safety ... Fall ... Goal ... Free from fall injury ... INTERVENTIONS: 1. Assess patient frequently for physical needs. 2. Identify cognitive and physical deficits and behaviors that affect risk of falls. 3. Institute fall precautions ..."

During a review of the facility's Investigation Report (IR), dated 3/15/20, the IR indicated, Resident A slipped out of the wheelchair, and fell inside the van during transport back to the facility from her appointment on 3/14/20. The IR indicated, Resident A was diagnosed with fracture of her right tibia and fibula.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	C 12/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2	F 689		

During an interview on 12/8/21, at 1:37 PM, with Patient Care Assistant (PCA) 1, PCA 1 confirmed she was assigned to escort Resident A to her dialysis (kidney failure treatment that filters and purifies the blood using a machine) appointment on 3/14/20. PCA 1 stated, after the treatment, a dialysis staff transferred the resident back to her wheelchair, placed a blanket on her lap and tucked her in the chair. PCA stated, it was her responsibility to ensure Resident A's seat belt was fastened, and the vehicle driver's responsibility to make sure the wheelchair was secured inside the van. PCA 1 stated, during transport, she saw Resident A slipped from the wheelchair and fell on the floor inside the vehicle. PCA 1 said, " ...I didn't think to strap her in ..." PCA stated, she never thought to check if Resident A's seat belt was buckled or not. PCA 1 said, "I learned from my mistake ... I will check ..." PCA 1 stated, "I wish I was proactive ... that's where I messed up..."

During an interview on 12/8/21, at 2:13 PM, Nurse Manager (NM), NM stated, Resident A passed away on 6/30/20. NM stated, the fall incident could have been prevented. NM confirmed Resident A's seatbelt was not buckled during transport on 3/14/20 which resulted in a fall and right lower leg bone fractures. NM stated, PCA 1 should have checked Resident A was securely buckled up in her seat while inside the vehicle to ensure safety during transport back to the facility. NM stated, it was the facility's policy and expectation for PCA escorts to ensure residents were safe during transport. NM stated, licensed nurses were also expected to give to PCA escorts a report that included safety precautions and reminders.

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F 689	Continued From page 3	F 689		

During a review of the facility's policy and procedure (P&P), titled, "FALLS," with revision dated 7/9/19, the P&P indicated, " ... PURPOSE ... Provide a safe environment for residents ... PROCEDURE ... Interventions shall be developed and implemented for each resident individually based on ... potential hazards in the environment. The interventions shall include adequate supervision of residents whom are at risk for falling ..."

During a review of the facility's policy and procedure (P&P), titled, "PROTOCOL FOR RESIDENT ESCORT OFF HOSPITAL GROUNDS," dated 11/10/15, the P&P indicated, " ... PURPOSE ... To maintain resident safety while escorting the resident ... Responsibilities of the Escort ... The escort's sole responsibility is the resident's safety and well-being ...The escort should assert their responsibility for safety of the resident ...Attachment 1: Instruction to Escort Form ...INSTRUCTIONS TO ESCORT ...A. Precautions ... Fall Risk ..."

During a review of the facility's policy and procedure (P&P), titled, "OFF CAMPUS APPOINTMENTS OR ACTIVITIES," with revision dated 1/14/20, the P&P indicated, " ... POLICY ... Escorts shall be provided with the necessary training and or information for resident safety ...PURPOSE ... To provide resident safety and supervision during off campus appointments and activities ... PROCEDURE ... The Resident Care Team (RCT) ... shall determine ... if a resident needs to be accompanied by an escort, and the escort must be deemed appropriate to accompany the resident ...The Day of the appointment ... The Charge Nurse or designee

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F 689	Continued From page 4 will: give hand off report to the escort ... The escort shall: obtain hand off report from the Charge Nurse or designee ..."	F 689		

EXHIBIT 11

State of California-Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Rcvd Laguna Honda Hosp
2022 JAN 14 PM1:2

January 13, 2022

Letter 6a

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Michael Phillips, Administrator
Laguna Honda Hospital & Rehabilitation Ctr D/P SNF
375 Laguna Honda Blvd.
San Francisco, CA 94116-1411

Dear Mr. Phillips:

On January 13, 2022 an abbreviated survey for facility reported incident no. CA00730893 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[ ] Widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (F).

[X] Isolated deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (G).

[ ] A pattern of deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (H).

[ ] Widespread deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form , whereby significant corrections are required (I).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the

deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)

A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS- 2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or State Medicaid Agency effective as soon as notice requirements are met.

Providers may now submit their plan of correction (POC) as a separate document attachment or may continue to document the POC on the right side of the CMS Form 2567- "Statement of Deficiencies and Plan of Correction" and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by January 24, 2022.

Recommended Remedies

The remedies which will be recommended include the following:

[X] A civil money penalty will be recommended to CMS Regional Office if substantial compliance has not been achieved. (§488.430)

[X] Termination effective . (§488.456)

We are also recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on April 14, 2022 if substantial compliance

is not achieved by that time.

Denial of Payment for New Admissions (DPNA)
Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective January 14, 2022. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.)

FILING AN APPEAL
If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the

requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit. In such a case, neither the CMS Regional Office nor the State Medicaid

Agency will impose the previously recommended remedy(ies) at that time.
If, upon the subsequent revisit, it is determined your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter will be imposed by the CMS Regional Office beginning on January 13, 2022 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the

revisit, if appropriate.

Informal Dispute Resolution
In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies, to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact Raquel Larsen, Health Facilites Evaluator Supervisor, at (415) 330-6353.

Sincerely,

Raquel Larsen HFES
for

Diana Marana, R.N.
District Manager
Licensing and Certification

Enclosure *(CMS 2567)*

DM:cr

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Facility Reported Incident: CA00730893 Representing the California Department of Public Health: ID 40454, Health Facilities Evaluator Nurse The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was written as a result of Facility Reported Incident CA00730893.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe environment for one of three sampled residents (Resident 1) when : a. Residents 1's behavior of putting her hands and fingers on the holes and playing with the bed	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

M. Hullo | Chief Executive Officer | 01/20/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1	F 689		

siderails was not reassessed;

b. Patient Care Assistant (PCA, a caregiver) used the EZ lift (device used to assist with transfers and movement of patients who require support for mobility beyond the manual support provided by caregivers alone) by herself, and without assistance when transferring Resident 1.

This facility failure resulted in Resident 1 sustaining a left index finger (forefinger) fracture (broken bone) and a bruise (bleeding under the skin caused by an injury causing the blood vessels to burst) of the right chest.

Findings:

a. During a review of Minimum Data Set (MDS, a standardized assessment tool) dated 3/1/21, the MDS indicated, Resident 1 had diagnoses including traumatic brain injury (a brain injury usually caused by a violent blow to the head), dementia (decline in memory or other thinking skills), and paralysis (loss of movement) of the lower limbs (legs). The Brief Interview of Mental Status (BIMS, a brief memory test to help determine cognitive function) score of 3 indicated, severe cognitive impairment. Under functional status, Resident 1 required one to two persons physical assistance to perform activities of daily living including bed mobility, transfer, and personal hygiene.

During an observation on 5/19/21, at 2:50 PM, Resident 1 is awake, sitting up in a wheelchair, smiling. Her verbal responses were limited to "I'm fine, I'm okay, yes, and no." She did not

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F 689	Continued From page 2 remember the incidents that resulted to the left index finger fracture and bruise to the right chest. During an interview on 5/19/21, at 2:50 PM, with Charge Nurse, Charge Nurse stated, "Resident 1 cannot tell us what happened. She has dementia. She moves around. She might have had the fracture when she reached for the siderail and hit her finger. Maybe she reached for something else. We did not monitor her behavior of reaching for the siderail." During an interview on 5/19/21, at 3 PM, with Registered Nurse (RN) 1, RN 1 stated, "She cannot tell us how she hurt her finger, and how she had the bruise on the chest. She does not remember any incident. She has memory problem. We padded the bed siderails after the incident." During an interview on 5/19/21, at 3 PM, with Patient Care Assistant (PCA, a caregiver) 1, PCA 1 stated, "Resident 1 has memory problem. She is confused. She repeats what she said again and again. We use EZ lift to transfer from her bed and her wheelchair. There has to be two people when using the EZ lift. It is for residents safety." During an interview on 8/25/21, at 11:10 AM, with CNA 2, CNA 2 stated, "I have provided care to the resident Resident 1 for almost a year when I did overtime. She is confused. We use the EZ lift to transfer her from chair to bed. She always hold on to siderails. I have seen her put her hands and fingers on siderails. She also play with the	F 689		

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F 689	Continued From page 3	F 689		

siderails. She can get hurt doing that. I did not report the behavior."

During an interview on 8/25/21, at 11:20 AM, with CNA 3, CNA 3 stated, "I have been providing care to Resident 1 for four years. Resident 1 remembers on and off. During the shift endorsement from the night shift, everything is okay with Resident 1. I did not notice anything during breakfast. She ate by herself. It was her shower day. I used the EZ lift to transfer her from the bed to the chair. She was holding on to the siderail. Maybe she thinks she is going to fall. After the shower I transferred her back to bed. I transferred her using the EZ lift by myself. She was making noises. It was around lunch when I was handing her the cup, I saw her left index finger swollen, bruised and she was in pain. I should have asked for another staff for help. I know I am not supposed to use the EZ lift by myself."

During a review of nursing note dated 3/28/21, the nursing note indicated "Team Leader (TL) reported that around 1315 (1:15 PM), PCA noted bruise on resident's left index finger...TL said that resident had a shower this morning. According to PCA, she did not note the bruise during shower this morning. Only when helping resident at lunch time and was handing her a cup. She noted the bruise. Left finger slightly swelling, painful to touch..."

During a review of the X-ray of fingers...left...result dated 3/28/21, the X-ray result indicated, "...acute non displaced

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F 689	Continued From page 4 fracture(when the bone breaks but does not move out of alignment [position]) of the second proximal phalanx (second finger, forefinger) ..." During a review of the Nurse Manager (NM) Incident Interview Report dated 3/30/21, the Incident Interview Report indicated, "...Licensed Vocational Nurse (LVN) 1 noted Resident 1 inserting her both hands on the holes of both of her siderails. He also stated Resident 1 has this habit/behavior." During a review of the NM Incident Interview Report dated 3/30/21, the Incident Interview Report indicated, "... PCA 2 observes Resident 1 to be holding/gripped her hands onto the bedside rails. PCA 2 said that this is her behavior and or habit." During a review of the NM Incident Interview Report dated 3/30/21, the Incident Interview Report indicated, "... PCA 3 said Resident 1 likes to hold/grip on her bedside rails..." During a review of the NM Incident Interview Report dated 3/30/21, the Incident Interview Report indicated, "... PCA 4 said Resident 1 likes to hold/grip on her bedside rails..." During an interview on 10/7/21, at 6:30 AM, with LVN 2, LVN 2 stated, " Resident 1 does put her hands and fingers in the bed siderail. We were not monitoring that behavior. We were not able to determine the cause of the left index finger	F 689		

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F 689	Continued From page 5	F 689		

fracture. There is no care plan because we do not know that it will be a destructive behavior."

b. During a review of the nursing note, dated 3/29/21, the nursing note indicated, " ...noted yellowish discoloration at resident's right chest wall. There are 2 round shaped yellow mark measuring 8.1 centimeter (cm) by (x) 1.5 cm and 1.1 x 0.7 cm...Resident did not know what cause it..."

During a review of multidisciplinary problems, dated 7/14/21, the multidisciplinary problems indicated, " ...Activity of Daily Living (ADL) Maintenance... Interventions...14...two person assist with EZ transfer..."

During a review of the facility's Investigation of Alleged Abuse dated 4/1/21, the Investigation indicated, "...The most probable cause of the fracture of Resident 1's left index finger fracture was from her behavior/habit of putting/gripped her hands on the bed siderails. The finger might have caught in the siderail. In regards to the bruise of Resident 1's right chest wall; the EZ bar hanger might have hit her chest during transfer from bed to chair..."

EXHIBIT 12

State of California-Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

March 28, 2022

Letter 6a

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Michael Phillips, Administrator
Laguna Honda Hospital & Rehabilitation Ctr D/P SNF
375 Laguna Honda Blvd.
San Francisco, CA 94116-1411

Dear Mr. Phillips:

On February 3, 2022 an abbreviated survey for facility reported incident no. CA00752781 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[ ] Widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (F).

[X] Isolated deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (G).

[ ] A pattern of deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (H).

[ ] Widespread deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form , whereby significant corrections are required (I).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the

deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)

A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS- 2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or State Medicaid Agency effective as soon as notice requirements are met.

Providers may now submit their plan of correction (POC) as a separate document attachment or may continue to document the POC on the right side of the CMS Form 2567- "Statement of Deficiencies and Plan of Correction" and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by April 8, 2022.

Recommended Remedies

The remedies which will be recommended include the following:

[X] A civil money penalty will be recommended to CMS Regional Office if substantial compliance has not been achieved. (§488.430)

[X] Termination effective April 14, 2022. (§488.456)

We are also recommending to the CMS Regional Office and/or State Medicaid Agency

that your provider agreement be terminated on April 14, 2022 if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective January 14, 2022. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.)

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil*

Remedies Division on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit. In such a case, neither the CMS Regional Office nor the State Medicaid

Agency will impose the previously recommended remedy(ies) at that time.
If, upon the subsequent revisit, it is determined your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter will be imposed by the CMS Regional Office beginning on February 3, 2022 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose revised remedy(ies), based upon changes in the seriousness of the

noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies, to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact Pinky Suriben, District Administrator at (415) 330-6353.

Sincerely,

Sherla Tolentino, HFES for....
Diana Marana, R.N.
District Manager
Licensing and Certification

Enclosure *(CMS 2567)*

DM:cr

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	C 02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Facility Reported Incident: CA00752781 Representing the California Department of Public Health: 44877, Pharmaceutical Consultant II 27000, Pharmaceutical Consultant II Inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were written as a result of facility reported incident CA0752781.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to provide treatment and care to maintain normal blood pressure (BP) for one of three sampled residents (Resident 1) in accordance with the facility policy and procedure	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	Continued From page 1	F 684		

when:

1. Medications to treat elevated BP were not administered from 8/26/21 through 9/7/21 (13 days period).
2. Physician and the Pharmacist (healthcare professionals who specialized in safe use of medications or drugs) did not did not follow the facility protocol in addressing "Expiring Medications Renewal." (Refer to F 755)
3. Nursing staff did not address Resident 1's elevated BP reading and the missing medication order to treat elevated BP.

This failure resulted Resident 1 suffered from stroke (loss of blood flow to the brain) that required increased level of care from minimal assistance to total dependence on caregivers for activities of daily living (ADLs). In addition, Resident 1 "could not ambulate, could not hold a conversation" and had "noticeable facial twitching."

Findings:

Review of Resident 1's History and Physical, dated 8/11/21, indicated Resident 1 was originally admitted to the facility on 7/9/19 with diagnoses of Alzheimer's Dementia (a type of disease that affects the memory, thinking and behavior), Hypertension (HTN - elevated BP), Rheumatoid Arthritis (RA, a disease of the joints that causes pain, swelling, stiffness) and Pulmonary Embolism (PE, a condition where a clot has lodged in a lung artery and is blocking blood flow).

Review of Resident 1's physician orders indicated the following medication orders dated 8/27/20 at

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F 684	Continued From page 2 9:00 AM and expiring on 8/26/21 at 8:39 AM: (i) Amlodipine (trade name Norvasc indicated for HTN), 10 mg (miligram, unit of dose measurement) by mouth once daily, (ii) Aspirin (trade name Bayer Low Dose indicated for myocardial infarction (MI) prevention, a disease caused when heart muscle does not get enough oxygen), 81 mg by mouth once daily, (iii) Atorvastatin (trade name Lipitor indicated for hyperlipidemia - a disease where the blood has too much fat), 40 mg by mouth once daily, (iv) Hydroxychloroquine (trade name Plaquenil indicated for RA), 200 mg by mouth once daily, (v) Metoprolol succinate (trade name Toprol XL indicated for HTN), 100 mg by mouth once daily, (vi) Isosorbide mononitrate (trade name Imdur indicated for HTN), 30 mg by mouth once daily. 1. Review of Resident 1's MAR dated 8/26/21 to 9/8/21 indicated, Amlodipine, Aspirin, Atorvastatin, Hydroxychloroquine, Metoprolol succinate, Isosorbide mononitrate were discontinued in patient medication profile and were not administered from 8/26/21 to 9/8/21 (a period of 13 days). A review of MD 1's progress notes, dated 9/8/21 at 3:58 PM, it indicated, "I came to see [Resident 1] because the daytime charge nurse reported to me shortly before 3 PM that nurses had reported that [Resident 1] had new left arm weakness that had been noted on Tuesday September 7th but not reported until today. Nurses were unable to ambulate her yesterday because she was too weak in the left arm to hold her walker. She was not ambulated on Monday, September 6th per report to me. I was also notified by the clinical pharmacist that several of her meds had been dropped by [eHR system] as they had expired	F 684		

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F 684	Continued From page 3 while I was out of the office at the end of August and she missed several meds. I noted that her blood pressure had been high ..." On 12/14/21, at 9:40 AM, during an interview with Risk Management Registered Nurse (RMRN) 1, RMRN 2, and Director of Regulatory Affairs (DRA), DRA stated Resident 1 did not receive Amlodipine, Aspirin, Atorvastatin, Hydroxychloroquine, Metoprolol succinate, Isosorbide mononitrate from 8/26/21 to 9/8/21 (a period of 13 days). DRA stated, MD (Physician) 1 ordered to re-start the medications on 9/8/21 and at 3 AM, Registered Nurse (RN) 1 called MD 1 at Resident 1's bedside to evaluate for left arm weakness. Upon MD 1's evaluation of left arm weakness, Resident 1 was transferred to Hospital A for further evaluation. During an interview with the Director of Nursing (DON) 1, on 12/14/12, at 11:36 AM, he stated that the licensed nurses assigned to the care of the residents "should have been familiar" with their regular medications. They should have questioned why Resident 1's routine medications were not there on the MAR anymore or why they were no longer on the active medication list. 2. During an interview, on 12/14/21, at 10:30 AM, the Director of Pharmacy (DOP) stated, the medication orders in the eHR were only good for 365 days from the original entry date. The system was set up to alert the physicians 7 days before the medication expired. The alerts were noted as a "red prompt" in the eHR asking them to take action such as "renew" or "let expire". The DOP explained that after 7 days, if no actions were taken by the physicians, the medication orders	F 684		

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F 684	Continued From page 4	F 684		

would be automatically dropped off from the active medication list, and therefore would not be appearing on the MAR for the nursing staff to administer to the residents. DOP also explained and demonstrated in the eHR, via conference room computer and wall mounted monitor, that there was a list created specifically for Medical Doctors to review daily and address expiring medications. She showed in the eHR Resident 1's above medications were ordered on 8/27/20 and were set to expire on 8/26/21 (1 year). She explained that as a safety check, she would normally run the daily medication expiring report to "catch" any medications that expired unintentionally but failed to manually run the report on 8/27/21. As a result, Resident 1's medications were removed from the active medication list as of 8/26/21.

During an interview with MD 1, on 12/14/21, at 2:30 PM, she stated she was on vacation when Resident 1's medications were inadvertently dropped from Resident 1's MAR. She explained she was notified by a pharmacist performing a monthly drug regimen review on the morning of 9/8/21 (13 days after the medications got dropped off) about the medications no longer being active, and she restarted the medications on that day (9/8/21). In the afternoon around 3 PM, RN 1 called to notify her that Resident 1 was experiencing some left sided weakness in her arm. She stated she went to evaluate Resident 1 and determined that Resident 1 needed further evaluation and sent her to Hospital A. MD 1 stated, in evaluating Resident 1 upon readmission, noted that Resident 1 had not recovered and was not likely to recover to her baseline pre stroke as evidenced by the resident could not ambulate, could not hold a

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F 684	Continued From page 5	F 684		

conversation, and loss of independence. MD 1 stated she was aware of the 'red prompts' and thought they were only available for 5 days. She also explained that she was not aware of a resident list with the 'red prompts' for physicians to review in the eHR. MD 1 stated the PCAs had noticed the resident's left sided weakness two days prior (9/6/21 and 9/7/21) but did not inform her until 9/8/21. MD 1 also stated the LN (Licensed Nurse) did not inform her of Resident 1's high BP prior to 9/8/21 and the missing of multiple critical medications for many days was "highly likely they are responsible for the resident's stroke."

During a concurrent interview on 12/15/21, at 10:45 AM, with the Chief of Medicine (MD 2), Chief of Staff (MD 3), and Director of Risk Management (DRM), MD 2 identified MD 1 was on vacation from 8/20/21 to 8/27/21, and that she scheduled three different physicians to cover MD 1's vacation. Resident 1's above medications were set to expire on 8/26/21; therefore, the 7-day red prompts to alert the physicians of the medication orders about to expire would have appeared on the eHR from 8/19/21 to 8/26/21, the period during MD 1's vacation. MD 2 stated standard work for a covering physician was to call the unit in the morning and speak with the nurse manager for any events, sign out/in eHR for specific units assigned, and review expiring medication orders list for residents. MD 2 explained the expiring medication list was created a year ago as standard work, so the expectation was for providers to check the list and address red prompts for expiring medication orders. MD 2 confirmed the covering physicians did not follow the standard work expectations and failed to address Resident 1's expiring medications during

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F 684	Continued From page 6 8/19/21 to 8/26/21. MD 2 elaborated that the pharmacy did not properly notify the physicians as the standard work indicated as the pharmacy was designated to be a safety check. MD 2 provided a copy of standard work for expiring medications and in-service log, dated 9/15/20 at 1 PM, showing expiration medication standard work discussed in physician's meeting. It indicated the standard work instructions and step-by-step workflow for expiring medications renewal. The document indicated in the purpose that "...this standard work is necessary to ensure timely review and renewal of expiring medication on the eHR and avoid unintentional expiration of critical medications ..." Under section titled 'major steps' indicated, "Primary care physicians (PCPS) will routinely review and renew expiring medications in the eHR daily Monday to Friday... PCPs when preparing for time away will review for expiring medications ... coverage physicians will review expiring medications on the coverage unit Monday to Friday... unit nursing will ensure safety check to prevent lapses in expiring medications and notify MD 1 day before expiration... pharmacy will ensure a backup safety check... on Friday, pharmacy will notify physicians of meds expiring over the weekend..." 3. A concurrent interview and record review of Resident 1's medical record was conducted with RN 5 and DON 1, on 12/15/21, at 9:45 AM. The medical record indicated the following: On 8/27/21 at 11 PM the resident's BP was 169/76; On 8/30/21 at 8:30 AM, the BP was 145/99; at 7 PM, the BP was 169/82; On 8/31/21 at 1 AM, the BP was 161/81; at 10:14 AM, the BP was 155/90; at 4:30 PM, the BP was 164/79;	F 684		

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F 684	Continued From page 7 On 9/1/21 at 8:20 AM, the BP was 145/86; On 9/2/21 at 00:43 AM, the BP was 159/85; at 9:26 AM, the BP was 148/82; On 9/6/21 at 9:00 AM, the BP was 158/69 and On 9/7/21 at 8:20 AM and 9:24 AM, the BP was 188/88 (critically high value); at 4:00 PM, the BP was 163/86; at 4:53 PM, the BP was 153/86. The DON 1 stated the expectation was for the LNs is to recheck the BP if the reading was high, and if it was still high upon re-check, they should inform the physician of these high readings. RN 5 and DON 1 confirmed there was no documented evidence the LNs rechecked the BP, re-assessed the resident, and/or notify the physician of these critically high BP reading. According to Centers for Disease Control and Prevention accessed at https://www.cdc.gov/bloodpressure/about.htm, "...A normal blood pressure level is less than 120/80 mmHg...High blood pressure can cause the arteries that supply blood and oxygen to the brain to burst or be blocked, causing a stroke. Brain cells die during a stroke because they do not get enough oxygen. Stroke can cause serious disabilities in speech, movement, and other basic activities. A stroke can also kill you..." During an interview with RN 2 and RN 3, on 12/14/21, at 12:55 AM, RN 2 explained that when they give medications, they scanned the resident's identification band, then the medication, and then document in the eHR. They were not expected to review the MAR as a standard work when they passed medications. They gave medications based on what was due and they have 1 hour before and 1 hour after the due time to administer the medication. RN 3 stated that when the staff checked the blood	F 684		

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F 684	Continued From page 8	F 684		

pressure they would re-check if BP was not normal and report the results to the charge nurse who would review and give further instructions as needed.

During a concurrent observation and interview 12/14/21 at 3:15 PM with Resident 1, she was lying in bed listening to music. She was pleasant and alert to questions. Her responses were delayed and sometimes difficult to understand.

During an interview on 12/14/21 at 3:25 PM with RN 4, she explained that she noticed that prior to event on 9/8/21, Resident 1 did not have any twitching on left side of face and arm. After incident, RN 4 noticed twitching and significant weakness in left arm preventing Resident 1 from activities. RN 4 stated that prior to the event, Resident 1 was feeding self with minimal assistance and was able to ambulate using front wheeled walker (FWW) with minimal assistance. After incident, RN 4 stated Resident 1 was now total care for activities of daily living such as feeding, ambulating, and getting out of bed.

During an interview on 12/15/21 at 9:00 AM with Patient Care Assistant (PCA) 1, she stated in the morning on 9/8/21, Resident 1 did not want to get out of bed, and by afternoon when Resident 1 was ready to get up that was when left arm weakness was noticed. Resident 1 could not keep her hand on the walker and grip the walker. PCA 1 stated prior to 9/8/21, she was able to assist Resident 1 by herself with Hoyer Lift (a mobility tool used to help people with mobility challenges) and then she could ambulate with walker to bathroom and activities. PCA 1 stated that prior to incident Resident 1 needed minimal assistance with eating, bathing, and dressing.

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F 684	Continued From page 9 After the stroke, Resident 1 needed 2 persons for Hoyer Lift and total care for all activities of daily living. PCA elaborated total care was a resident who could not help themselves anymore and must be assisted with all activities of daily living. PCA 1 noticed intermittent facial twitching post stroke. During an interview, on 12/15/21, at 11:40 AM, with the Social Worker (SW), she stated that when she went to interview Resident 1 after she returned from Hospital A, she was a lot less verbal and harder to engage. SW stated she observed Resident 1 to be more tired, exhibited less range of motion/movement, and significantly less engaged in physical activities. She stated she noticed Resident 1 engaged in dancing in her wheelchair, still tapping with music and attempting to sing along. During a phone interview, on 12/16/21, at 3:15 PM, with PCA 2, she stated the blood pressure of 169/76 which she obtained on 8/27/21 at 11:00 PM was abnormal. She stated that when she recorded the abnormal BP she was supposed to notify the charge nurse. However, she could not remember if she reported to charge nurse on that shift. She explained, prior to stroke, Resident 1 was using the walker; and after stroke, she was no longer able to use the walker. She indicated that prior to stroke, Resident 1 needed some assistance for eating; and after stroke, required full assistance for eating. During a phone interview, on 12/22/21, at 2:30 PM, with RN 6, she stated she was the regular charge nurse in the unit where Resident 1 resided. Her responsibilities included administering medications to residents. She	F 684		

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explained she "overlooked and did not pay attention" to the abnormal blood pressure on 9/7/21 and did not notify physician. She explained that when passing medications that she would click the "due meds" button on MAR and that will show all the meds to be administered on her shift. She stated she would not check MAR for history of medications. She stated, on 9/7/21, the day shift reported during "shift change" (an event on the unit for communication between staff ending a shift and starting a shift) that Resident 1 had left side weakness but did not take any further actions. RN 6 stated that before the incident, Resident 1 used to eat by herself, she used to transfer with two persons' assistance from the wheelchair to bed; and after incident, she needed the Hoyer lift for transfer. She explained that Resident 1 was previously continent (able to control her bladder and bowel); and after incident, the resident was completely incontinent (unable to control her bladder and bowel requiring diapers). She defined extensive help to be 1 person helping to assist a resident and total dependence is 2 or more people helping. She mentioned that Resident 1 speech has improved since incident but was not the same as prior to stroke.

During a phone interview, on 12/28/21, at 1:30 PM, with Nurse Manager (NM) 1, she explained she was informed on 9/8/21 about the incident by the day shift PCA. She went to discuss the incident and found out that the previous day PCA had noticed some weakness in Resident 1 but did not report because PCA didn't know baseline level of strength and ambulation. NM 1 did observe Resident 1 after returning from Hospital A and explained resident 1 used to have mobility in bed with holding the side rail; and after

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incident, she could not hold the rail. She stated she also observed Resident 1 could not utilize walker as ambulation had declined.

A review of the Admission History and Physical by MD 1, dated 9/14/21, indicated, "I had been notified on the morning of 09/08/21 by the clinical pharmacist that multiple medications had been discontinued by [eHR system] as they had come up for renewal when I was out of the office in August and had not been administered for several weeks including Vitamin D, amlodipine, aspirin, Lipitor, hydroxychloroquine, Imdur and metoprolol, and her blood pressures were elevated when she was off her meds ... During her [Hospital A] Admission she had a CT [computer tomography, a diagnostic imaging exam that uses X-ray technology to produce images of the inside of the body] scan whose preliminary report showed increased hydrocephalus [buildup of fluid in areas deep within the brain] and an MRI done on 9/10/21 confirmed a small Right occipital lobe/Right MCA stroke that on review of her CT was also noted ...The attending physician reported to me that [Resident 1] had a new facial droop and hemispasm [a sudden involuntary muscular contraction of one side of the body] of the left side, but was in stable condition ..."

A review of Hospital A's report titled "CT Brain without Contrast", dated 9/8/21, under "section narrative' indicated" (as provided by referring clinician): TIA or Stroke (known or suspected) weakness."

A review of Hospital A's report titled "MR Brain Without Contrast - Focused Brain", dated 9/9/21, under 'section impression', number 1 indicated,

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F 684	Continued From page 12 "acute [sharp and sudden onset] to sub-acute [mildly acute] focus of infarction [death of tissue resulting from a failure of blood supply] involving the right perirolandic region [part of brain essential for neurological - branch of medicine concerned especially with the structure, function, and diseases of the nervous system] functions, supporting motricity [the faculty or power of movement by the body or a body part], and sensitivity of trunk [the central part or core of the body] and extremities [limbs of body, arms and legs] with a minimal petechial hemorrhage [acute bleeding of veins], but no frank [used to describe the obvious, visible presence of blood] intraparenchymal [within a part of the brain with structures called parenchyma] hematoma [when a blood vessel leaks into surrounding tissue]." A review of Resident 1's flowsheet history dated 8/23/21 to 9/21/21 indicated that prior to incident, Resident 1 needed one person for help with transfer and after incident primarily needed two or more persons. The flowsheet documentation also indicated, prior to incident, Resident 1 needed extensive help with eating; and after event, the resident became totally dependent on staff for eating. The flowsheet documentation also indicated, Resident 1 prior to incident needed extensive help with using the toilet; and after event, became totally dependent for help with using the toilet. Review of Resident 1's Minimum Data Set (MDS, an assessment tool) Section G: Functional dated 7/10/21 (prior to incident), indicated no impairment of upper and lower extremities. The MDS assessment, dated 9/25/21 (after the incident) indicated, the lower and upper extremities of Resident 1 were impaired.	F 684		

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F 684	Continued From page 13 A review of the facility's policy and procedures titled, "Vital Signs" approved on 3/6/2018, on page 2 section "C. Reporting" indicated, "...that a CNA (Certified Nursing Assistant) or PCA should report immediately to the licensed nurse in charge of the resident if: a BP is less than 90/50 or greater than 160/90." The policy on page 2 indicated, "...Licensed Nurse (LN) is to assess resident immediately and notify physician as needed further medical evaluation..." A review of the facility's policy and procedures titled, "Notification and Documentation of Change in Resident Condition", approved on 5/19/20, under "policy" indicated, "...The Licensed Nurse will notify the physician whenever there is an unanticipated change in resident's physical, mental, or psychosocial condition indicative of decline resulting from injury, acute medical illness or from progression of chronic medical conditions..." A review of the facility's policy and procedures titled, "Medication Administration", approved on 9/14/21, indicated, ""...It is the legal and ethical responsibility of the NL to prevent and report medication errors." On page 3, "Critical Points" indicated, "Six Rights of Medication Administration" number 2 read Right Drug - "Review eMAR for drug/medication ordered...ii. Monitor and document in flowsheet the blood pressure for antihypertensive and combined antiarrhythmic/antihypertensive medications before each dose for 7 days, then weekly..."	F 684		
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		

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F 755	Continued From page 14 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) received six anti hypertensive medications necessary to maintain her health and well-being during a period of 13 days, from 8/26/21 to 9/7/21 when:	F 755		

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F 755	Continued From page 15 1. The medication orders for six anti-hypertensive medications were inadvertently removed from the electronic Health Record (eHR) from 8/26/21 to 9/7/21. 2. The Physicians and Pharmacist (healthcare professionals who specialized in safe use of medications or drugs) did not follow the facility protocol in addressing "Expiring Medications Renewal." The failure resulted in Resident 1 not receiving critical routine medications for 13 days; transferred to the acute care hospital which indicated that she suffered a stroke and needed increased level of care (total dependence on caregivers for activities of daily living or ADLs) after hospitalization. Findings: Review of Resident 1's History and Physical, dated 8/11/21, indicated she was originally admitted to the facility on 7/9/19 with diagnoses including Alzheimer's Dementia (a type of disease that affects the memory, thinking and behavior), Hypertension (HTN a disease in which the blood circulating in vessels has a long term force against the artery walls that causes health problems), Rheumatoid Arthritis (RA, a disease of the joints that causes pain, swelling, stiffness and loss of function in joints) and Pulmonary Embolism (PE, a condition where a clot has lodged in a lung artery and is blocking blood flow). A review of Resident 1's physician orders indicated the following medication orders dated 8/27/20 at 9:00 AM and the order expired on	F 755		

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F 755	Continued From page 16 8/26/21 at 8:39 AM: (i) Amlodipine (trade name Norvasc indicated for HTN), 10 mg (mg, unit of dose measurement) by mouth once daily, (ii) Aspirin (trade name Bayer Low Dose indicated for myocardial infarction (MI) prevention, a disease caused when heart muscle does not get enough oxygen), 81 mg by mouth once daily, (iii) Atorvastatin (trade name Lipitor indicated for hyperlipidemia - a disease where the blood has too much fat), 40 mg by mouth once daily, (iv) Hydroxychloroquine (trade name Plaquenil indicated for RA), 200 mg by mouth once daily, (v) Metoprolol succinate (trade name Toprol XL indicated for HTN), 100 mg by mouth once daily, (vi) Isosorbide mononitrate (trade name Imdur indicated for HTN), 30 mg by mouth once daily. Review of Resident 1's Medication Administration Record (MAR) dated 8/26/21 to 9/8/21 indicated, Amlodipine, Aspirin, Atorvastatin, Hydroxychloroquine, Metoprolol succinate, Isosorbide mononitrate were discontinued in patient medication profile and were not administered from 8/26/21 to 9/8/21 (a period of 13 days). Review of Resident 1's Vital Signs Flowsheet Data indicated the following: On 8/27/21 at 11 PM the resident's BP was 169/76; On 8/30/21 at 8:30 AM, the BP was 145/99; at 7 PM, the BP was 169/82; On 8/31/21 at 1 AM, the BP was 161/81; at 10:14 AM, the BP was 155/90; at 4:30 PM, the BP was 164/79; On 9/1/21 at 8:20 AM, the BP was 145/86; On 9/2/21 at 00:43 AM, the BP was 159/85; at 9:26 AM, the BP was 148/82;	F 755		

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F 755	Continued From page 17 On 9/6/21 at 9:00 AM, the BP was 158/69 and On 9/7/21 at 8:20 AM and 9:24 AM, the BP was 188/88 (critically high value); at 4:00 PM, the BP was 163/86; at 4:53 PM, the BP was 153/86. According to Centers for Disease Control and Prevention accessed at https://www.cdc.gov/bloodpressure/about.htm, "...A normal blood pressure level is less than 120/80 mmHg...High blood pressure can cause the arteries that supply blood and oxygen to the brain to burst or be blocked, causing a stroke. Brain cells die during a stroke because they do not get enough oxygen. Stroke can cause serious disabilities in speech, movement, and other basic activities. A stroke can also kill you..." During an interview with Risk Management Registered Nurse (RMRN) 1, RMRN 2, and Director of Regulatory Affairs (DRA) on 12/14/21 at 9:40 AM, the DRA stated Resident 1 did not receive Amlodipine, Atorvastatin, Hydroxychloroquine, Metoprolol succinate, and Isosorbide mononitrate from 8/26/21 to 9/8/21 (a period of 13 days). DRA stated, MD (Physician) 1 ordered to re-start the medications on 9/8/21 and at 3 AM, Registered Nurse (RN) 1 called MD 1 at Resident 1's bedside to evaluate for left arm weakness. Upon MD 1's evaluation of left arm weakness, Resident 1 was transferred to Hospital A for further evaluation. A review of MD 1's progress notes, dated 9/8/21 at 3:58 PM, it indicated, "I came to see [Resident 1] because the daytime charge nurse reported to me shortly before 3 PM that nurses had reported that [Resident 1] had new left arm weakness that had been noted on Tuesday September 7th but not reported until today. Nurses were unable to	F 755		

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ambulate her yesterday because she was too weak in the left arm to hold her walker. She was not ambulated on Monday, September 6th per report to me. I was also notified by the clinical pharmacist that several of her meds had been dropped by [eHR system] as they had expired while I was out of the office at the end of August and she missed several meds. I noted that her blood pressure had been high ..."

During an interview with the Director of Pharmacy (DOP) on 12/14/21 at 10:30 AM, the DOP explained medication orders in the eHR were only good for 365 days (1 year) from the original entry date. The system was set up to alert the physicians for seven days before the medication expired. The alerts were noted as a "red prompt" in the eHR asking them to take action such as "renew" or "let expire." The DOP explained that after 7 days, if no actions were taken by the physicians, the medication orders would be automatically dropped off from the active medication list, and therefore would not be appearing on the MAR for the nursing staff to administer to the residents. The DOP also explained that there was a list created in the eHR specifically for Medical Doctors to review daily and address expiring medications. She stated Resident 1's medications were ordered on 8/27/20 and were set to expire on 8/26/21 (1 year). As a safety check, she would normally run the daily medication expiring report to "catch" any medications that expired unintentionally but failed to manually run the report on 8/27/21. As a result, Resident 1's above medications were removed from the active medication list as of 8/26/21.

During an interview with MD 1 on 12/14/21 at 2:30 PM, she stated she was on vacation when

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F 755	Continued From page 19 Resident 1's medications were inadvertently dropped from Resident 1's MAR. She explained a pharmacist performing the monthly drug regimen review on the morning of 9/8/21 (13 days after the medications got dropped off) notified her about the medications no longer being active, and she restarted the medications on 9/8/21. In the afternoon around 3 PM, RN 1 called to notify her that Resident 1 was experiencing some left sided weakness in her arm. She went to evaluate Resident 1 and determined that Resident 1 needed further evaluation and was sent to Hospital A. MD 1 stated, in evaluating Resident 1 upon readmission to the facility, she noted Resident 1 had not recovered and was not likely to recover to her baseline pre stroke as evidenced by the resident could not ambulate, could not hold a conversation, and loss of independence. MD 1 stated she was aware of the 'red prompts' and thought they were only available for 5 days. She also explained that she was not aware of a resident list with the 'red prompts' for physicians to review in the eHR. MD 1 stated the PCAs (Patient Care Assistant) had noticed the resident's left sided weakness two days prior (on 9/6/21 and 9/7/21) but did not inform her until 9/8/21. MD 1 also stated the Licensed Nurses did not inform her of Resident 1's high BP prior to 9/8/21; and the missing of multiple critical medications for many days "highly likely they are responsible for the resident's stroke." During a concurrent observation and interview, 12/14/21, at 3:15 PM, Resident 1 was lying in bed listening to music. She was pleasant and alert to questions. Her responses were delayed and sometimes difficult to understand.	F 755		

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F 755	Continued From page 20 During an interview on 12/14/21 at 3:25 PM, Registered Nurse (RN) 4 explained she noticed that prior to event on 9/8/21, Resident 1 did not have any twitching on left side of face and arm. After incident, RN 4 noticed twitching and significant weakness in left arm preventing Resident 1 from activities. RN 4 stated that prior to the event, Resident 1 was feeding self with minimal assistance and was able to ambulate using front wheeled walker (FWW) with minimal assistance. After incident, RN 4 stated Resident 1 was now total care for activities of daily living such as feeding, ambulating, and getting out of bed. During an interview on 12/15/21 at 9:00 AM, PCA 1 stated in the morning on 9/8/21, Resident 1 did not want to get out of bed, and by afternoon when Resident 1 was ready to get up that was when left arm weakness was noticed. Resident 1 could not keep her hand on the walker and grip the walker. PCA 1 stated prior to 9/8/21, she was able to assist Resident 1 by herself with Hoyer Lift (a mobility tool used to help people with mobility challenges) and then she could ambulate with walker to bathroom and activities. PCA 1 stated that prior to incident Resident 1 needed minimal assistance with eating, bathing, and dressing. After the stroke, Resident 1 needed 2 persons for Hoyer Lift and total care for all activities of daily living. PCA elaborated total care was a resident who could not help themselves anymore and must be assisted with all activities of daily living. PCA 1 noticed intermittent facial twitching post stroke. During a concurrent interview on 12/15/21 at 10:45 AM, with the Chief of Medicine (MD 2), Chief of Staff (MD 3), and Director of Risk	F 755		

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	555020	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 755	Continued From page 21	F 755		

Management (DRM), MD 2 identified MD 1 was on vacation from 8/20/21 to 8/27/21, and that she scheduled three different physicians to cover MD 1's vacation. Resident 1's above medications were set to expire on 8/26/21; therefore, the 7-day red prompts to alert the physicians of the medication orders about to expire would have appeared on the eHR from 8/19 to 8/26/21, the period during MD 1's vacation. MD 2 stated standard work for a covering physician was to call the unit in the morning and speak with the nurse manager for any events, sign out/in eHR for specific units assigned, and review expiring medication orders list for residents. MD 2 explained the expiring medication list was created a year ago as standard work, so the expectation was for providers to check the list and address red prompts for expiring medication orders. MD 2 confirmed the covering physicians did not follow the standard work expectations and failed to address Resident 1's expiring medications during 8/19/21 to 8/26/21. MD 2 elaborated that the pharmacy did not properly notify the physicians as the standard work indicated as the pharmacy was designated to be a safety check. MD 2 provided a copy of standard work for expiring medications and in-service log, dated 9/15/20 at 1 PM, showing expiration medication standard work discussed in physician's meeting. It indicated the standard work instructions and step-by-step workflow for expiring medications renewal. The document indicated in the purpose that "...this standard work is necessary to ensure timely review and renewal of expiring medication on the eHR and avoid unintentional expiration of critical medications ..." Under 'major steps' section indicated, "Primary care physicians (PCPS) will routinely review and renew expiring medications in the eHR daily Monday to Friday... PCPs when

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F 755	Continued From page 22	F 755		

preparing for time away will review for expiring medications... coverage physicians will review expiring medications on the coverage unit Monday to Friday... unit nursing will ensure safety check to prevent lapses in expiring medications and notify MD 1 day before expiration... pharmacy will ensure a backup safety check... on Friday, pharmacy will notify physicians of meds expiring over the weekend..."

During an interview on 12/15/21 at 11:40 AM, with the Social Worker (SW), she stated that when she went to interview Resident 1 after she returned from Hospital A, she was a lot less verbal and harder to engage. SW stated she observed Resident 1 to be more tired, exhibited less range of motion/movement, and significantly less engaged in physical activities. She stated she noticed Resident 1 engaged in dancing in her wheelchair, still tapping with music and attempting to sing along.

During a phone interview on 12/16/21 at 3:15 PM, with PCA 2, she stated the blood pressure of 169/76 which she obtained on 8/27/2021 at 11:00 PM was abnormal. She stated that when she recorded the abnormal BP she was supposed to notify the charge nurse. However, she could not remember if she reported to charge nurse on that shift. She explained, prior to stroke, Resident 1 was using the walker; and after stroke, she was no longer able to use the walker. She indicated that prior to stroke, Resident 1 needed some assistance for eating; and after stroke, required full assistance for eating.

During a phone interview on 12/22/21 at 2:30 PM, with RN 6, she stated she was the regular charge nurse in the unit where Resident 1 resided; her

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F 755	Continued From page 23	F 755		

responsibilities included administering medications to residents. She explained she "overlooked and did not pay attention" to the abnormal blood pressure on 9/7/21 and did not notify physician. She explained that when passing medications that she would click the "due meds" button on the MAR and that will show all the medications to be administered on her shift. She stated she would not check MAR for history of medications. She stated, on 9/7/21, the day shift reported during "shift change" (an event on the unit for communication between staff ending a shift and starting a shift) that Resident 1 had left side weakness but did not take any further actions. RN 6 stated that before the incident, Resident 1 used to eat by herself, she used to transfer with two persons' assistance from the wheelchair to bed; and after incident, she needed the Hoyer lift for transfer. She explained that Resident 1 was previously continent (able to control her bladder and bowel); and after incident, the resident was completely incontinent (unable to control her bladder and bowel requiring diapers). She defined extensive help to be 1 person helping to assist a resident and total dependance is 2 or more people helping. She mentioned that Resident 1 speech has improved since incident but was not the same as prior to stroke.

During a phone interview on 12/28/21 at 1:30 PM with Nurse Manager (NM) 1, she explained she was informed on 9/8/21 about the incident by the day shift PCA. She went to discuss the incident and found out that the previous day PCA had noticed some weakness in Resident 1 but did not report because PCA didn't know baseline level of strength and ambulation. NM 1 did observe Resident 1 after returning from Hospital A and

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F 755	Continued From page 24	F 755		

explained resident 1 used to have mobility in bed with holding the side rail; and after incident, she could not hold the rail. She stated she also observed Resident 1 could not utilize walker as ambulation had declined.

A review of the Admission History and Physical by MD 1, dated 9/14/21, indicated, "I had been notified on the morning of 09/08/2021 by the clinical pharmacist that multiple medications had been discontinued by [eHR system] as they had come up for renewal when I was out of the office in August and had not been administered for several weeks including Vitamin D, amlodipine, aspirin, Lipitor, hydroxychloroquine, Imdur and metoprolol, and her blood pressures were elevated when she was off her meds ...During her [Hospital A] Admission she had a CT [computer tomography, a diagnostic imaging exam that uses X-ray technology to produce images of the inside of the body] scan whose preliminary report showed increased hydrocephalus [buildup of fluid in areas deep within the brain] and an MRI done on 9/10/21 confirmed a small Right occipital lobe/Right MCA stroke that on review of her CT was also noted ...The attending physician reported to me that [Resident 1] had a new facial droop and hemispasm [a sudden involuntary muscular contraction of one side of the body] of the left side, but was in stable condition ..."

A review of Hospital A's report titled "CT Brain without Contrast", dated 9/8/21, under "section narrative' indicated "(as provided by referring clinician): TIA (Trans Ischemic Attack)or Stroke (known or suspected) weakness".

A review of Hospital A's report titled "MR [Magnetic Resonance] Brain Without Contrast -

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F 755	Continued From page 25 Focused Brain", dated 9/9/21, indicated, "...acute [sharp and sudden onset] to sub-acute [mildly acute] focus of infarction [death of tissue resulting from a failure of blood supply] involving the right perirolandic region [part of brain essential for neurological - branch of medicine concerned especially with the structure, function, and diseases of the nervous system] functions, supporting motricity [the faculty or power of movement by the body or a body part], and sensitivity of trunk [the central part or core of the body] and extremities [limbs of body, arms and legs] with a minimal petechial hemorrhage [acute bleeding of veins], but no frank [used to describe the obvious, visible presence of blood] intraparenchymal [within a part of the brain with structures] hematoma [when a blood vessel leaks into surrounding tissue]". During review of Resident 1's flowsheet history dated 8/23/21 to 9/21/21 with RN 5 on 12/15/21 at 9:43 AM, indicated prior to incident, Resident 1 required one person for help with transfer; and after incident primarily needed two or more persons. The flowsheet documentation also indicated, prior to incident, Resident 1 needed extensive help with eating; and after event, the resident became totally dependent on staff for eating. The flowsheet documentation also indicated, Resident 1 prior to incident needed extensive help with using the toilet; and after event, became totally dependent for help with using the toilet. Review of Resident 1's Minimum Data Set (MDS, an assessment tool) Section G: Functional dated 7/10/21 (prior to incident), indicated no impairment of upper and lower extremities. The MDS assessment, dated 9/25/21 (after the	F 755		

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F 755	Continued From page 26 incident) indicated, the lower and upper extremities of Resident 1 were impaired. A review of the facility's policy and procedures for Medical Staff Committees on page 83 stated the function of the Pharmacy and Therapeutics Committee, is "to determine policy pertaining to evaluation, selection, procurement, storage, distribution, safe practice and use of medicines" and "to establish or plan programs or other methods of communication for the professional staff about pertinent matters related to medications and their use." A review of the facility's policy and procedures titled "Medication Administration", approved on 9/14/21, indicated, "...It is the legal and ethical responsibility of the NL to prevent and report medication errors." On page 3, section titled "Critical Points" indicated, "Six Rights of Medication Administration" number 2 read Right Drug - "Review eMAR for drug/medication ordered..."	F 755		

EXHIBIT 13

State of California-Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

March 30, 2022

Letter 4

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Michael Phillips, Administrator
Laguna Honda Hospital & Rehabilitation Center D/P SNF
375 Laguna Honda Blvd.
San Francisco, CA 94116-1411

Dear Mr. Phillips:

On March 30, 2022, an abbreviated survey for complaint CA00746831 and facility reported incident no. CA00746752 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency to be:

[X] Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (D).

[ ] A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (E).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)
Providers may now submit their plan of correction (POC) as a separate document attachment or may continue to document the POC on the right side of the CMS Form 2567- "Statement of Deficiencies and Plan of Correction".

A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS-2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or the State Medicaid Agency effective as soon as notice requirements are met.

Your POC must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by April 14, 2022.

Recommended Remedies
The remedies, which will be recommended if substantial compliance has not been achieved by **April 14, 2022,** include the following:

[X] A civil money penalty will be recommended to CMS Regional Office if substantial compliance has not been achieved (§488.430).

We are also recommending to the CMS Regional Office and/or the State Medicaid Agency that your provider agreement be terminated on April 14, 2022, if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)
Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective January 14, 2022. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable POC and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial Compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

FILING AN APPEAL
If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division

form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005 . We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon a subsequent revisit or by other means it is determined your facility has not achieved substantial compliance, we will recommend the remedies previously mentioned in this letter be imposed by the CMS Regional Office beginning on March 30, 2022, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose a revised remedy(ies), based upon changes in the

seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies to Diana Marana, District Manager, California Department of Public Health, Licensing and Certification Program, San Francisco District Office, 150 North Hill Drive, Suite 22, Brisbane, CA 94005.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact Pinky Suriben, District Administrator, at (415) 330-6353.

Sincerely,

Diana Marana, R.N.
District Manager
Licensing and Certification

Enclosure *(CMS 2567)*

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during the investigation of a Complaint and a Facility Reported Incident (FRI). For Complaint CA00746831 and FRI CA00746752, a federal deficiency was identified. (see F600) The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 40454, Health Facilities Evaluator Nurse	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 Based on observation, interview, and record review, the facility failed to ensure resident is physical abuse for one of three sampled residents (Resident 1) when a Patient Care Assistant (PCA, caregiver) hit Resident 1 on the face. This facility failure resulted to Resident 1 to sustain a cut on the upper lip and to not feel safe in the facility. Definition: Abuse - the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, and or mental anguish. Willful - means the individual must have acted deliberately. Physical abuse - includes but not limited to hitting, slapping, punching, and kicking. Findings: A review of Minimum Data Set (MDS, a standardized assessment tool) dated 7/2/21, indicated Resident 1 was admitted with diagnosis including dementia (decline in memory or other thinking skills) and stroke. Brief Interview of Mental Status (BIMS, a brief memory test to help determine cognitive function) indicated Resident 1 had moderate cognitive impairment. Under the functional status, Resident 1 required extensive assistance in performance of activities of daily living (ADL) including mobility, toileting and personal hygiene. During an observation on 9/16/21, at 11:20 AM, Resident 1 was calm and pleasant. Resident 1 stated, "My lips are not swollen now. It used to be	F 600		

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	555020	A. BUILDING _____ B. WING _____	C 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2	F 600		

big. You should have seen this before (touching his mouth). That man beat me up (refering to PCA 1). It (the incident) was at night, late night. He comes to work on the night shift. He told me not to talk to nobody. I thought about my safety here. I must defend myself. I tried to throw some punches too. The nurse said I was bleeding. He hasn't work since it happened. I don't see him now. I feel safer."

During an interview on 9/17/21, at 1:12 AM, PCA 2 stated, "We all know that (Resident 1) has behavior issues. He can be aggressive and will hit you during care. We remind the other PCA and floaters (replacement staff) to take precautions when being assigned to him. If the resident is having behavior or refusing care, we have to leave the patient, report the nurse that he is refusing and then check with the resident later."

During an interview on 9/17/21, at 1:23 AM, Registered Nurse 1 stated, "It was around 7 AM when PCA 1 asked me to check on (name of Resident 1). I went to see him (Resident 1), and I saw he was bleeding on the mouth. I wiped the blood off with gauze and found a cut on the inside of the upper lip. He (Resident 1) said (PCA 1) hit him. There was no endorsement of any injury for this resident from the morning shift and evening shifts. There was no report of any injury from the team leader, and from the PCA's. The injury was found after the altercation between the resident and the PCA (PCA 1) that morning."

During an interview on 10/5/21, at 4 PM, Resident 1's family member stated, "My brother has told the family that a facility staff has been messing with him. We didn't take it seriously, we couldn't imagine. It was in one of those quarterly meeting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	C 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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F 600	Continued From page 3	F 600		

over a year ago. My sister was there. We didn't have evidence then, but we have now. We took pictures of the injury. He (PCA 1) assaulted our brother (Resident 1). That's a criminal case. He had been my brother's caregiver. It is scary to think how long he had been hurting my brother. The police said that they cannot do anything, that we have to deal with facility sheriff. The sheriff said that they cannot give us information unless we give them the pictures of the injury."

During an interview on 10/6/21, 2:09 PM, Nursing Director 1 stated, "I'm the one that substantiated that abuse incident. Resident reported that the PCA (name of PCA) was rough with him during care and grabbed his penis hard that caused him pain. There was an altercation that occurred between them that resulted to the PCA hitting the resident. Resident's roommate (Resident 2) stated he heard the resident and the PCA arguing. He said (name of Resident 1) said the PCA grabbed his penis and that the PCA kicked him."

During an interview on 9/16/21, at 11:25 AM, Nursing Director 1 stated, "The PCA involved (PCA 1) was placed on administrative leave. It was referred to the Human Resources (HR) and the dismissal was initiated."

A review of the facility document titled, "Investigation of Alleged Abuse" dated 8/3/21, indicated, "... Interviews were conducted among staff, residents (victim and the roommate). The resident (Resident 1) claimed that during a perineal care (peri care, washing the genital and rectal areas of the body) the PCA grabbed his penis hard. The resident and the PCA had a verbal altercation as overheard by Resident 1's

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F 600	Continued From page 4	F 600		

roommate... there were no previous reports of injuries prior to the PCA's shift (AM, 11 PM to 7 AM work hours) of 8/2/21. It is likely the PCA fought back and punched him on the face. Resident reported pain in his mouth and penis, and a cut on the upper lip. Resident 1 injuries led to resident being sent out to (name of hospital). Resident (Resident 1) also stated that he did not feel safe... He said he knows (name of PCA) and that the PCA is a regular in South 6 (unit location). He said, "I know him. I think he came in a bad mood. This guy has been messing with me for the past few nights." When asked what he means by messing, he said that the PCA was rough on handling him..."

A review of facility document dated 9/13/21 indicated a notification of the PCA's resignation from his position.

A review of the facility Policy and Procedure titled, "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response," dated 2/9/21, indicated, "(name of the facility) shall promote an environment that enhances resident well-being and protects residents from abuse, neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms. Policy: 1. (name of facility) employees, contractors, and volunteers should 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..."

EXHIBIT 14

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City and County of San Francisco

Office of Contract Administration

Purchasing Division

City Hall, Room 430

1 Dr. Carlton B. Goodlett Place

San Francisco, California 94102-4685

Agreement between the City and County of San Francisco and

Health Services Advisory Group, Inc.

Contract ID # 1000027817

DocuSign Envelope ID: F57C3D5F-FECE-451F-9406-DF1803CD4D88

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This Agreement is made this 6th day of December 2022 in the City and County of San Francisco ("City"), State of California, by and between Health Services Advisory Group, Inc. 3133 E. Camelback Rd., Suite 140 Phoenix, Arizona 85016 ("Contractor") and City.

Recitals

WHEREAS, the Department of Public Heath ("Department") wishes to consulting and assessment services as described in Appendix A-1; and

WHEREAS, Contractor represents and warrants that it is qualified to perform the Services required by City as set forth under this Agreement; and

WHEREAS, this Agreement is made in accordance with the Settlement and Systems Improvement Agreement between the City and County of San Francisco, the California Department of Public Health, and the United States Department of Health and Human Services, effective November 10, 2022 ("Settlement Agreement," attached hereto as Appendix H), as approved by the San Francisco Board of Supervisors by Ordinance No. 224-22, passed on November 8, 2022 ("Ordinance," attached hereto as Appendix I); and

WHEREAS, the Section 21 of the Administrative Code does not apply because of the approval of Ordinance No. 224-22, passed on November 8, 2022 ; and

WHEREAS, approval for the Agreement was obtained on March 8,2018 from the Civil Service Commission under PSC number 49607 – 15/16 in the amount of $17,000,000 for the period of five years and

Now, THEREFORE, the parties agree as follows:

Article 1 Definitions

The following definitions apply to this Agreement:

1.1 **"Agreement"** means this contract document, including all attached appendices, and all applicable City Ordinances and Mandatory City Requirements specifically incorporated into this Agreement by reference as provided herein**.**

1.2 **"City" or "the City"** means the City and County of San Francisco, a municipal corporation, acting by and through both its Director of the Office of Contract Administration or the Director's designated agent, hereinafter referred to as "Purchasing" and the Department of Public Health

1.3 **"City Data"** means that data as described in Article 13 of this Agreement which includes, without limitation, all data collected, used, maintained, processed, stored, or generated by or on behalf of the City in connection with this Agreement. City Data includes, without limitation, Confidential Information.

1.4 **"CMD"** means the Contract Monitoring Division of the City**.**

1.5 **"Confidential Information"** means confidential City information including, but not limited to, personally-identifiable information ("PII"), protected health information ("PHI"), or individual financial information (collectively, "Proprietary or Confidential Information") that is subject to local, state or federal laws restricting the use and disclosure of such information, including, but not limited to, Article 1, Section 1 of the California Constitution; the California Information Practices Act (Civil Code § 1798 et seq.); the California Confidentiality of Medical Information Act (Civil Code § 56 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §§ 6801(b) and 6805(b)(2)); the privacy and information security aspects of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act (45 CFR Part 160 and Subparts A, C, and E of part 164); and San Francisco Administrative Code Chapter 12M (Chapter 12M)**.**

1.6 **"Contractor" or "Consultant"** means Health Services Advisory Group, Inc. 3133 E. Camelback Rd., Suite 140 Phoenix, Arizona 85016

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1.7 **"Deliverables"** means Contractor's work product resulting from the Services provided by Contractor to City during the course of Contractor's performance of the Agreement, including without limitation, the work product described in the "Scope of Services" attached as Appendix A.

1.8 **"Mandatory City Requirements"** means those City laws set forth in the San Francisco Municipal Code, including the duly authorized rules, regulations, and guidelines implementing such laws that impose specific duties and obligations upon Contractor.

1.9 **"Party" and "Parties"** means the City and Contractor either collectively or individually.

1.10 **"Services"** means the work performed by Contractor under this Agreement as specifically described in the "Scope of Services" attached as Appendix A, including all services, labor, supervision, materials, equipment, actions and other requirements to be performed and furnished by Contractor under this Agreement.

Article 2 Term of the Agreement

2.1 **Term.** The term of this Agreement shall commence on November 8, 2022, and expire on December 31, 2023 unless earlier terminated as otherwise provided herein**.**

Article 3 Financial Matters

3.1 **Certification of Funds; Budget and Fiscal Provisions; Termination in the Event of Non-Appropriation.** This Agreement is subject to the budget and fiscal provisions of the City's Charter. Charges will accrue only after prior written authorization certified by the Controller, and the amount of City's obligation hereunder shall not at any time exceed the amount certified for the purpose and period stated in such advance authorization. This Agreement will terminate without penalty, liability or expense of any kind to City at the end of any fiscal year if funds are not appropriated for the next succeeding fiscal year. If funds are appropriated for a portion of the fiscal year, this Agreement will terminate, without penalty, liability or expense of any kind at the end of the term for which funds are appropriated. City has no obligation to make appropriations for this Agreement in lieu of appropriations for new or other agreements. City budget decisions are subject to the discretion of the Mayor and the Board of Supervisors. Contractor's assumption of risk of possible non-appropriation is part of the consideration for this Agreement.

THIS SECTION CONTROLS AGAINST ANY AND ALL OTHER PROVISIONS OF THIS AGREEMENT.

3.2 **Guaranteed Maximum Costs.** The City's payment obligation to Contractor cannot at any time exceed the amount certified by City's Controller for the purpose and period stated in such certification. Absent an authorized Emergency per the City Charter or applicable Code, no City representative is authorized to offer or promise, nor is the City required to honor, any offered or promised payments to Contractor under this Agreement in excess of the certified maximum amount without the Controller having first certified the additional promised amount and the Parties having modified this Agreement as provided in Section 11.5, "Modification of this Agreement."

3.3 **Compensation.**

3.3.1 **Calculation of Charges.** Contractor shall provide an invoice to the City on a monthly basis for goods delivered and/or Services completed in the immediate preceding month, unless a different schedule is set out in Appendix B, "Calculation of Charges." Compensation shall be made for goods and/or Services identified in the invoice that the City, in his or her sole discretion, concludes has been satisfactorily performed. In no event shall the amount of this Agreement exceed TWO MILLION SIX HUNDRED EIGHTY FIVE THOUSAND ONE HUNDRED SEVEN DOLLARS ($2,685,107) The breakdown of charges associated with this Agreement appears in Appendix B, "Calculation of Charges." A portion of payment may be withheld until conclusion of the Agreement if agreed to by both Parties as

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agreed to by both Parties as retainage, described in Appendix B. In no event shall City be liable for interest or late charges for any late payments. City will not honor minimum service order charges for any services covered by this Agreement.

3.3.2 **Payment Limited to Satisfactory Services and Delivery of Goods.** Contractor is not entitled to any payments from City until City approves the goods and/or Services delivered pursuant to this Agreement. Payments to Contractor by City shall not excuse Contractor from its obligation to replace unsatisfactory delivery of goods and/or Services even if the unsatisfactory character may not have been apparent or detected at the time such payment was made. Goods and/or Services delivered pursuant to this Agreement that do not conform to the requirements of this Agreement may be rejected by City and in such case must be replaced by Contractor without delay at no cost to the City.

3.3.3 **Withhold Payments.** If Contractor fails to provide goods and/or Services in accordance with Contractor's obligations under this Agreement, the City may withhold any and all payments due Contractor until such failure to perform is cured, and Contractor shall not stop work as a result of City's withholding of payments as provided herein.

3.3.4 **Invoice Format**. Invoices furnished by Contractor under this Agreement must be in a form acceptable to the Controller and City and include a unique invoice number and a specific invoice date. Payment shall be made by City as specified in Section 3.3.7, or in such alternate manner as the Parties have mutually agreed upon in writing. All invoices must show the PeopleSoft Purchase Order ID Number, PeopleSoft Supplier Name and ID, Item numbers (if applicable), complete description of goods delivered or Services performed, sales/use tax (if applicable), contract payment terms and contract price. Invoices that do not include all required information or contain inaccurate information will not be processed for payment.

3.3.5 **Reserved (LBE Payment and Utilization Tracking System**

3.3.6 **Getting paid by the City for Goods and/or Services.**

(a) The City and County of San Francisco utilizes the Paymode-X® service offered by Bank of America Merrill Lynch to pay City contractors. Contractor must sign up to receive electronic payments to be paid under this Agreement. To sign up for electronic payments, visit http://portal.paymode.com/city_countyofsanfrancisco.

(b) At the option of the City, Contractor may be required to submit invoices directly in the City's financial and procurement system (PeopleSoft) via eSettlement. Refer to https://sfcitypartner.sfgov.org/pages/training.aspx for more information on eSettlement. For access to PeopleSoft eSettlement, submit a request through sfemployeeportalsupport@sfgov.org.

3.3.7 **Reserved (Grant Funded Contracts).**

3.3.8 **Payment Terms.**

(a) **Payment Due Date**: Unless City notifies the Contractor that a dispute exists, Payment shall be made within 30 calendar days, measured from (1) the delivery of goods and/or the rendering of services or (2) the date of receipt of the invoice, whichever is later. Payment is deemed to be made on the date on which City has issued a check to Contractor or, if Contractor has agreed to electronic payment, the date on which City has posted electronic payment to Contractor.

(b) **Reserved (Payment Discount Terms).**

3.4 **Audit and Inspection of Records.**

3.4.1 Contractor agrees to maintain and make available to the City, during regular business hours, accurate books and accounting records relating to its Services. Contractor will permit City

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to audit, examine and make excerpts and transcripts from such books and records, and to make audits of all invoices, materials, payrolls, records or personnel and other data related to all other matters covered by this Agreement, whether funded in whole or in part under this Agreement. Contractor shall maintain such data and records in an accessible location and condition for a period of not fewer than five years, unless required for a longer duration due to Federal, State, or local requirements of which the City will notify contractor in writing, after final payment under this Agreement or until after final audit has been resolved, whichever is later. The State of California or any Federal agency having an interest in the subject matter of this Agreement shall have the same rights as conferred upon City by this Section. Contractor shall include the same audit and inspection rights and record retention requirements in all subcontracts.

Contractor shall annually have its books of accounts audited by a Certified Public Accountant and a copy of said audit report and the associated management letter(s) shall be transmitted to the Director of Public Health or his /her designee within one hundred eighty (180) calendar days following Contractor's fiscal year end date. If Contractor expends $750,000 or more in Federal funding per year, from any and all Federal awards, said audit shall be conducted in accordance with 2 CFR Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Said requirements can be found at the following website address: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title02/2cfr200_main_02.tpl.

3.4.2 If Contractor expends less than $750,000 a year in Federal awards, Contractor is exempt from the single audit requirements for that year, but records must be available for review or audit by appropriate officials of the Federal Agency, pass-through entity and General Accounting Office. Contractor agrees to reimburse the City any cost adjustments necessitated by this audit report. Any audit report which addresses all or part of the period covered by this Agreement shall treat the service components identified in the detailed descriptions attached to Appendix A and referred to in the Program Budgets of Appendix B as discrete program entities of the Contractor.

3.4.3 The Director of Public Health or his / her designee may approve a waiver of the audit requirement in Section 3.4.2 above, if the contractual Services are of a consulting or personal services nature, these Services are paid for through fee for service terms which limit the City's risk with such contracts, and it is determined that the work associated with the audit would produce undue burdens or costs and would provide minimal benefits. A written request for a waiver must be submitted to the DIRECTOR ninety (90) calendar days before the end of the Agreement term or Contractor's fiscal year, whichever comes first.

3.4.4 Any financial adjustments necessitated by this audit report shall be made by Contractor to the City. If Contractor is under contract to the City, the adjustment may be made in the next subsequent billing by Contractor to the City, or may be made by another written schedule determined solely by the City. In the event Contractor is not under contract to the City, written arrangements shall be made for audit adjustments.

3.5 **Submitting False Claims.** The full text of San Francisco Administrative Code Chapter 21, Section 21.35, including the enforcement and penalty provisions, is incorporated into this Agreement. Pursuant to San Francisco Administrative Code §21.35, any contractor or subcontractor who submits a false claim shall be liable to the City for the statutory penalties set forth in that section. A contractor or subcontractor will be deemed to have submitted a false claim to the City if the contractor or subcontractor: (a) knowingly presents or causes to be presented to an officer or employee of the City a false claim or request for payment or approval; (b) knowingly makes, uses, or causes to be made or used a

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false record or statement to get a false claim paid or approved by the City; (c) conspires to defraud the City by getting a false claim allowed or paid by the City; (d) knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the City; or (e) is a beneficiary of an inadvertent submission of a false claim to the City, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the City within a reasonable time after discovery of the false claim.

3.6 **Reserved (Payment of Prevailing Wages).**

3.7 **Contract Amendments; Budgeting Revisions.**

3.7.1 **Formal Contract Amendment:** Contractor shall not be entitled to an increase in the Compensation or an extension of the Term unless the Parties agree to a Formal Amendment in accordance with the San Francisco Administrative Code and Section 11.5 (Modifications of this Agreement).

3.7.2 **City Revisions to Program Budgets:** The City shall have authority, without the execution of a Formal Amendment, to purchase additional Services and/or make changes to the work in accordance with the terms of this Agreement (including such terms that require Contractor's agreement), not involving an increase in the Compensation or the Term by use of a written City Revision to Program Budget.

3.7.3 **City Program Scope Reduction.** In order to preserve the Agreement and enable Contractor to continue to perform work albeit potentially on a reduced basis, the City shall have authority during the Term of the Agreement, without the execution of a Formal Amendment, to reduce scope, temporarily suspend the Agreement work, and/or convert the Term to month-to-month (Program Scope Reduction), by use of a written Revision to Program Budgets, executed by the Director of Health, or his or her designee, and Contractor. Contractor understands and agrees that the City's right to effect a Program Scope Reduction is intended to serve a public purpose and to protect the public fisc and is not intended to cause harm to or penalize Contractor. Contractor provides City with a full and final release of all claims arising from a Program Scope Reduction. Contractor further agrees that it will not sue the City for damages arising directly or indirectly from a City Program Scope Reduction

Article 4 Services and Resources

4.1 **Services Contractor Agrees to Perform.** Contractor agrees to perform the Services stated in Appendix A, "Scope of Services." Officers and employees of the City are not authorized to request, and the City is not required to reimburse the Contractor for, Services beyond the Scope of Services listed in Appendix A, unless Appendix A is modified as provided in Section 11.5, "Modification of this Agreement."

4.2 **Personnel**

4.2.1 **Qualified Personnel**. Contractor shall utilize only competent personnel under the supervision of, and in the employment of, Contractor (or Contractor's authorized subcontractors) to perform the Services. Contractor will comply with City's reasonable requests regarding assignment and/or removal of personnel, but all personnel, including those assigned at City's request, must be supervised by Contractor. Contractor shall commit adequate resources to allow timely completion within the project schedule specified in this Agreement.

4.2.2 **Contractor Vaccination Policy**.

(a) Contractor acknowledges that it has read the requirements of the 38th Supplement to Mayoral Proclamation Declaring the Existence of a Local Emergency ("Emergency Declaration"), dated February 25, 2020, and the Contractor Vaccination Policy for City Contractors issued by the City Administrator ("Contractor Vaccination Policy"), as those documents may be amended

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from time to time. A copy of the Contractor Vaccination Policy can be found at: https://sf.gov/confirm-vaccine-status-your-employees-and-subcontractors.

(b) A Contract subject to the Emergency Declaration is an agreement between the City and any other entity or individual and any subcontract under such agreement, where Covered Employees of the Contractor or Subcontractor work in-person with City employees in connection with the work or services performed under the agreement at a City owned, leased, or controlled facility. Such agreements include, but are not limited to, professional services contracts, general services contracts, public works contracts, and grants. Contract includes such agreements currently in place or entered into during the term of the Emergency Declaration. Contract does not include an agreement with a state or federal governmental entity or agreements that do not involve the City paying or receiving funds.

(c) In accordance with the Contractor Vaccination Policy, Contractor agrees that:

(i) Where applicable, Contractor shall ensure it complies with the requirements of the Contractor Vaccination Policy pertaining to Covered Employees, as they are defined under the Emergency Declaration and the Contractor Vaccination Policy, and insure such Covered Employees are either fully vaccinated for COVID-19 or obtain from Contractor an exemption based on medical or religious grounds; and

(ii) If Contractor grants Covered Employees an exemption based on medical or religious grounds, Contractor will promptly notify City by completing and submitting the Covered Employees Granted Exemptions Form ("Exemptions Form"), which can be found a*t* https://sf.gov/confirm-vaccine-status-your-employees-and-subcontractors (navigate to "Exemptions" to download the form).

(d) The City reserves the right to impose a more stringent COVID-19 vaccination policy for the San Francisco Department of Public Health, acting in its sole discretion.

4.3 **Subcontracting.**

4.3.1 Contractor may subcontract portions of the Services only upon prior written approval of City. Contractor is responsible for its subcontractors throughout the course of the work required to perform the Services. All Subcontracts must incorporate the terms of Article 10 "Additional Requirements Incorporated by Reference" of this Agreement, unless inapplicable. Neither Party shall, on the basis of this Agreement, contract on behalf of, or in the name of, the other Party. Any agreement made in violation of this provision shall be null and void.

4.3.2 Sub-Contractors are not used in this Agreement.

4.4 **Independent Contractor; Payment of Employment Taxes and Other Expenses.**

4.4.1 **Independent Contractor**. For the purposes of this Section 4.4, "Contractor" shall be deemed to include not only Contractor, but also any agent or employee of Contractor. Contractor acknowledges and agrees that at all times, Contractor or any agent or employee of Contractor shall be deemed at all times to be an independent contractor and is wholly responsible for the manner in which it performs the services and work requested by City under this Agreement. Contractor, its agents, and employees will not represent or hold themselves out to be employees of the City at any time. Contractor or any agent or employee of Contractor shall not have employee status with City, nor be entitled to participate in any plans, arrangements, or distributions by City pertaining to or in connection with any retirement, health or other benefits that City may offer its employees. Contractor or any agent or employee of Contractor is liable for the acts and omissions of itself, its employees and its agents. Contractor shall be responsible for all obligations and payments, whether imposed by federal, state or

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local law, including, but not limited to, FICA, income tax withholdings, unemployment compensation, insurance, and other similar responsibilities related to Contractor's performing services and work, or any agent or employee of Contractor providing same. Nothing in this Agreement shall be construed as creating an employment or agency relationship between City and Contractor or any agent or employee of Contractor. Any terms in this Agreement referring to direction from City shall be construed as providing for direction as to policy and the result of Contractor's work only, and not as to the means by which such a result is obtained. City does not retain the right to control the means or the method by which Contractor performs work under this Agreement. Contractor agrees to maintain and make available to City, upon request and during regular business hours, accurate books and accounting records demonstrating Contractor's compliance with this Section. Should City determine that Contractor, or any agent or employee of Contractor, is not performing in accordance with the requirements of this Agreement, City shall provide Contractor with written notice of such failure. Within five (5) business days of Contractor's receipt of such notice, and in accordance with Contractor policy and procedure, Contractor shall remedy the deficiency. Notwithstanding, if City believes that an action of Contractor, or any agent or employee of Contractor, warrants immediate remedial action by Contractor, City shall contact Contractor and provide Contractor in writing with the reason for requesting such immediate action.

4.4.2 **Payment of Employment Taxes and Other Expenses**. Should City, in its discretion, or a relevant taxing authority such as the Internal Revenue Service or the State Employment Development Division, or both, determine that Contractor is an employee for purposes of collection of any employment taxes, the amounts payable under this Agreement shall be reduced by amounts equal to both the employee and employer portions of the tax due (and offsetting any credits for amounts already paid by Contractor which can be applied against this liability). City shall then forward those amounts to the relevant taxing authority. Should a relevant taxing authority determine a liability for past services performed by Contractor for City, upon notification of such fact by City, Contractor shall promptly remit such amount due or arrange with City to have the amount due withheld from future payments to Contractor under this Agreement (again, offsetting any amounts already paid by Contractor which can be applied as a credit against such liability). A determination of employment status pursuant to this Section 4.4 shall be solely limited to the purposes of the particular tax in question, and for all other purposes of this Agreement, Contractor shall not be considered an employee of City. Notwithstanding the foregoing, Contractor agrees to indemnify and save harmless City and its officers, agents and employees from, and, if requested, shall defend them against any and all claims, losses, costs, damages, and expenses, including attorneys' fees, arising from this Section.

4.5 **Assignment**. The Services to be performed by Contractor are personal in character. Neither this Agreement, nor any duties or obligations hereunder, may be directly or indirectly assigned, novated, hypothecated, transferred, or delegated by Contractor, or, where the Contractor is a joint venture, a joint venture partner, (collectively referred to as an "Assignment") unless first approved by City by written instrument executed and approved in the same manner as this Agreement in accordance with the Administrative Code. The City's approval of any such Assignment is subject to the Contractor demonstrating to City's reasonable satisfaction that the proposed transferee is: (i) reputable and capable, financially and otherwise, of performing each of Contractor's obligations under this Agreement and any other documents to be assigned, (ii) not forbidden by applicable law from transacting business or entering into contracts with City; and (iii) subject to the jurisdiction of the courts of the State of California. A change of ownership or control of Contractor or a sale or transfer of substantially all of the assets of Contractor shall be deemed an Assignment for purposes of this Agreement. Contractor shall immediately notify City about any Assignment. Any purported Assignment made in violation of this provision shall be null and void.

4.6 **Warranty.** Contractor warrants to City that the Services will be performed with the degree of skill and care that is required by current, good and sound professional procedures and practices, and in conformance with generally accepted professional standards prevailing at the time the Services are

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performed so as to ensure that all Services performed are correct and appropriate for the purposes contemplated in this Agreement.

Article 5 Insurance and Indemnity

5.1 Insurance.

5.1.1 **Required Coverages.** Insurance limits are subject to Risk Management review and revision, as appropriate, as conditions warrant. Without in any way limiting Contractor's liability pursuant to the "Indemnification" section of this Agreement, Contractor must maintain in force, during the full term of the Agreement, insurance in the following amounts and coverages:

(a) Commercial General Liability Insurance with limits not less than $1,000,000 each occurrence for Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations.

(b) Commercial Automobile Liability Insurance with limits not less than $1,000,000 each occurrence, "Combined Single Limit" for Bodily Injury and Property Damage, including Owned, Non-Owned and Hired auto coverage, as applicable.

(c) Workers' Compensation, in statutory amounts, with Employers' Liability Limits not less than $1,000,000 each accident, injury, or illness.

(d) Professional Liability Insurance, applicable to Contractor's profession, with limits not less than $1,000,000 for each claim with respect to negligent acts, errors or omissions in connection with the Services.

(e) Reserved (Technology Errors and Omissions Liability coverage)

(f) Cyber and Privacy Insurance with limits of not less than $10,000,000 per claim. Such insurance shall include coverage for liability arising from theft, dissemination, and/or use of confidential information, including but not limited to, bank and credit card account information or personal information, such as name, address, social security numbers, protected health information or other personally identifying information, stored or transmitted in any form.

(g) Reserved (Pollution Liability Insurance)

5.1.2 **Additional Insured Endorsements**

(a) The Commercial General Liability policy must be endorsed to name as Additional Insured the City and County of San Francisco, its Officers, Agents, and Employees.

(b) The Commercial Automobile Liability Insurance policy must be endorsed to name as Additional Insured the City and County of San Francisco, its Officers, Agents, and Employees.

(c) Reserved (Auto Pollution Additional Insured Endorsement and MCS-90)

5.1.3 **Waiver of Subrogation Endorsements**

(a) The Workers' Compensation policy(ies) shall be endorsed with a waiver of subrogation in favor of the City for all work performed by the Contractor, its employees, agents and subcontractors.

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5.1.4 **Primary Insurance Endorsements**

(a) The Commercial General Liability policy shall provide that such policies are primary insurance to any other insurance available to the Additional Insureds, with respect to any claims arising out of this Agreement, and that the insurance applies separately to each insured against whom claim is made or suit is brought.

(b) The Commercial Automobile Liability Insurance policy shall provide that such policies are primary insurance to any other insurance available to the Additional Insureds, with respect to any claims arising out of this Agreement, and that the insurance applies separately to each insured against whom claim is made or suit is brought.

(c) Reserved (The Pollution Liability Insurance Endorsement)

5.1.5 **Other Insurance Requirements**

(a) Thirty (30) days' advance written notice shall be provided to the City of cancellation, intended non-renewal, or reduction in coverages, except for non-payment for which no less than ten (10) days' notice shall be provided to City. Notices shall be sent to the City email address: **insurance-contractsrm410@sfdph.org** .

(b) Should any of the required insurance be provided under a claims-made form, Contractor shall maintain such coverage continuously throughout the term of this Agreement and, without lapse, for a period of three years beyond the expiration of this Agreement, to the effect that, should occurrences during the Agreement term give rise to claims made after expiration of the Agreement, such claims shall be covered by such claims-made policies.

(c) Should any of the required insurance be provided under a form of coverage that includes a general annual aggregate limit or provides that claims investigation or legal defense costs be included in such general annual aggregate limit, such general annual aggregate limit shall be double the occurrence or claims limits specified above.

(d) Should any required insurance lapse during the term of this Agreement, requests for payments originating after such lapse shall not be processed until the City receives satisfactory evidence of reinstated coverage as required by this Agreement, effective as of the lapse date. If insurance is not reinstated, the City may, at its sole option, terminate this Agreement effective on the date of such lapse of insurance.

(e) Before commencing any Services, Contractor shall furnish to City certificates of insurance and additional insured policy endorsements with insurers with ratings comparable to A-, VIII or higher, that are authorized to do business in the State of California, and that are satisfactory to City, in form evidencing all coverages set forth above. Approval of the insurance by City shall not relieve or decrease Contractor's liability hereunder.

(f) If Contractor will use any subcontractor(s) to provide Services, Contractor shall require the subcontractor(s) to provide all necessary insurance and to name the City and County of San Francisco, its officers, agents and employees and the Contractor as additional insureds.

5.2 **Indemnification.**

5.2.1 Contractor shall indemnify and hold harmless City and its officers, agents and employees from, and, if requested, shall defend them from and against any and all claims, demands, losses, damages, costs, expenses, and liability (legal, contractual, or otherwise) arising from or in any way connected with any: (i) injury to or death of a person, including employees of City or Contractor; (ii) loss of or damage to property; (iii) violation of local, state, or federal common law, statute or regulation,

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including but not limited to privacy or personally identifiable information, health information, disability and labor laws or regulations; (iv) strict liability imposed by any law or regulation; or (v) losses arising from Contractor's execution of subcontracts not in accordance with the requirements of this Agreement applicable to subcontractors; so long as such injury, violation, loss, or strict liability (as set forth in subsections (i) – (v) above) arises directly or indirectly from Contractor's performance of this Agreement, including, but not limited to, Contractor's use of facilities or equipment provided by City or others, regardless of the negligence of, and regardless of whether liability without fault is imposed or sought to be imposed on City, except to the extent that such indemnity is void or otherwise unenforceable under applicable law, and except where such loss, damage, injury, liability or claim is the result of the active negligence or willful misconduct of City and is not contributed to by any act of, or by any omission to perform some duty imposed by law or agreement on Contractor, its subcontractors, or either's agent or employee. Contractor shall also indemnify, defend and hold City harmless from all suits or claims or administrative proceedings for breaches of federal and/or state law regarding the privacy of health information, electronic records or related topics, arising directly or indirectly from Contractor's performance of this Agreement. The foregoing indemnity shall include, without limitation, reasonable fees of attorneys, consultants and experts and related costs and City's costs of investigating any claims against the City.

5.2.2 In addition to Contractor's obligation to indemnify City, Contractor specifically acknowledges and agrees that it has an immediate and independent obligation to defend City from any claim which actually or potentially falls within this indemnification provision, even if the allegations are or may be groundless, false or fraudulent, which obligation arises at the time such claim is tendered to Contractor by City and continues at all times thereafter.

5.2.3 Contractor shall indemnify and hold City harmless from all loss and liability, including attorneys' fees, court costs and all other litigation expenses for any infringement of the patent rights, copyright, trade secret or any other proprietary right or trademark, and all other intellectual property claims of any person or persons arising directly or indirectly from the receipt by City, or any of its officers or agents, of Contractor's Services.

Article 6 Liability of the Parties

6.1 **Liability of City.** CITY'S PAYMENT OBLIGATIONS UNDER THIS AGREEMENT SHALL BE LIMITED TO THE PAYMENT OF THE COMPENSATION PROVIDED FOR IN SECTION 3.3.1, "PAYMENT," OF THIS AGREEMENT. NOTWITHSTANDING ANY OTHER PROVISION OF THIS AGREEMENT, IN NO EVENT SHALL CITY BE LIABLE, REGARDLESS OF WHETHER ANY CLAIM IS BASED ON CONTRACT OR TORT, FOR ANY SPECIAL, CONSEQUENTIAL, INDIRECT OR INCIDENTAL DAMAGES, INCLUDING, BUT NOT LIMITED TO, LOST PROFITS, ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT OR THE SERVICES PERFORMED IN CONNECTION WITH THIS AGREEMENT.

6.2 **Liability for Use of Equipment.** City shall not be liable for any damage to persons or property as a result of the use, misuse or failure of any equipment used by Contractor, or any of its subcontractors, or by any of their employees, even though such equipment is furnished, rented or loaned by City.

6.3 **Liability for Incidental and Consequential Damages.** Contractor shall be responsible for incidental and consequential damages resulting in whole or in part from Contractor's acts or omissions.

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Article 7 Payment of Taxes

7.1 **Contractor to Pay All Taxes.** Except for any applicable California sales and use taxes charged by Contractor to City, Contractor shall pay all taxes, including possessory interest taxes levied upon or as a result of this Agreement, or the Services delivered pursuant hereto. Contractor shall remit to the State of California any sales or use taxes paid by City to Contractor under this Agreement. Contractor agrees to promptly provide information requested by the City to verify Contractor's compliance with any State requirements for reporting sales and use tax paid by City under this Agreement.

7.2 **Possessory Interest Taxes.** Contractor acknowledges that this Agreement may create a "possessory interest" for property tax purposes. Generally, such a possessory interest is not created unless the Agreement entitles the Contractor to possession, occupancy, or use of City property for private gain. If such a possessory interest is created, then the following shall apply:

7.2.1 Contractor, on behalf of itself and any permitted successors and assigns, recognizes and understands that Contractor, and any permitted successors and assigns, may be subject to real property tax assessments on the possessory interest.

7.2.2 Contractor, on behalf of itself and any permitted successors and assigns, recognizes and understands that the creation, extension, renewal, or assignment of this Agreement may result in a "change in ownership" for purposes of real property taxes, and therefore may result in a revaluation of any possessory interest created by this Agreement. Contractor accordingly agrees on behalf of itself and its permitted successors and assigns to report on behalf of the City to the County Assessor the information required by Revenue and Taxation Code Section 480.5, as amended from time to time, and any successor provision.

7.2.3 Contractor, on behalf of itself and any permitted successors and assigns, recognizes and understands that other events also may cause a change of ownership of the possessory interest and result in the revaluation of the possessory interest. (see, e.g., Rev. & Tax. Code Section 64, as amended from time to time). Contractor accordingly agrees on behalf of itself and its permitted successors and assigns to report any change in ownership to the County Assessor, the State Board of Equalization or other public agency as required by law.

7.2.4 Contractor further agrees to provide such other information as may be requested by the City to enable the City to comply with any reporting requirements for possessory interests that are imposed by applicable law.

7.3 **Withholding.** Contractor agrees that it is obligated to pay all amounts due to the City under the San Francisco Business and Tax Regulations Code during the term of this Agreement. Pursuant to Section 6.10-2 of the San Francisco Business and Tax Regulations Code, Contractor further acknowledges and agrees that City may withhold any payments due to Contractor under this Agreement if Contractor is delinquent in the payment of any amount required to be paid to the City under the San Francisco Business and Tax Regulations Code. Any payments withheld under this paragraph shall be made to Contractor, without interest, upon Contractor coming back into compliance with its obligations.

Article 8 Termination and Default

8.1 **Termination for Convenience**

8.1.1 City shall have the option, in its sole discretion, to terminate this Agreement, at any time during the term hereof, for convenience and without cause. City shall exercise this option by giving Contractor written notice of termination. The notice shall specify the date on which termination shall become effective.

8.1.2 Upon receipt of the notice of termination, Contractor shall commence and perform, with diligence, all actions necessary on the part of Contractor to effect the termination of this

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Agreement on the date specified by City and to minimize the liability of Contractor and City to third parties as a result of termination. All such actions shall be subject to the prior approval of City. Such actions may include any or all of the following, without limitation:

(a) Halting the performance of all Services under this Agreement on the date(s) and in the manner specified by City.

(b) Terminating all existing orders and subcontracts, and not placing any further orders or subcontracts for materials, Services, equipment or other items.

(c) At City's direction, assigning to City any or all of Contractor's right, title, and interest under the orders and subcontracts terminated. Upon such assignment, City shall have the right, in its sole discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts.

(d) Subject to City's approval, settling all outstanding liabilities and all claims arising out of the termination of orders and subcontracts.

(e) Completing performance of any Services that City designates to be completed prior to the date of termination specified by City.

(f) Taking such action as may be necessary, or as the City may direct, for the protection and preservation of any property related to this Agreement which is in the possession of Contractor and in which City has or may acquire an interest.

8.1.3 Within 30 days after the specified termination date, Contractor shall submit to City an invoice, which shall set forth each of the following as a separate line item:

(a) The reasonable cost to Contractor, without profit, for all Services prior to the specified termination date, for which Services City has not already tendered payment. Reasonable costs may include a reasonable allowance for actual overhead, not to exceed a total of 10% of Contractor's direct costs for Services. Any overhead allowance shall be separately itemized. Contractor may also recover the reasonable cost of preparing the invoice.

(b) A reasonable allowance for profit on the cost of the Services described in the immediately preceding subsection (a), provided that Contractor can establish, to the satisfaction of City, that Contractor would have made a profit had all Services under this Agreement been completed, and provided further, that the profit allowed shall in no event exceed 5% of such cost.

(c) The reasonable cost to Contractor of handling material or equipment returned to the vendor, delivered to the City or otherwise disposed of as directed by the City.

(d) A deduction for the cost of materials to be retained by Contractor, amounts realized from the sale of materials and not otherwise recovered by or credited to City, and any other appropriate credits to City against the cost of the Services or other work.

8.1.4 In no event shall City be liable for costs incurred by Contractor or any of its subcontractors after the termination date specified by City, except for those costs specifically listed in Section 8.1.3. Such non-recoverable costs include, but are not limited to, anticipated profits on the Services under this Agreement, post-termination employee salaries, post-termination administrative expenses, post-termination overhead or unabsorbed overhead, attorneys' fees or other costs relating to the prosecution of a claim or lawsuit, prejudgment interest, or any other expense which is not reasonable or authorized under Section 8.1.3.

8.1.5 In arriving at the amount due to Contractor under this Section, City may deduct: (i) all payments previously made by City for Services covered by Contractor's final invoice; (ii) any claim which City may have against Contractor in connection with this Agreement; (iii) any invoiced costs or

expenses excluded pursuant to the immediately preceding subsection 8.1.4; and (iv) in instances in which, in the opinion of the City, the cost of any Service performed under this Agreement is excessively high due to costs incurred to remedy or replace defective or rejected Services, the difference between the invoiced amount and City's estimate of the reasonable cost of performing the invoiced Services in compliance with the requirements of this Agreement.

8.1.6 City's payment obligation under this Section shall survive termination of this Agreement.

8.2 **Termination for Default; Remedies.**

8.2.1 Each of the following shall constitute an immediate event of default ("Event of Default") under this Agreement:

8.2.2 Contractor fails or refuses to perform or observe any term, covenant or condition contained in any of the following Sections of this Agreement:

3.5	Submitting False Claims.	10.10	Alcohol and Drug-Free Workplace
4.5	Assignment	10.13	Working with Minors
Article 5	Insurance and Indemnity	11.10	Compliance with Laws
Article 7	Payment of Taxes	Article 13	Data and Security

(a) Contractor fails or refuses to perform or observe any other term, covenant or condition contained in this Agreement, including any obligation imposed by ordinance or statute and incorporated by reference herein, and such default is not cured within ten days after written notice thereof from City to Contractor. If Contractor defaults a second time in the same manner as a prior default cured by Contractor, City may in its sole discretion immediately terminate the Agreement for default or grant an additional period not to exceed five days for Contractor to cure the default.

(b) Contractor (i) is generally not paying its debts as they become due; (ii) files, or consents by answer or otherwise to the filing against it of a petition for relief or reorganization or arrangement or any other petition in bankruptcy or for liquidation or to take advantage of any bankruptcy, insolvency or other debtors' relief law of any jurisdiction; (iii) makes an assignment for the benefit of its creditors; (iv) consents to the appointment of a custodian, receiver, trustee or other officer with similar powers of Contractor or of any substantial part of Contractor's property; or (v) takes action for the purpose of any of the foregoing.

(c) A court or government authority enters an order (i) appointing a custodian, receiver, trustee or other officer with similar powers with respect to Contractor or with respect to any substantial part of Contractor's property, (ii) constituting an order for relief or approving a petition for relief or reorganization or arrangement or any other petition in bankruptcy or for liquidation or to take advantage of any bankruptcy, insolvency or other debtors' relief law of any jurisdiction or (iii) ordering the dissolution, winding-up or liquidation of Contractor.

8.2.3 On and after any Event of Default, City shall have the right to exercise its legal and equitable remedies, including, without limitation, the right to terminate this Agreement or to seek specific performance of all or any part of this Agreement. In addition, in accordance with San Francisco Administrative Code Section 21.33 (Procedure Upon Contractor's Failure to Deliver) where applicable, City shall have the right (but no obligation) to cure (or cause to be cured) on behalf of Contractor any Event of Default; Contractor shall pay to City on demand all costs and expenses incurred by City in effecting such cure, with interest thereon from the date of incurrence at the maximum rate then permitted by law. Further, in accordance with San Francisco Administrative Code Section 10.27.1 (Controller may Offset), City shall have the right to offset from any amounts due to Contractor under this Agreement or

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any other agreement between City and Contractor: (i) all damages, losses, costs or expenses incurred by City as a result of an Event of Default; and (ii) any liquidated damages levied upon Contractor pursuant to the terms of this Agreement; and (iii), any damages imposed by any ordinance or statute that is incorporated into this Agreement by reference, or into any other agreement with the City. This Section 8.2.3 shall survive termination of this Agreement.

8.2.4 All remedies provided for in this Agreement may be exercised individually or in combination with any other remedy available hereunder or under applicable laws, rules and regulations. The exercise of any remedy shall not preclude or in any way be deemed to waive any other remedy. Nothing in this Agreement shall constitute a waiver or limitation of any rights that City may have under applicable law.

8.2.5 Any notice of default must be sent by registered mail to the address set forth in Article 11.

8.3 **Non-Waiver of Rights.** The omission by either Party at any time to enforce any default or right reserved to it, or to require performance of any of the terms, covenants, or provisions hereof by the other Party at the time designated, shall not be a waiver of any such default or right to which the Party is entitled, nor shall it in any way affect the right of the Party to enforce such provisions thereafter.

8.4 **Rights and Duties upon Termination or Expiration.**

8.4.1 This Section and the following Sections of this Agreement listed below, shall survive termination or expiration of this Agreement:

3.3.2	Payment Limited to Satisfactory Services		9.1	Ownership of Results
3.3.7(a)	Grant Funded Contracts – Disallowance		9.2	Works for Hire
3.4	Audit and Inspection of Records		11.6	Dispute Resolution Procedure
3.5	Submitting False Claims		11.7	Agreement Made in California; Venue
Article 5	Insurance and Indemnity		11.8	Construction
6.1	Liability of City		11.9	Entire Agreement
6.3	Liability for Incidental and Consequential Damages		11.10	Compliance with Laws
Article 7	Payment of Taxes		11.11	Severability
8.1.6	Payment Obligation		Article 13	Data and Security
			Appendix E	Business Associate Agreement

8.4.2 Subject to the survival of the Sections identified in Section 8.4.1, above, if this Agreement is terminated prior to expiration of the term specified in Article 2, this Agreement shall be of no further force or effect. Contractor shall transfer title to City, and deliver in the manner, at the times, and to the extent, if any, directed by City, any work in progress, completed work, supplies, equipment, and other materials produced as a part of, or acquired in connection with the performance of this Agreement, and any completed or partially completed work which, if this Agreement had been completed, would have been required to be furnished to City.

Article 9 Rights In Deliverables

9.1 **Reserved (Ownership of Results)**.

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9.2 **Reserved (Works for Hire).**

Article 10 Additional Requirements Incorporated by Reference

10.1 **Laws Incorporated by Reference**. The full text of the laws listed in this Article 10, including enforcement and penalty provisions, are incorporated by reference into this Agreement. The full text of the San Francisco Municipal Code provisions incorporated by reference in this Article and elsewhere in the Agreement ("Mandatory City Requirements") are available at http://www.amlegal.com/codes/client/san-francisco_ca/ .

10.2 **Conflict of Interest.** By executing this Agreement, Contractor certifies that it does not know of any fact which constitutes a violation of Section 15.103 of the City's Charter; Article III, Chapter 2 of City's Campaign and Governmental Conduct Code; Title 9, Chapter 7 of the California Government Code (Section 87100 *et seq.*), or Title 1, Division 4, Chapter 1, Article 4 of the California Government Code (Section 1090 *et seq.*), and further agrees promptly to notify the City if it becomes aware of any such fact during the term of this Agreement.

10.3 **Prohibition on Use of Public Funds for Political Activity.** In performing the Services, Contractor shall comply with San Francisco Administrative Code Chapter 12G, which prohibits funds appropriated by the City for this Agreement from being expended to participate in, support, or attempt to influence any political campaign for a candidate or for a ballot measure. Contractor is subject to the enforcement and penalty provisions in Chapter 12G.

10.4 **Consideration of Salary History.** Contractor shall comply with San Francisco Administrative Code Chapter 12K, the Consideration of Salary History Ordinance or "Pay Parity Act." Contractor is prohibited from considering current or past salary of an applicant in determining whether to hire the applicant or what salary to offer the applicant to the extent that such applicant is applying for employment to be performed on this Agreement or in furtherance of this Agreement, and whose application, in whole or part, will be solicited, received, processed or considered, whether or not through an interview, in the City or on City property. The ordinance also prohibits employers from (1) asking such applicants about their current or past salary or (2) disclosing a current or former employee's salary history without that employee's authorization unless the salary history is publicly available. Contractor is subject to the enforcement and penalty provisions in Chapter 12K. Information about and the text of Chapter 12K is available on the web at https://sfgov.org/olse/consideration-salary-history. Contractor is required to comply with all of the applicable provisions of 12K, irrespective of the listing of obligations in this Section.

10.5 **Nondiscrimination Requirements.**

10.5.1 **Nondiscrimination in Contracts**. Contractor shall comply with the provisions of Chapters 12B and 12C of the San Francisco Administrative Code. Contractor shall incorporate by reference in all subcontracts the provisions of Sections 12B.2(a), 12B.2(c)-(k), and 12C.3 of the San Francisco Administrative Code and shall require all subcontractors to comply with such provisions. Contractor is subject to the enforcement and penalty provisions in Chapters 12B and 12C.

10.5.2 **Nondiscrimination in the Provision of Employee Benefits**. San Francisco Administrative Code 12B.2. Contractor does not as of the date of this Agreement, and will not during the term of this Agreement, in any of its operations in San Francisco, on real property owned by San Francisco, or where work is being performed for the City elsewhere in the United States, discriminate in the provision of employee benefits between employees with domestic partners and employees with spouses and/or between the domestic partners and spouses of such employees, subject to the conditions set forth in San Francisco Administrative Code Section 12B.2.

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10.6 **Local Business Enterprise and Non-Discrimination in Contracting Ordinance.** Contractor shall comply with all applicable provisions of Chapter 14B ("LBE Ordinance"). Contractor is subject to the enforcement and penalty provisions in Chapter 14B.

10.7 **Minimum Compensation Ordinance.** If Administrative Code Chapter 12P applies to this contract, Contractor shall pay covered employees no less than the minimum compensation required by San Francisco Administrative Code Chapter 12P, including a minimum hourly gross compensation, compensated time off, and uncompensated time off. Contractor is subject to the enforcement and penalty provisions in Chapter 12P. Information about and the text of the Chapter 12P is available on the web at http://sfgov.org/olse/mco. Contractor is required to comply with all of the applicable provisions of 12P, irrespective of the listing of obligations in this Section. By signing and executing this Agreement, Contractor certifies that it complies with Chapter 12P.

10.8 **Health Care Accountability Ordinance.** If Administrative Code Chapter 12Q applies to this contract, Contractor shall comply with the requirements of Chapter 12Q. For each Covered Employee, Contractor shall provide the appropriate health benefit set forth in Section 12Q.3 of the HCAO. If Contractor chooses to offer the health plan option, such health plan shall meet the minimum standards set forth by the San Francisco Health Commission. Information about and the text of the Chapter 12Q, as well as the Health Commission's minimum standards, is available on the web at http://sfgov.org/olse/hcao. Contractor is subject to the enforcement and penalty provisions in Chapter 12Q. Any Subcontract entered into by Contractor shall require any Subcontractor with 20 or more employees to comply with the requirements of the HCAO and shall contain contractual obligations substantially the same as those set forth in this Section.

10.9 **First Source Hiring Program.** Contractor must comply with all of the provisions of the First Source Hiring Program, Chapter 83 of the San Francisco Administrative Code, that apply to this Agreement, and Contractor is subject to the enforcement and penalty provisions in Chapter 83.

10.10 **Alcohol and Drug-Free Workplace.** City reserves the right to deny access to, or require Contractor to remove from, City facilities personnel of any Contractor or subcontractor who City has reasonable grounds to believe has engaged in alcohol abuse or illegal drug activity which in any way impairs City's ability to maintain safe work facilities or to protect the health and well-being of City employees and the general public. City shall have the right of final approval for the entry or re-entry of any such person previously denied access to, or removed from, City facilities. Illegal drug activity means possessing, furnishing, selling, offering, purchasing, using or being under the influence of illegal drugs or other controlled substances for which the individual lacks a valid prescription. Alcohol abuse means possessing, furnishing, selling, offering, or using alcoholic beverages, or being under the influence of alcohol.

10.11 **Limitations on Contributions.** By executing this Agreement, Contractor acknowledges its obligations under Section 1.126 of the City's Campaign and Governmental Conduct Code, which prohibits any person who contracts with, or is seeking a contract with, any department of the City for the rendition of personal services, for the furnishing of any material, supplies or equipment, for the sale or lease of any land or building, for a grant, loan or loan guarantee, or for a development agreement, from making any campaign contribution to (i) a City elected official if the contract must be approved by that official, a board on which that official serves, or the board of a state agency on which an appointee of that official serves, (ii) a candidate for that City elective office, or (iii) a committee controlled by such elected official or a candidate for that office, at any time from the submission of a proposal for the contract until the later of either the termination of negotiations for such contract or twelve months after the date the City approves the contract. The prohibition on contributions applies to each prospective party to the contract; each member of Contractor's board of directors; Contractor's chairperson, chief executive officer, chief financial officer and chief operating officer; any person with an ownership interest of more than 10% in Contractor; any subcontractor listed in the bid or contract; and any committee that is sponsored or

controlled by Contractor. Contractor certifies that it has informed each such person of the limitation on contributions imposed by Section 1.126 by the time it submitted a proposal for the contract, and has provided the names of the persons required to be informed to the City department with whom it is contracting.

10.12 **Reserved (Slavery Era Disclosure).**

10.13 **Reserved (Working with Minors).**

10.14 **Consideration of Criminal History in Hiring and Employment Decisions.**

10.14.1 Contractor agrees to comply fully with and be bound by all of the provisions of Chapter 12T, "City Contractor/Subcontractor Consideration of Criminal History in Hiring and Employment Decisions," of the San Francisco Administrative Code ("Chapter 12T"), including the remedies provided, and implementing regulations, as may be amended from time to time. The provisions of Chapter 12T are incorporated by reference and made a part of this Agreement as though fully set forth herein. The text of the Chapter 12T is available on the web at http://sfgov.org/olse/fco. Contractor is required to comply with all of the applicable provisions of 12T, irrespective of the listing of obligations in this Section. Capitalized terms used in this Section and not defined in this Agreement shall have the meanings assigned to such terms in Chapter 12T.

10.14.2 The requirements of Chapter 12T shall only apply to a Contractor's or Subcontractor's operations to the extent those operations are in furtherance of the performance of this Agreement, shall apply only to applicants and employees who would be or are performing work in furtherance of this Agreement, and shall apply when the physical location of the employment or prospective employment of an individual is wholly or substantially within the City of San Francisco. Chapter 12T shall not apply when the application in a particular context would conflict with federal or state law or with a requirement of a government agency implementing federal or state law.

10.15 **Public Access to Nonprofit Records and Meetings.** If Contractor receives a cumulative total per year of at least $250,000 in City funds or City-administered funds and is a non-profit organization as defined in Chapter 12L of the San Francisco Administrative Code, Contractor must comply with the City's Public Access to Nonprofit Records and Meetings requirements, as set forth in Chapter 12L of the San Francisco Administrative Code, including the remedies provided therein.

10.16 **Food Service Waste Reduction Requirements.** Contractor shall comply with the Food Service Waste Reduction Ordinance, as set forth in San Francisco Environment Code Chapter 16, including but not limited to the remedies for noncompliance provided therein.

10.17 **Reserved (Distribution of Beverages and Water).**

10.18 **Tropical Hardwood and Virgin Redwood Ban.** Pursuant to San Francisco Environment Code Section 804(b), the City urges Contractor not to import, purchase, obtain, or use for any purpose, any tropical hardwood, tropical hardwood wood product, virgin redwood or virgin redwood wood product.

10.19 **Reserved (Preservative Treated Wood Products).**

Article 11 General Provisions

11.1 **Notices to the Parties.** Unless otherwise indicated in this Agreement, all written communications sent by the Parties may be by U.S. mail or e-mail, and shall be addressed as follows:

To CITY: Office of Contract Management and Compliance
Department of Public Health
101 Grove Street, Room 410

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	San Francisco, California 94102	e-mail:	robert.longhitano@sfdph.org
And:	Program Person SECTION ADDRESS SAN FRANCISCO, CA ZIP	e-mail:	baljeet.sangha@sfdph.org
To CONTRACTOR:	HEALTH SERVICES ADVISORY GROUP, INC. 3133 E. CAMELBACK RD., SUITE 140 PHOENIX, ARIZONA 85016	e-mail:	mdalton@hsag.com

Any notice of default must be sent by registered mail or other trackable overnight mail. Either Party may change the address to which notice is to be sent by giving written notice thereof to the other Party. If email notification is used, the sender must specify a receipt notice.

11.2 **Compliance with Americans with Disabilities Act**. Contractor shall provide the Services in a manner that complies with the Americans with Disabilities Act (ADA), including but not limited to Title II's program access requirements, and all other applicable federal, state and local disability rights legislation.

11.3 **Incorporation of Recitals.** The matters recited above are hereby incorporated into and made part of this Agreement.

11.4 **Sunshine Ordinance.** Contractor acknowledges that this Agreement and all records related to its formation, Contractor's performance of Services, and City's payment are subject to the California Public Records Act, (California Government Code §6250 et. seq.), and the San Francisco Sunshine Ordinance, (San Francisco Administrative Code Chapter 67). Such records are subject to public inspection and copying unless exempt from disclosure under federal, state or local law.

11.5 **Modification of this Agreement**. This Agreement may not be modified, nor may compliance with any of its terms be waived, except as noted in Section 11.1, "Notices to Parties," regarding change in personnel or place, and except by written instrument executed and approved in the same manner as this Agreement. Contractor shall cooperate with Department to submit to the Director of CMD any amendment, modification, supplement or change order that would result in a cumulative increase of the original amount of this Agreement by more than 20% (CMD Contract Modification Form).

11.6 **Dispute Resolution Procedure**.

11.6.1 **Negotiation; Alternative Dispute Resolution.** The Parties will attempt in good faith to resolve any dispute or controversy arising out of or relating to the performance of services under this Agreement. If the Parties are unable to resolve the dispute, then, pursuant to San Francisco Administrative Code Section 21.36, Contractor may submit to the Contracting Officer a written request for administrative review and documentation of the Contractor's claim(s). Upon such request, the Contracting Officer shall promptly issue an administrative decision in writing, stating the reasons for the action taken and informing the Contractor of its right to judicial review. If agreed by both Parties in writing, disputes may be resolved by a mutually agreed-upon alternative dispute resolution process. If the Parties do not mutually agree to an alternative dispute resolution process or such efforts do not resolve the dispute, then either Party may pursue any remedy available under California law. The status of any dispute or controversy notwithstanding, Contractor shall proceed diligently with the performance of its obligations under this Agreement in accordance with the Agreement and the written directions of the City. Neither Party will be entitled to legal fees or costs for matters resolved under this Section.

11.6.2 **Government Code Claim Requirement.** No suit for money or damages may be brought against the City until a written claim therefor has been presented to and rejected by the City in

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conformity with the provisions of San Francisco Administrative Code Chapter 10 and California Government Code Section 900, et seq. Nothing set forth in this Agreement shall operate to toll, waive or excuse Contractor's compliance with the California Government Code Claim requirements set forth in San Francisco Administrative Code Chapter 10 and California Government Code Section 900, et seq.

11.7 **Agreement Made in California; Venue.** The formation, interpretation and performance of this Agreement shall be governed by the laws of the State of California. Venue for all litigation relative to the formation, interpretation and performance of this Agreement shall be in San Francisco.

11.8 **Construction.** All paragraph captions are for reference only and shall not be considered in construing this Agreement.

11.9 **Entire Agreement.** This contract sets forth the entire Agreement between the Parties, and supersedes all other oral or written provisions. This Agreement may be modified only as provided in Section 11.5, "Modification of this Agreement."

11.10 **Compliance with Laws.** Contractor shall keep itself fully informed of the City's Charter, codes, ordinances and duly adopted rules and regulations of the City and of all state, and federal laws in any manner affecting the performance of this Agreement, and must at all times comply with such local codes, ordinances, and regulations and all applicable laws as they may be amended from time to time.

11.11 **Severability**. Should the application of any provision of this Agreement to any particular facts or circumstances be found by a court of competent jurisdiction to be invalid or unenforceable, then (i) the validity of other provisions of this Agreement shall not be affected or impaired thereby, and (ii) such provision shall be enforced to the maximum extent possible so as to effect the intent of the Parties and shall be reformed without further action by the Parties to the extent necessary to make such provision valid and enforceable.

11.12 **Cooperative Drafting.** This Agreement has been drafted through a cooperative effort of City and Contractor, and both Parties have had an opportunity to have the Agreement reviewed and revised by legal counsel. No Party shall be considered the drafter of this Agreement, and no presumption or rule that an ambiguity shall be construed against the Party drafting the clause shall apply to the interpretation or enforcement of this Agreement.

11.13 **Order of Precedence.** Contractor agrees to perform the services described below in accordance with the terms and conditions of this Agreement, the Settlement Agreement, and the Ordinance. Should there be a conflict of terms or conditions, the Settlement Agreement and Ordinance shall control over the terms of this Agreement.

11.14 **Notification of Legal Requests.** Contractor shall immediately notify City upon receipt of any subpoenas, service of process, litigation holds, discovery requests and other legal requests ("Legal Requests") related to all data given to Contractor by City in the performance of this Agreement ("City Data" or "Data"), or which in any way might reasonably require access to City's Data, and in no event later than 24 hours after it receives the request. Contractor shall not respond to Legal Requests related to City without first notifying City other than to notify the requestor that the information sought is potentially covered under a non-disclosure agreement. Contractor shall retain and preserve City Data in accordance with the City's instruction and requests, including, without limitation, any retention schedules and/or litigation hold orders provided by the City to Contractor, independent of where the City Data is stored.

Article 12 Department Specific Terms

12.1 **Third Party Beneficiaries.** No third parties are intended by the parties hereto to be third party beneficiaries under this Agreement, and no action to enforce the terms of this Agreement may be brought against either party by any person who is not a party hereto.

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12.2 **Exclusion Lists and Employee Verification.** Upon hire and monthly thereafter, Contractor will check the exclusion lists published by the Office of the Inspector General (OIG), General Services Administration (GSA), and the California Department of Health Care Services (DHCS) to ensure that any employee, temporary employee, volunteer, consultant, or governing body member responsible for oversight, administering or delivering state or federally-funded services who is on any of these lists is excluded from (may not work in) your program or agency. Proof of checking these lists must be retained for seven years.

12.3 **Materials Review.** Contractor agrees that all materials, including without limitation print, audio, video, and electronic materials, developed, produced, or distributed by personnel or with funding under this Agreement shall be subject to review and approval by the Contract Administrator prior to such production, development or distribution. Contractor agrees to provide such materials sufficiently in advance of any deadlines to allow for adequate review. City agrees to conduct the review in a manner which does not impose unreasonable delays on Contractor's work, which may include review by members of target communities.

Article 13 Data and Security

13.1 **Nondisclosure of Private, Proprietary or Confidential Information.**

13.1.1 **Protection of Private Information.** If this Agreement requires City to disclose "Private Information" to Contractor within the meaning of San Francisco Administrative Code Chapter 12M, Contractor and subcontractor shall use such information only in accordance with the restrictions stated in Chapter 12M and in this Agreement and only as necessary in performing the Services. Contractor is subject to the enforcement and penalty provisions in Chapter 12M.

13.1.2 **Confidential Information.** In the performance of Services, Contractor may have access to, or collect on City's behalf, City's proprietary or Confidential Information, the disclosure of which to third parties may damage City. If City discloses proprietary or Confidential Information to Contractor, or Contractor collects such information on City's behalf, such information must be held by Contractor in confidence and used only in performing the Agreement. Contractor shall exercise the same standard of care to protect such information as a reasonably prudent contractor would use to protect its own proprietary or Confidential Information.

13.2 **Reserved (Payment Card Industry ("PCI") Requirements).**

13.3 **Business Associate Agreement.** The parties acknowledge that City is a Covered Entity as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and is required to comply with the HIPAA Privacy Rule governing the access, use, disclosure, transmission, and storage of protected health information (PHI) and the Security Rule under the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act").

The parties acknowledge that CONTRACTOR will:

1. ☒ Do **at least one** or more of the following:

A. Create, receive, maintain, or transmit PHI for or on behalf of CITY/SFDPH (including storage of PHI, digital or hard copy, even if Contractor does not view the PHI or only does so on a random or infrequent basis); or

B. Receive PHI, or access to PHI, from CITY/SFDPH or another Business Associate of City, as part of providing a service to or for CITY/SFDPH, including legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial; or

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C. Transmit PHI data for CITY/SFDPH and require access on a regular basis to such PHI. (Such as health information exchanges (HIEs), e-prescribing gateways, or electronic health record vendors)

FOR PURPOSES OF THIS AGREEMENT, CONTRACTOR IS A BUSINESS ASSOCIATE OF CITY/SFDPH, AS DEFINED UNDER HIPAA. CONTRACTOR MUST COMPLY WITH AND COMPLETE THE FOLLOWING ATTACHED DOCUMENTS, INCORPORATED TO THIS AGREEMENT AS THOUGH FULLY SET FORTH HEREIN:

a. **Appendix E** SFDPH Business Associate Agreement (BAA) (08-03-2022)

1. SFDPH Attestation 1 PRIVACY (06-07-2017)
2. SFDPH Attestation 2 DATA SECURITY (06-07-2017)

2. ☐ **NOT do any of the activities listed above in subsection 1;**

Contractor is not a Business Associate of CITY/SFDPH. Appendix E and attestations are not required for the purposes of this Agreement.

13.4 **Management of City Data and Confidential Information**.

13.4.1 **Use of City Data and Confidential Information.** Contractor agrees to hold City's Data received from, or collected on behalf of, the City, in strictest confidence. Contractor shall not use or disclose City's Data except as permitted or required by the Agreement or as otherwise authorized in writing by the City. Any work using, or sharing or storage of, City's Data outside the United States is subject to prior written authorization by the City. Access to City's Data must be strictly controlled and limited to Contractor's staff assigned to this project on a need-to-know basis only. Contractor is provided a limited non-exclusive license to use the City Data solely for performing its obligations under the Agreement and not for Contractor's own purposes or later use. Nothing herein shall be construed to confer any license or right to the City Data or Confidential Information, by implication, estoppel or otherwise, under copyright or other intellectual property rights, to any third-party. Unauthorized use of City Data by Contractor, subcontractors or other third-parties is prohibited. For purpose of this requirement, the phrase "unauthorized use" means the data mining or processing of data, stored or transmitted by the service, for commercial purposes, advertising or advertising-related purposes, or for any purpose other than security or service delivery analysis that is not explicitly authorized.

13.4.2 **Disposition of Confidential Information**. Upon request of City or termination or expiration of this Agreement, and pursuant to any document retention period required by this Agreement, Contractor shall promptly, but in no event later than thirty (30) calendar days, return all data given to or collected by Contractor on City's behalf, which includes all original media. Once Contractor has received written confirmation from City that City's Data has been successfully transferred to City, Contractor shall within ten (10) business days clear or purge all City Data from its servers, any hosted environment Contractor has used in performance of this Agreement, including its subcontractors environment(s), work stations that were used to process the data or for production of the data, and any other work files stored by Contractor in whatever medium. Contractor shall provide City with written certification that such purge occurred within five (5) business days of the purge. Secure disposal shall be accomplished by "clearing," "purging" or "physical destruction," in accordance with National Institute of Standards and Technology (NIST) Special Publication 800-88 or most current industry standard.

13.5 **Ownership of City Data.** The Parties agree that as between them, all rights, including all intellectual property rights, in and to the City Data and any derivative works of the City Data is the exclusive property of the City.

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13.6 **Protected Health Information.** Contractor, all subcontractors, all agents and employees of Contractor and any subcontractor shall comply with all federal and state laws regarding the transmission, storage and protection of all private health information disclosed to Contractor by City in the performance of this Agreement. Contractor agrees that any failure of Contractor to comply with the requirements of federal and/or state and/or local privacy laws shall be a material breach of the Contract. In the event that City pays a regulatory fine, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible use or disclosure of protected health information given to Contractor or its subcontractors or agents by City, Contractor shall indemnify City for the amount of such fine or penalties or damages, including costs of notification. In such an event, in addition to any other remedies available to it under equity or law, the City may terminate the Contract.

Article 14 MacBride And Signature

14.1 **MacBride Principles - Northern Ireland.** The provisions of San Francisco Administrative Code §12F are incorporated herein by this reference and made part of this Agreement. By signing this Agreement, Contractor confirms that Contractor has read and understood that the City urges companies doing business in Northern Ireland to resolve employment inequities and to abide by the MacBride Principles, and urges San Francisco companies to do business with corporations that abide by the MacBride Principles.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the day first mentioned above.

CITY

Recommended by:

DocuSigned by:
Greg Wagner
28527524752949F...
01/05/2023 | 9:36 AM PST

Grant Colfax, MD
Director of Health
Department of Public Health

Approved as to Form:

David Chiu
City Attorney

By: DocuSigned by:
Louise Simpson
BD54168A4C3B452...
12/28/2022 | 10:18 AM PST

Louise S. Simpson
Deputy City Attorney

CONTRACTOR

Health Services Advisory Group, Inc.

DocuSigned by:
Mary Ellen Dalton
BAB3544EBD314D7...
12/27/2022 | 10:15 AM PS

Mary Ellen Dalton, PhD, MBA, RN
President and Chief Executive Officer
3133 E. Camelback Rd., Suite 140
Phoenix, Arizona 85016

Supplier ID: **0000049228**

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Appendices

A: Scope of Services
B: Calculation of Charges
C: Reserved
D: Data Access Agreement
E: HIPAA Business Associate Agreement
F: Invoice
G: Travel and Expense Policy
H. Settlement and Systems Improvement Agreement
I: Ordinance No. 224-22

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Appendix A
Scope of Services

1. Terms

A. Contract Administrator:

In performing the Services hereunder, Contractor shall report to **Baljeet Sangha**, Contract Administrator for the City, or his / her designee.

B. Reports:

Contractor shall submit written reports as requested by the City. The format for the content of such reports shall be determined by the City. The timely submission of all reports is a necessary and material term and condition of this Agreement. All reports, including any copies, shall be submitted on recycled paper and printed on double-sided pages to the maximum extent possible.

For services solicited under a Group Purchasing Organization (GPO) the Contractor shall report all applicable sales under this agreement to the respective GPO.

C. Evaluation:

Contractor shall participate as requested with the City, State and/or Federal government in evaluative studies designed to show the effectiveness of Contractor's Services. Contractor agrees to meet the requirements of and participate in the evaluation program and management information systems of the City.

For contracts for the provision of services at San Francisco General or Laguna Honda Hospital and Rehabilitation Center, the evaluation program shall include agreed upon performance measures as specified in the Performance Improvement Plan and Performance Measure Grid which is presented in Attachment 1 to Appendix A. Performance measures are reported annually to the Zuckerberg San Francisco General performance improvement committees (PIPS and Quality Council) or the to the Administration Office of Laguna Honda Hospital and Rehabilitation Center.

The City agrees that any final written reports generated through the evaluation program shall be made available to Contractor within thirty (30) working days. Contractor may submit a written response within thirty working days of receipt of any evaluation report and such response will become part of the official report.

D. Possession of Licenses/Permits:

Contractor warrants the possession of all licenses and/or permits required by the laws and regulations of the United States, the State of California, and the City to provide the Services. Failure to maintain these licenses and permits shall constitute a material breach of this Agreement.

E. Adequate Resources:

Contractor agrees that it has secured or shall secure at its own expense all persons, employees and equipment required to perform the Services required under this Agreement, and that all such Services shall be performed by Contractor, or under Contractor's supervision, by persons authorized by law to perform such Services.

F. Infection Control, Health and Safety:

(1) Contractor must have a Bloodborne Pathogen (BBP) Exposure Control plan for its employees, agents and subcontractors as defined in the California Code of Regulations, Title 8, Section 5193, Bloodborne Pathogens (http://www.dir.ca.gov/title8/5193.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, training, immunization, use of

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personal protective equipment and safe needle devices, maintenance of a sharps injury log, post-exposure medical evaluations, and recordkeeping.

(2) Contractor must demonstrate personnel policies/procedures for protection of its employees, agents, subcontractors and clients from other communicable diseases prevalent in the population served. Such policies and procedures shall include, but not be limited to, work practices, personal protective equipment, staff/client Tuberculosis (TB) surveillance, training, etc.

(3) Contractor must demonstrate personnel policies/procedures for Tuberculosis (TB) exposure control consistent with the Centers for Disease Control and Prevention (CDC) recommendations for health care facilities and based on the Francis J. Curry National Tuberculosis Center: Template for Clinic Settings, as appropriate.

(4) Contractor is responsible for site conditions, equipment, health and safety of their employees, and all other persons who work or visit the job site.

(5) Contractor shall assume liability for any and all work-related injuries/illnesses including infectious exposures such as BBP and TB and demonstrate appropriate policies and procedures for reporting such events and providing appropriate post-exposure medical management as required by State workers' compensation laws and regulations.

(6) Contractor shall comply with all applicable Cal-OSHA standards including maintenance of the OSHA 300 Log of Work-Related Injuries and Illnesses.

(7) Contractor assumes responsibility for procuring all medical equipment and supplies for use by its employees, agents and subcontractors, including safe needle devices, and provides and documents all appropriate training.

(8) Contractor shall demonstrate compliance with all state and local regulations with regard to handling and disposing of medical waste.

G. Aerosol Transmissible Disease Program, Health and Safety:

(1) Contractor must have an Aerosol Transmissible Disease (ATD) Program as defined in the California Code of Regulations, Title 8, Section 5199, Aerosol Transmissible Diseases (http://www.dir.ca.gov/Title8/5199.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, screening procedures, source control measures, use of personal protective equipment, referral procedures, training, immunization, post-exposure medical evaluations/follow-up, and recordkeeping.

(2) Contractor shall assume liability for any and all work-related injuries/illnesses including infectious exposures such as Aerosol Transmissible Disease and demonstrate appropriate policies and procedures for reporting such events and providing appropriate post-exposure medical management as required by State workers' compensation laws and regulations.

(3) Contractor shall comply with all applicable Cal-OSHA standards including maintenance of the OSHA 300 Log of Work-Related Injuries and Illnesses.

(4) Contractor assumes responsibility for procuring all medical equipment and supplies for use by their employees, agents, subcontractors including Personnel Protective Equipment such as respirators, and provides and documents all appropriate training.

H. Acknowledgment of Funding:

Contractor agrees to acknowledge the San Francisco Department of Public Health in any printed material or public announcement describing the San Francisco Department of Public Health-funded Services. Such documents or announcements shall contain a credit substantially as follows: “This

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program/service/activity/research project was funded through the Department of Public Health, City and County of San Francisco."

2. Description of Services

Contractor agrees to perform the following Services:

All written Deliverables, including any copies, shall be submitted on recycled paper and printed on double-sided pages to the maximum extent possible.

Detailed description of services are listed below and are attached hereto

Appendix A-1: Laguna Honda Quality Improvement Expert (QIE) Services

3. Services Provided by Attorneys. Any services to be provided by a law firm or attorney to the City must be reviewed and approved in writing in advance by the City Attorney. No invoices for services provided by law firms or attorneys, including, without limitation, as subcontractors of Contractor, will be paid unless the provider received advance written approval from the City Attorney.

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Attachment 1 to Appendix A

PERFORMANCE IMPROVEMENT PLAN

AND PERFORMANCE MEASURE GRID

Contract Services

AIM: All services provided through contractual agreement are provided safely and effectively for patient care and support services, annually.

Contract Name	Services Provided	Measure Name	Metric (What data is being collected?)
1.	**Laguna Honda Quality Improvement Expert (QIE) Services**	**Contracted tasks listed in Appendix A-1 has mutually agreed to by the parties.**	**100% of tasks mutually agreed to by the parties completed.**

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Appendix A-1
Services To Be Performed by Contractor
Laguna Honda Quality Improvement Expert (QIE) Services

Laguna Honda Hospital & Rehabilitation Center (LHH) requests Health Services Advisory Group (HSAG) to provide a root cause analysis (RCA), as specified below:

> *RCA to determine the factors that have precluded LHH from achieving and maintaining substantial compliance with federal participation requirements at 42 C.F.R. Part 483, Subpart B and to ensure long-term substantial compliance in the future. As part of the Root Cause Analysis, identifying and defining problems; investigate and collect supporting information; and analyze and identify the root causes of each identified problem, including the findings from the multiple surveys/revisits since October 14, 2021.*

SCOPE

1. RCA and RCA Report

The scope of activities will include HSAG performing an RCA consistent with the RCA Methodology (discussed below). The RCA will result in a report (RCA Report) providing RCA results and findings for the identified survey citations identified since October 14, 2021 (see Attachment 1). There are 21 identified citations that has been provided to HSAG by LHH (Attachment 1).

2. Action Plan

HSAG will assist LHH in developing and implementing an action plan (Action Plan) that will include recommendations for changes and improvements necessary for LHH to achieve and maintain compliance with applicable federal participation requirements. HSAG will assist LHH in establishing a timeline of activities, including a detailed list of milestones and completion dates for each corrective action. HSAG will assist LHH in incorporating the results of the RCA and Action Plan, as well as any revisions of the RCA and Action Plan as the result of additional deficiencies (addressed below) into LHH's Facility Assessment to meet the requirements of 42 C.F.R. § 483.70(e).

3. Additional Deficiencies

CMS and/or CDPH may identify additional deficiencies during the monitoring surveys required by its settlement agreement with LHH. While not required by the settlement agreement, LHH will also use its internal Quality Assurance & Performance Improvement (QAPI) processes to self-identify additional deficiencies. The QIE will (1) perform an RCA on any additional deficiencies (identified by CMS, CDPH, or LHH), (2) update the RCA report, and (3) update the Action Plan to address the additional deficiencies. LHH will use its QAPI processes to make improvements in response to these additional deficiencies.

4. Ongoing Reporting

After CMS approves the Action Plan, HSAG will provide a written monthly report (Compliance Report) to CMS, CDPH, and LHH by the 10th calendar day of each month. The Compliance Report will include, but is not limited to, the following information related to the Action Plan:

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i. Dates and times of the visits by HSAG at LHH;
ii. Summary of observations made during the visits;
iii. Summary of any interviews conducted and with whom;
iv. Summary of any records reviewed;
v. Any quality of care concerns identified;
vi. Any complaints related to quality of care received and reviewed by HSAG;
vii. Number and description of complaints related to quality of care received by LHH from any source;
viii. Number and description of incidents reported to CDPH;
ix. Summary of additional CMS/CDPH deficiencies, including deficiencies self-identified by LHH's QAPI process
x. Assessment of LHH in meeting established goals outlined in the Action Plan;
xi. Obstacles on each item of LHH's Action Plan and proposed solutions to those barriers; and
xii. Summary of any proposed or enacted transfers and discharges.

CMS may request a follow-on meeting or call with HSAG and such discussions will be confidential between CMS and HSAG. Following such discussions, HSAG will disclose to LHH any concerns or challenges identified and disclosed to CMS, but HSAG will not disclose the statements made during the confidential discussion unless allowed by CMS.

5. Presentation to CMS

Following submission of the RCA Report, HSAG will assist LHH in developing a deliverable to CMS demonstrating LHH's progress on implementing the Action Plan and applying for recertification in the Medicare and Medicaid programs.

STAFFING

HSAG will designate the following individuals to lead the RCA deliverables and serve as the Quality Improvement Expert (QIE) for LHH:

- Barb Averyt, MHA, Senior Executive Director, Health Services Advisory Group
- Keith Chartier, DrPH, MPH, Executive Director, Health Services Advisory Group
- Kathy McCanna, RN, BSN, Regulatory and Health Care Survey/Licensing Consultant

This core team has subject-matter expertise in the RCA process, skilled nursing facility (SNF) operations, and federal SNF regulations. CMS has also approved the core team to serves as LHH's QIE. Additional HSAG staff will provide focused support for the RCA activities given their clinical expertise. HSAG will also provide services to LHH related to preparing the facility for certification readiness under a separate scope of work between HSAG and LHH.

TIMELINE

It is understood that the completion of the RCA activities, RCA Report and the Action Plan shall occur by December 1, 2022 (for the RCA Report) and January 6, 2023 (for the Action Plan). To achieve this, HSAG recommends the following cadence:

- **09/21/22:** HSAG initiates RCA deliverable activities.
- **12/01/22:** HSAG provides initial RCA Report for CMS review and comment.
- **12/11/22:** CMS approves or provides RCA Report feedback to HSAG. If CMS does not provide feedback by 12/11/22, the RCA Report is deemed approved.
- **01/06/23:** LHH and HSAG provide CMS/CDPH the Action Plan.

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- **01/17/23:** CMS approves Action Plan or provides Action Plan feedback to LHH/HSAG. If CMS does not provide feedback by 1/17/23, the Action Plan is deemed approved.
- **Ongoing for duration of settlement agreement:** HSAG provides written monthly compliance reports to CMS.
- **11/13/23:** Proposed end date of services

HSAG will assist LHH in implementing the Action Plan, after the completion of the RCA Report deliverable by May 13, 2023.

RCA METHODOLOGY

Root-cause analysis (RCA) is a quality-improvement tactic used to describe systematic processes to get to the underlying cause of a problem (CMS, n.d.). Corrective actions tied to RCA findings are vital in sustaining systems-based improvement (National Patient Safety Forum, 2016). A sustained RCA process also creates a culture of accountability and a culture in which individual staff speak up to support overall improvement. Therefore, HSAG will apply the Root Cause Analysis and Action (RCA^2) methodology to its RCA of LHH's past regulatory non-compliance (NPSA, 2016). RCA^2 identifies system vulnerabilities so they can be eliminated or mitigated. This method was developed by a wide-ranging panel of experts with the National Patient Safety Forum and is endorsed by a wide range of healthcare organizations, including the Institute for Healthcare Improvement, the Joint Commission, and the National Association for Healthcare Quality.

The RCA Process for the Initial RCA Report

The RCA process will follow three primary steps: (1) fact-finding, (2) development of causal statements, and (3) identification of solutions and corrective actions (NPSA, 2016). HSAG will apply its RCA methodology to the 21 survey citations LHH received since October 14, 2021, through decertification.

RCA Initial Fact Finding

The initial fact-finding will be used to identify what happened and why it happened. During this phase, HSAG will review CMS Form-2567 reports, mock survey findings, and the federal regulations regarding the 21 citations. HSAG will also review submitted plans of corrections and subsequent results to create a baseline of knowledge. This will be followed by HSAG consultant meetings to review their firsthand knowledge about each citation and their observations from their consultative work. This will conclude with a set of team-generated questions, which will be answered though interviews, internal document review (*e.g.*, policies and procedures, electronic medical records), and any pertinent external documents that can provide additional insight.

RCA Causal Statements

HSAG will develop a series of causal statements after identifying system vulnerabilities for each of the 21 survey citations. These causal statements will be written to describe (1) cause, (2) effect, and (3) the event/citation (NPSA, 2016). These statements will help connect the identified RCA systemic vulnerabilities with the potential corrective actions.

The following is an example of a causal statement: "A high volume of activity and noise in the emergency department led to (cause) the resident being distracted when entering medication orders (effect) which increased the likelihood that the wrong dose would be ordered (event) (NPSA, 2016)."

RCA Solutions and Corrective Actions

Lastly, HSAG will identify solutions and corrective actions that can be implemented to eliminate or control systemic vulnerabilities identified by the RCA causal statements. HSAG will use the Action Hierarchy developed by the U.S. Department of Veterans Affairs Center for Patient Safety to categorize actions as stronger,

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intermediate, and weaker (IHI, 2022). Stronger actions require less reliance on people to remember how to perform tasks and may include physical plant changes, simplified processes, and tangible leadership involvement. Weaker actions require people to remember how to correctly perform tasks, and may include double checks, warnings, and trainings. Intermediate actions may include addressing staffing issues, simulation-based training, checklists, and enhanced documentation. HSAG will follow the National Patient Safety Forum recommendation to identify at least one stronger or intermediate strength action for each RCA item (NPSA, 2016).

The Ongoing RCA Process During the Action Plan Phase

After submitting its initial RCA findings, the QIE will assist LHH in developing and implementing an Action Plan that will include recommendations for changes and improvements necessary for LHH to achieve and maintain compliance with applicable federal participation requirements. During this Action Plan phase, CMS and/or CDPH may identify additional deficiencies under its agreement with LHH. LHH will also self-identify additional deficiencies through its QAPI Program. The QIE will (1) perform an RCA on any additional deficiencies using the aforementioned RCA methodology, including fact-finding and developing causal statements, (2) update the RCA report, and (3) update the Action Plan to address the additional deficiencies. LHH will then use its QAPI processes to make improvements in response to these additional deficiencies.

References

Centers for Medicare & Medicaid Services. (n.d.). QAPI at a glance: A step by step guide to implementing quality assurance and performance improvement (QAPI) in your nursing home. https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiataglance.pdf

Institute for Healthcare Improvement. (2022). Action hierarchy (part of RCA2). https://www.ihi.org/resources/_layouts/download.aspx?SourceURL=%2fresources%2fKnowledge+Center+Assets%2fTools+-+PatientSafetyEssentialsToolkit_71ec4acf-a9cc-4a59-8fab-7ef9d0237471%2fSafetyToolkit_ActionHierarchy.pdf

Institute for Healthcare Improvement. (2022). Quality Improvement Essentials Toolkit. https://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx?utm_campaign=QI-Toolkit-Promotion&utm_medium=Whiteboard-Video&utm_source=ihi

National Patient Safety Forum. (2016). RCA^2: Improving root cause analysis and actions to prevent harm. https://www.ashp.org/-/media/assets/policy-guidelines/docs/endorsed-documents/endorsed-documents-improving-root-cause-analyses-actions-prevent-harm.ashx

RATES FOR SERVICES

The hourly rate for staff will continue as per the current amendment terms wherein Keith Chartier is paid at the Assistant Nursing Home Administrator (AHNA) rate, Barb Averyt is at a Quality Improvement Specialist rate, and Kathy McCanna is at the Discharge/Transfer Coach rate.

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Attachment 1

Citation List for Root Cause Analysis

1. The adequacy and competency of LHH staffing and the provision of quality of care and quality of life for LHH's residents in compliance with 42 C.F.R. § 483.35(a)(3)(4)(c) (F726).

2. Training of all LHH staff regarding the identification of contraband and the systems in place to ensure resident safety with regards to contraband in compliance with 42 C.F.R. § 483.35(a)(3)(4)(c) (F726).

3. Ensuring that all LHH residents receive appropriate and sufficient supervision, as specified in the State Operations Manual, and that LHH implements appropriate interventions to keep LHH residents safe from accidental hazards, including illegal drug use, illegal drug possession, and other contraband possession in compliance with 42 C.F.R. § 483.25(d)(1)(2) (F689). Such interventions must include both facility-wide interventions and appropriate, individualized interventions for each affected resident. To address compliance with this regulation, LHH should review and implement improvements consistent with CMS's guidance to the state survey agencies set forth in the Advanced Copy of Appendix PP of the State Operations Manual ("SOM") expected to be published on October 24, 2022 related to the prevention of accidents for individuals with substance use disorders. If the SOM is further revised or modified at any time during the term of this Agreement, LHH agrees and understands that the most recent revised or modified version is CMS's current guidance to the state survey agencies. To the extent there is any conflict between the SOM and 42 C.F.R. § 483.25(d)(1)(2), LHH acknowledges and agrees that the regulation prevails as the instructive term for this Agreement.

4. Ensuring that each resident is free from abuse, neglect, misappropriation of resident property, and exploitation in compliance with 42 C.F.R. § 483.12(a)(1) (F600).

5. Ensuring that residents only self-administer medications if the interdisciplinary team determines the practice is clinically appropriate in compliance with 42 C.F.R. § 483.10(c)(7) (F554).

6. Developing comprehensive care plans and completing comprehensive assessments of all residents in compliance with 42 C.F.R. § 483.21(b)(2)(i)-(iii) (F657) and ensuring that all care plans meet professional standards of quality in compliance with 42 C.F.R. § 483.21(b)(3)(i) (F658).

7. Ensuring that residents admitted to LHH with limited ranges of motion receive appropriate treatment and services to increase their range of motion or prevent further decrease in their range of motion in compliance with 42 C.F.R. § 483.25(c)(1)-(3) (F688).

8. Ensuring that residents who need respiratory care are provided such care consistent with professional standards of practice, a comprehensive person-centered care plan, and the residents' goals and preferences in compliance with 42 C.F.R. § 483.25(i) (F695).

9. Ensuring that pain management is provided to residents who require those services consistent with the professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences in compliance in compliance with 42 C.F.R. § 483.25(k) (F697).

10. Labeling drugs and biologicals used in the facility in accordance with currently accepted professional principles, including appropriate accessory and cautionary instructions, and the expiration date when applicable in compliance with 42 C.F.R. § 483.45(g)(h)(1)(2) (F761).

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11. Establishing and maintaining an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections in compliance with 42 C.F.R. § 483.80(a)(1)(2)(4)(e)(f) (F880).

12. Ensuring that residents are provided the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility in compliance with 42 C.F.R. § 483.10(a)(1)(2)(b)(1)(2) (F550).

13. Ensuring that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care in compliance with 42 C.F.R. § 483.24 (F675).

14. Ensuring that each resident receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices in compliance with 42 C.F.R. § 483.25 (F684).

15. Providing routine and emergency drugs and biologicals to residents, or obtaining them under an agreement, and ensuring that pharmaceutical services are provided to each resident that meets their individual needs in compliance with 42 C.F.R. § 483.45 (F755).

16. Ensuring that, based on a comprehensive assessment, residents who use psychotropic drugs receive gradual dose reductions, and behavior interventions, unless clinically contraindicated, in an effort to discontinue these drugs in compliance with 42 C.F.R. § 483.45(e)(2) (F756).

17. Developing, implementing, and maintaining an effective, comprehensive, data-driven quality assurance performance improvement program that focuses on indicators of the outcomes of care and quality of life and that is accountable to the governing body in compliance with 42 C.F.R. § 483.75 (F865).

18. Ensuring that the facility is designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public and in compliance with 42 C.F.R. § 483.90.

19. Complying with all applicable Federal, State, and local emergency preparedness requirements, and establishing and maintaining an emergency preparedness program in compliance with 42 C.F.R. § 483.73.

20. Ensuring that each resident receives the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, including but not limited to providing prevention and treatment for mental and substance use disorders in compliance with 42 C.F.R. § 483.40 (F740).

21. Ensuring each resident is provided nourishing, palatable, and well-balanced diet that meets the individual's daily nutritional and special dietary needs, taking into consideration the preferences of each resident in compliance with 42 C.F.R. § 483.60 (F800).

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Appendix B
Calculation of Charges

1. Method of Payment

A. Contractor shall submit monthly invoices by the fifteenth (15th) working day of each month, in the format attached in Appendix F, based upon the number of units of service that were delivered in the immediately preceding month. All deliverables associated with the Services listed in Section 2 of Appendix A, times the unit rate as shown in the Program Budgets listed in Section 2 of Appendix B shall be reported on the invoice(s) each month

2. Program Budgets and Final Invoice

A. Program Budgets are listed below and are attached hereto.

Appendix B-1: Laguna Honda Quality Improvement Expert (QIE) Services

B. Contractor understands that, of the maximum dollar obligation listed in section 3.3.1 of this Agreement, **$244,100** is included as a contingency amount and is neither to be used in Program Budgets attached to this Appendix, or available to Contractor without a modification to this Agreement as specified in Section 3.7 Contract Amendments; Budgeting Revisions. Contractor further understands that no payment of any portion of this contingency amount will be made unless and until such modification or budget revision has been fully approved and executed in accordance with applicable City and Department of Public Health laws, regulations and policies/procedures and certification as to the availability of funds by Controller. Contractor agrees to fully comply with these laws, regulations, and policies/procedures.

D. A final closing invoice, clearly marked "FINAL," shall be submitted no later than forty-five (45) calendar days following the closing date of the Agreement, and shall include only those Services rendered during the referenced period of performance. If Services are not invoiced during this period, all unexpended funding set aside for this Agreement will revert to City. City's final reimbursement to the Contractor at the close of the Agreement period shall be adjusted to conform to actual units certified multiplied by the unit rates identified in the Program Budgets attached hereto, and shall not exceed the total amount authorized and certified for this Agreement.

3. No invoices for Services provided by law firms or attorneys, including, without limitation, as subcontractors of Contractor, will be paid unless the provider received advance written approval from the City Attorney.

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Appendix B-1
Calculation of Charges - Budget
Laguna Honda Quality Improvement Expert (QIE) Services

Staff Resources

Root Cause Analysis & Action Plan Development (11/8/2022 - 12/31/2023)	**Estimated Hours**	**Hourly Rate**	**Budgeted Amount**
QIE Subject Matter Experts	1,560	$ 420.00	$ 655,200.00
Compliance Monitoring (11/8/2022 - 12/31/2023)			
QIE Subject Matter Experts	3,120	$ 420.00	$ 1,310,400.00
Infection Preventionist		$ 341.00	$ -
Quality Improvement Specialist		$ 341.00	$ -
Senior Data Scientist		$ 289.00	$ -
Data Coordinator	520	$ 167.00	$ 86,840.00
Project Coordinator	520	$ 167.00	$ 86,840.00
		Subtotal of Services	**$ 2,139,280.00**
Travel (Hotel, Airfare, Transportation, and Per Diem)			$ 233,625.00
General and Administrative (29.15% of Travel)			$ 68,102.00
		Project Subtotal	**$ 2,441,007.00**
		Contingency (10% of Project Subtotal)	**$ 244,100.00**
		Total Not To Exceed Amount:	**$ 2,685,107.00**

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Appendix C

Reserved

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APPENDIX D

Data Access Agreement

Article 1 Access

1.1 Revision to Scope of Access (RSA):

Any added access may be granted by the City to Agency and each Agency Data User through a Revision to Scope of Access in writing and executed by both parties. Any Revision to Scope of Access shall be considered a part of and incorporated into this Agreement, governed by all its terms, by reference.

1.2 Primary and Alternate Agency Site Administrator.

Before System(s) access is granted, Agency must appoint a primary and alternate Agency Site Administrator responsible for System(s) access tasks, including but not limited to the following:

1.2.1 Completing and obtaining City approval of the Account Provisioning Request documents and/or Data Set Request documents;

1.2.2 Communicating with the SFDPH IT Service Desk;

1.2.3 Providing Agency Data User(s) details to the City;

1.2.4 Ensuring that Agency Data User(s) complete required SFDPH trainings annually;

1.2.5 Ensuring that Agency Data User(s) understand and execute SFDPH's data access confidentiality agreement; and

1.2.6 Provisioning and deprovisioning Agency Data Users as detailed herein. To start the process, the Agency Site Administrator must contact the SFDPH IT Service Desk at 628-206-7378, dph.helpdesk@sfdph.org.

1.3 SFDPH IT Service Desk.

For new provisioning requests, only Agency Site Administrators are authorized to contact the SFDPH IT Service Desk. The City reserves the right to decline any call placed by other than the Agency Site Administrator. Individual Agency Data Users are not authorized to contact the SFDPH IT Service Desk.

1.4 Deprovisioning Schedule.

Agency, through the Agency Site Administrator, has sole responsibility to deprovision Agency Data Users from the System(s) as appropriate on an ongoing basis. Agency must immediately deprovision an Agency Data User upon any event ending that Data User's need to access the System(s), including job duty change and/or termination. Agency remains liable for the conduct of Agency Data Users until deprovisioned. When deprovisioning employees via the SFDPH IT Service Desk, Agency must maintain evidence that the SFDPH IT Service Desk was notified.

1.5 Active Directory.

Agency Data Users will need an SFDPH Active Directory account in order to access each System(s). These Active Directory Accounts will be created as part of the provisioning process.

1.6 Role Based Access.

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Each Agency Data User's access to the System(s) will be role-based and access is limited to that necessary for treatment, payment, and health care operations. The City will assign Agency Data User roles upon provisioning and reserves the right to deny, revoke, limit, or modify Agency Data User's access acting in its sole discretion.

1.7 **Training Requirements.**

Before System(s) access is granted, and annually thereafter, each Agency Data User must complete SFDPH compliance, privacy, and security training. Agency must maintain written records evidencing such annual training for each Agency Data User and provide copies upon request to the City. For questions about how to complete SFDPH's compliance, privacy, and security training, contact Compliance.Privacy@sfdph.org, (855) 729-6040.

Before Agency Data User first access to System(s), system-specific training must be completed. For training information, Agency Site Administrator may contact the SFDPH IT Service Desk,

1.8 **Agency Data User Confidentiality Agreement.**

Before System(s) access is granted, as part of SFDPH's compliance, privacy, and security training, each Agency Data User must complete SFDPH's individual user confidentiality, data security and electronic signature agreement form. The agreement must be renewed annually.

1.9 **Corrective Action.**

Agency shall take corrective action, including but not limited to termination and/or suspension of any System(s) access by any Agency Data User who acts in violation of this Agreement and/or applicable regulatory requirements.

1.10 **User ID and Password.**

Each Agency Data User will be assigned or create a User ID and password. Agency and each Agency Data User shall protect the confidentiality of User IDs and passwords and shall not divulge them to any other person(s). Agency is responsible for the security of the User IDs and passwords issued to or created by Agency Data Users and is liable for any misuse.

1.11 **Notification of Compromised Password.**

In the event that a password assigned to or created by an Agency Data User is compromised or disclosed to a person other than the Agency Data User, Agency shall upon learning of the compromised password immediately notify the City, at Compliance.Privacy@sfdph.org, (855) 729-6040. Agency is liable for any such misuse. Agency's failure to monitor each Agency Data User's ID and/or password use shall provide grounds for the City to terminate and/or limit Agency's System(s) access.

1.12 **Multi Factor Authentication.**

Agency and each Agency Data User must use multi-factor authentication as directed by the City to access the System(s).

1.13 **Qualified Personnel.**

Agency shall allow only qualified personnel under Agency's direct supervision to act as Agency Data Users with access to the System(s).

1.14 **Workstation/Laptop encryption.**

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All workstations and laptops that process and/or store City Data must be encrypted using a current industry standard algorithm. The encryption solution must be full disk unless approved by the SFDPH Information Security Office.

1.15 **Server Security.**

Servers containing unencrypted City Data must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

1.16 **Removable media devices.**

All electronic files that contain City Data must be encrypted using a current industry standard algorithm when stored on any removable media or portable device (i.e. USB thumb drives, CD/DVD, smart devices tapes etc.).

1.17 **Antivirus software.**

All workstations, laptops and other systems that process and/or store City Data must install and actively use a comprehensive anti-virus software solution with automatic updates scheduled at least daily.

1.18 **Patch Management.**

All workstations, laptops and other systems that process and/or store City Data must have operating system and application security patches applied, with system reboot if necessary. There must be a documented patch management process that determines installation timeframe based on risk assessment and vendor recommendations.

1.19 **System Timeout.**

The system must provide an automatic timeout, requiring reauthentication of the user session after no more than 20 minutes of inactivity.

1.20 **Warning Banners.**

All systems containing City Data must display a warning banner each time a user attempts access, stating that data is confidential, systems are logged, and system use is for business purposes only. User must be directed to log off the system if they do not agree with these requirements.

1.21 **Transmission encryption.**

All data transmissions of City Data outside the Agency's secure internal network must be encrypted using a current industry standard algorithm. Encryption can be end to end at the network level, or the data files containing City Data can be encrypted. This requirement pertains to any type of City Data in motion such as website access, file transfer, and e-mail.

1.22 **No Faxing/Mailing.**

City Data may not be faxed or mailed.

1.23 **Intrusion Detection.**

All systems involved in accessing, holding, transporting, and protecting City Data that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

of the City.

1.24 **Security of PHI.**

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Agency is solely responsible for maintaining data security policies and procedures, consistent with those of the City that will adequately safeguard the City Data and the System. Upon request, Agency will provide such security policies and procedures to the City. The City may examine annually, or in response to a security or privacy incident, Agency's facilities, computers, privacy and security policies and procedures and related records as may be necessary to be assured that Agency is in compliance with the terms of this Agreement, and as applicable HIPAA, the HITECH Act, and other federal and state privacy and security laws and regulations. Such examination will occur at a mutually acceptable time agreed upon by the parties but no later than ten (10) business days of Agency's receipt of the request.

1.25 **Data Security and City Data**

Agency shall provide security for its networks and all internet connections consistent with industry best practices, and will promptly install all patches, fixes, upgrades, updates and new versions of any security software it employs. For information disclosed in electronic form, Agency agrees that appropriate safeguards include electronic barriers (e.g., "firewalls", Transport Layer Security (TLS), Secure Socket Layer [SSL] encryption, or most current industry standard encryption, intrusion prevention/detection or similar barriers).

1.26 **Data Privacy and Information Security Program.**

Without limiting Agency's obligation of confidentiality as further described herein, Agency shall be responsible for establishing and maintaining a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to: (i) ensure the security and confidentiality of the City Data; (ii) protect against any anticipated threats or hazards to the security or integrity of the City Data; (iii) protect against unauthorized disclosure, access to, or use of the City Data; (iv) ensure the proper disposal of City Data; and, (v) ensure that all of Agency's employees, agents, and subcontractors, if any, comply with all of the foregoing. In no case shall the safeguards of Agency's data privacy and information security program be less stringent than the safeguards and standards recommended by the National Institute of Standards and Technology (NIST) Cybersecurity Framework and the Health Information Technology for Economic and Clinical Health Act (HITECH).

1.27 **Disaster Recovery.**

Agency must establish a documented plan to protect the security of electronic City Data in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this agreement for more than 24 hours.

1.28 **Supervision of Data.**

City Data in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an Agency Data User authorized to access the information. City Data in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

1.29 **As Is Access.**

The City provides Agency and each Agency Data User with System(s) access on an "as is" basis with no guarantee as to uptime, accessibility, or usefulness. To the fullest extent permissible by applicable law, the City disclaims all warranties, express or implied, including, without limitation, implied warranties of merchantability, fitness for a particular purpose, title and non-infringement.

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1.30 **No Technical or Administrative Support.**

Except as provided herein, the City will provide no technical or administrative support to Agency or Agency Data Users for System(s) access.

1.31 **City Audit of Agency and Agency Data Users.**

The City acting in its sole discretion may audit Agency and Agency Data Users at any time. If an audit reveals an irregularity or security issue, the City may take corrective action including but not limited to termination of such Agency's and/or Agency Data User's access to the System(s) permanently or until the City determines that all irregularities have been satisfactorily cured. Agency and each Agency Data User understands that the City may create and review an audit trail for each Agency Data User, including but not limited to, noting each Agency Data User's ID(s), the patient information accessed, and/or the date accessed. Agency and each Agency Data User understands that any inappropriate access or use of patient information, as determined by the City, may result in the temporary and/or permanent termination of Agency's or such Agency Data User's access to the System(s). Agency remains liable for all inappropriate System(s) access, misuse and/or breach of patient information, whether in electronic or hard-copy form.

1.32 **Minimum Necessary.**

Agency and each Agency Data User shall safeguard the confidentiality of all City Data that is viewed or obtained through the System(s) at all times. Agency and each Agency Data User shall access patient information in the System(s) only to the minimum extent necessary for its assigned duties and shall only disclose such information to persons authorized to receive it, as minimally necessary for treatment, payment and health care operations.

1.33 **No Re-Disclosure or Reporting.**

Agency may not in any way re-disclose SFDPH Data or otherwise prepare reports, summaries, or any other material (in electronic or hard-copy format) regarding or containing City Data for transmission to any other requesting individuals, agencies, or organizations without prior written City approval and where such re-disclosure is otherwise permitted or required by law.

1.34 **Health Information Exchange.**

If Agency is qualified to enroll in a health information exchange, the City encourages Agency to do so in order to facilitate the secure exchange of data between Agency's electronic health record system (EHR) and the City's Epic EHR.

1.35 **Subcontracting.**

Agency may not subcontract any portion of Data Access Agreement, except upon prior written approval of City. If the City approves a subcontract, Agency remains fully responsible for its subcontractor(s) throughout the term and/or after expiration of this Agreement. All Subcontracts must incorporate the terms of this Data Access Agreement. To the extent that any subcontractor would have access to a System, each such subcontractor's access must be limited and subject to the same governing terms to the same extent as Agency's access. In addition, each contract between Agency and that subcontractor must, except as the City otherwise agrees, include a Business Associate Agreement requiring such subcontractor to comply with all regulatory requirements regarding third-party access, and include a provision obligating that subcontractor to (1) defend, indemnify, and hold the City harmless in the event of a data

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breach in the same manner in which Agency would be so obligated, (2) provide cyber and technology errors and omissions insurance with limits identified in Article 5, and (3) ensure that such data has been destroyed, returned, and/or protected as provided by HIPAA at the expiration of the subcontract term.

Article 2 Proprietary Rights and Data Breach

2.1 Ownership of City Data.

The Parties agree that as between them, all rights, including all intellectual property rights in and to the City Data and any derivative works of the City Data shall remain the exclusive property of the City.

2.2 Data Breach; Loss of City Data.

The Agency shall notify City immediately by telephone call plus email upon the discovery of a breach (as herein). For purposes of this Section, breaches and security incidents shall be treated as discovered by Agency as of the first day on which such breach or security incident is known to the Agency, or, by exercising reasonable diligence would have been known to the Agency. Agency shall be deemed to have knowledge of a breach if such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee or agent of the Agency.

Agency shall take:

i. prompt corrective action to mitigate any risks or damages involved with the breach or security incident and to protect the operating environment; and

ii. any action pertaining to a breach required by applicable federal and state laws.

2.2.1 **Investigation of Breach and Security Incidents**: The Agency shall immediately investigate such breach or security incident. As soon as the information is known and shall inform the City of:

i. what data elements were involved, and the extent of the data disclosure or access involved in the breach, including, specifically, the number of individuals whose personal information was breached; and

ii. a description of the unauthorized persons known or reasonably believed to have improperly used the City Data and/or a description of the unauthorized persons known or reasonably believed to have improperly accessed or acquired the City Data, or to whom it is known or reasonably believed to have had the City Data improperly disclosed to them; and

iii. a description of where the City Data is believed to have been improperly used or disclosed; and

iv. a description of the probable and proximate causes of the breach or security incident; and

v. whether any federal or state laws requiring individual notifications of breaches have been triggered.

2.2.2 **Written Report**: Agency shall provide a written report of the investigation to the City as soon as practicable after the discovery of the breach or security incident. The report shall include, but not be limited to, the information specified above, as well as a complete, detailed corrective action plan, including information on measures that were taken to halt and/or contain the breach or security

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incident, and measures to be taken to prevent the recurrence or further disclosure of data regarding such breach or security incident.

2.2.3 **Notification to Individuals**: If notification to individuals whose information was breached is required under state or federal law, and regardless of whether Agency is considered only a custodian and/or non-owner of the City Data, Agency shall, at its sole expense, and at the sole election of City, either:

i. make notification to the individuals affected by the breach (including substitute notification), pursuant to the content and timeliness provisions of such applicable state or federal breach notice laws. Agency shall inform the City of the time, manner and content of any such notifications, prior to the transmission of such notifications to the individuals; or

ii. cooperate with and assist City in its notification (including substitute notification) to the individuals affected by the breach.

2.2.4 **Sample Notification to Individuals**: If notification to individuals is required, and regardless of whether Agency is considered only a custodian and/or non-owner of the City Data, Agency shall, at its sole expense, and at the sole election of City, either:

i. electronically submit a single sample copy of the security breach notification as required to the state or federal entity and inform the City of the time, manner and content of any such submissions, prior to the transmission of such submissions to the Attorney General; or

ii. cooperate with and assist City in its submission of a sample copy of the notification to the Attorney General.

2.3 **Media Communications**

City shall conduct all media communications related to such Data Breach, unless in its sole discretion, City directs Agency to do so.

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Attachment 1 to Appendix D
System Specific Requirements

I. For Access to SFDPH Epic through Care Link the following terms shall apply:

A. SFDPH Care Link Requirements:

1. Connectivity.

a) Agency must obtain and maintain connectivity and network configuration and required hardware and equipment in accordance with specifications provided by Epic and must update the configuration of all first and third-party software as required. Technical equipment and software specifications for accessing SFDPH Care Link will change over time. Current required browser, system and connection requirements can be found on the Target Platform Roadmap and Target Platform Notes sections of the Epic Galaxy website galaxy.epic.com. Agency is responsible for all associated costs. Agency shall ensure that Agency Data Users access the System only through equipment owned or leased and maintained by Agency.

2. Compliance with Epic Terms and Conditions.

a) Agency will at all times access and use the System strictly in accordance with the Epic Terms and Conditions. The following Epic Care Link Terms and Conditions are embedded within the SFDPH Care Link application, and each Data User will need to agree to them electronically upon first sign-in before accessing SFDPH Care Link:

3. Epic-Provided Terms and Conditions

a) Some short, basic rules apply to you when you use your EpicCare Link account. Please read them carefully. The Epic customer providing you access to EpicCare Link may require you to accept additional terms, but these are the rules that apply between you and Epic.

b) Epic is providing you access to EpicCare Link, so that you can do useful things with data from an Epic customer's system. This includes using the information accessed through your account to help facilitate care to patients shared with an Epic customer, tracking your referral data, or otherwise using your account to further your business interests in connection with data from an Epic customer's system. However, you are not permitted to use your access to EpicCare Link to help you or another organization develop software that is similar to EpicCare Link. Additionally, you agree not to share your account information with anyone outside of your organization.

II. For Access to SFDPH Epic through Epic Hyperspace and Epic Hyperdrive the following terms shall apply:

A. SFDPH Epic Hyperspace and Epic Hyperdrive:

1. Connectivity.

a) Agency must obtain and maintain connectivity and network configuration and required hardware and equipment in accordance with specifications provided by Epic and SFDPH and must update the configuration of all first and third-party software as required. Technical equipment and software specifications for accessing SFDPH Epic Hyperspace will change over time. Epic Hyperdrive is a web-based platform that will replace Epic Hyperspace in the future. You may request a copy of current required browser, system and connection requirements from the SFDPH IT team. Agency is responsible for all

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associated costs. Agency shall ensure that Agency Data Users access the System only through equipment owned or leased and maintained by Agency.

2. Application For Access and Compliance with Epic Terms and Conditions.

a) Prior to entering into agreement with SFDPH to access SFDPH Epic Hyperspace or Epic Hyperdrive, Agency must first complete an Application For Access with Epic Systems Corporation of Verona, WI. The Application For Access is found at: https://userweb.epic.com/Forms/AccessApplication. Epic Systems Corporation must notify SFDPH, in writing, of Agency's permissions to access SFDPH Epic Hyperspace or Epic Hyperdrive prior to completing this agreement. Agency will at all times access and use the system strictly in accordance with the Epic Terms and Conditions.

III. For Access to SFDPH myAvatar through WebConnect and VDI the following terms shall apply:

A. SFDPH myAvatar via WebConnect and VDI:

1. Connectivity.

a. Agency must obtain and maintain connectivity and network configuration and required hardware and equipment in accordance with specifications provided by SFDPH and must update the configuration of all first and third-party software as required. Technical equipment and software specifications for accessing SFDPH myAvatar will change over time. You may request a copy of current required browser, system and connection requirements from the SFDPH IT team. Agency is responsible for all associated costs. Agency shall ensure that Agency Data Users access the System only through equipment owned or leased and maintained by Agency.

2. Information Technology (IT) Support.

a. Agency must have qualified and professional IT support who will participate in quarterly CBO Technical Workgroups.

3. Access Control.

a. Access to the BHS Electronic Heath Record is granted based on clinical and business requirements in accordance with the Behavioral Health Services EHR Access Control Policy (6.00-06). The Access Control Policy is found at: https://www.sfdph.org/dph/files/CBHSPolProcMnl/6.00-06.pdf

b. Each user is unique and agrees not to share accounts or passwords.

c. Applicants must complete the myAvatar Account Request Form found at https://www.sfdph.org/dph/files/CBHSdocs/BHISdocs/UserDoc/Avatar_Account_Request_Form.pdf

d. Applicants must complete the credentialling process in accordance with the DHCS MHSUDS Information Notice #18-019.

e. Applicants must complete myAvatar Training.

f. Level of access is based on "Need to Know", job duties and responsibilities.

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Attachment 2 to Appendix D

Protected Information Destruction Order
Purge Certification - Contract ID # 1000027817

In accordance with section 3.c (Effect of Termination) of the Business Associate Agreement, attached as Appendix E to the Agreement between the City and Contractor dated 12/6/2022 ("Agreement"), the City hereby directs Contractor to destroy all Protected Information that Contractor and its agents and subcontractors (collectively "Contractor") still maintain in any form. Contractor may retain no copies of destroyed Protected Information." Destruction must be in accordance with the guidance of the Secretary of the U.S. Department of Health and Human Services ("Secretary") regarding proper destruction of PHI.

Electronic Data: Per the Secretary's guidance, the City will accept destruction of electronic Protected Information in accordance with the standards enumerated in the NIST SP 800-88, Guidelines for Data Sanitization ("NIST").

Hard-Copy Data: Per the Secretary's guidance, the City will accept destruction of Protected Information contained in paper records by shredding, burning, pulping, or pulverizing the records so that the Protected Information is rendered unreadable, indecipherable, and otherwise cannot be reconstructed.

****

Contractor hereby certifies that Contractor has destroyed all Protected Information as directed by the City in accordance with the guidance of the Secretary of the U.S. Department of Health and Human Services ("Secretary") regarding proper destruction of PHI.

So Certified

_____
Signature

Title: _____

Date: _____

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APPENDIX E

San Francisco Department of Public Health

Business Associate Agreement

This Business Associate Agreement ("BAA") supplements and is made a part of the contract by and between the City and County of San Francisco, the Covered Entity ("CE"), and Contractor, the Business Associate ("BA") (the "Agreement"). To the extent that the terms of the Agreement are inconsistent with the terms of this BAA, the terms of this BAA shall control.

RECITALS

A. CE, by and through the San Francisco Department of Public Health ("SFDPH"), wishes to disclose certain information to BA pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("PHI") (defined below).

B. For purposes of the Agreement, CE requires Contractor, even if Contractor is also a covered entity under HIPAA, to comply with the terms and conditions of this BAA as a BA of CE.

C. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws, including, but not limited to, California Civil Code §§ 56, et seq., California Health and Safety Code § 1280.15, California Civil Code §§ 1798, et seq., California Welfare & Institutions Code §§5328, et seq., and the regulations promulgated there under (the "California Regulations").

D. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(a) and (e) and 164.504(e) of the Code of Federal Regulations ("C.F.R.") and contained in this BAA.

E. BA enters into agreements with CE that require the CE to disclose certain identifiable health information to BA. The parties desire to enter into this BAA to permit BA to have access to such information and comply with the BA requirements of HIPAA, the HITECH Act, and the corresponding Regulations.

In consideration of the mutual promises below and the exchange of information pursuant to this BAA, the parties agree as follows:

1. **Definitions.**

a. Breach means the unauthorized acquisition, access, use, or disclosure of PHI that compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information, and shall have the meaning given to such term under the HITECH Act and HIPAA Regulations [42 U.S.C. Section 17921 and 45 C.F.R. Section 164.402], as well as California Civil Code Sections 1798.29 and 1798.82.

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b. Breach Notification Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and D.

c. Business Associate is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information received from a covered entity, but other than in the capacity of a member of the workforce of such covered entity or arrangement, and shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

d. Covered Entity means a health plan, a health care clearinghouse, or a health care provider who transmits any information in electronic form in connection with a transaction covered under HIPAA Regulations, and shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

e. Data Aggregation means the combining of Protected Information by the BA with the Protected Information received by the BA in its capacity as a BA of another CE, to permit data analyses that relate to the health care operations of the respective covered entities, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

f. Designated Record Set means a group of records maintained by or for a CE, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

g. Electronic Protected Health Information means Protected Health Information that is maintained in or transmitted by electronic media and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 160.103. For the purposes of this BAA, Electronic PHI includes all computerized data, as defined in California Civil Code Sections 1798.29 and 1798.82.

h. Electronic Health Record means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff, and shall have the meaning given to such term under the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921.

i. Health Care Operations shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

j. Privacy Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

k. Protected Health Information or PHI means any information, including electronic PHI, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or

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with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Sections 160.103 and 164.501. For the purposes of this BAA, PHI includes all medical information and health insurance information as defined in California Civil Code Sections 56.05 and 1798.82.

l. Protected Information shall mean PHI provided by CE to BA or created, maintained, received or transmitted by BA on CE's behalf.

m. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, and shall have the meaning given to such term under the Security Rule, including, but not limited to, 45 C.F.R. Section 164.304.

n. Security Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

o. Unsecured PHI means PHI that is not secured by a technology standard that renders PHI unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute, and shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to, 42 U.S.C. Section 17932(h) and 45 C.F.R. Section 164.402.

2. Obligations of Business Associate.

a. Attestations. Except when CE's data privacy officer exempts BA in writing, the BA shall complete the following forms, attached and incorporated by reference as though fully set forth herein, SFDPH Attestations for Privacy (Attachment 1) and Data Security (Attachment 2) within sixty (60) calendar days from the execution of the Agreement. If CE makes substantial changes to any of these forms during the term of the Agreement, the BA will be required to complete CE's updated forms within sixty (60) calendar days from the date that CE provides BA with written notice of such changes. BA shall retain such records for a period of seven years after the Agreement terminates and shall make all such records available to CE within 15 calendar days of a written request by CE.

b. User Training. The BA shall provide, and shall ensure that BA subcontractors, provide, training on PHI privacy and security, including HIPAA and HITECH and its regulations, to each employee or agent that will access, use or disclose Protected Information, upon hire and/or prior to accessing, using or disclosing Protected Information for the first time, and at least annually thereafter during the term of the Agreement. BA shall maintain, and shall ensure that BA subcontractors maintain, records indicating the name of each employee or agent and date on which the PHI privacy and security trainings were completed. BA shall retain, and ensure that BA subcontractors retain, such records for a period of seven years after the Agreement terminates and shall make all such records available to CE within 15 calendar days of a written request by CE.

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c. Permitted Uses. BA may use, access, and/or disclose Protected Information only for the purpose of performing BA's obligations for, or on behalf of, the City and as permitted or required under the Agreement and BAA, or as required by law. Further, BA shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by CE. However, BA may use Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operations of CE [45 C.F.R. Sections 164.502, 164.504(e)(2). and 164.504(e)(4)(i)].

d. Permitted Disclosures. BA shall disclose Protected Information only for the purpose of performing BA's obligations for, or on behalf of, the City and as permitted or required under the Agreement and BAA, or as required by law. BA shall not disclose Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so disclosed by CE. However, BA may disclose Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operations of CE. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this BAA and used or disclosed only as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify BA of any breaches, security incidents, or unauthorized uses or disclosures of the Protected Information in accordance with paragraph 2 (n) of this BAA, to the extent it has obtained knowledge of such occurrences [42 U.S.C. Section 17932; 45 C.F.R. Section 164.504(e)]. BA may disclose PHI to a BA that is a subcontractor and may allow the subcontractor to create, receive, maintain, or transmit Protected Information on its behalf, if the BA obtains satisfactory assurances, in accordance with 45 C.F.R. Section 164.504(e)(1), that the subcontractor will appropriately safeguard the information [45 C.F.R. Section 164.502(e)(1)(ii)].

e. Prohibited Uses and Disclosures. BA shall not use or disclose Protected Information other than as permitted or required by the Agreement and BAA, or as required by law. BA shall not use or disclose Protected Information for fundraising or marketing purposes. BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the Protected Information solely relates [42 U.S.C. Section 17935(a) and 45 C.F.R. Section 164.522(a)(1)(vi)]. BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. Section 17935(d)(2), and the HIPAA regulations, 45 C.F.R. Section 164.502(a)(5)(ii); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement.

f. Appropriate Safeguards. BA shall take the appropriate security measures to protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of the CE, and shall prevent any use or disclosure of PHI other than as permitted by the Agreement or this

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BAA, including, but not limited to, administrative, physical and technical safeguards in accordance with the Security Rule, including, but not limited to, 45 C.F.R. Sections 164.306, 164.308, 164.310, 164.312, 164.314 164.316, and 164.504(e)(2)(ii)(B). BA shall comply with the policies and procedures and documentation requirements of the Security Rule, including, but not limited to, 45 C.F.R. Section 164.316, and 42 U.S.C. Section 17931. BA is responsible for any civil penalties assessed due to an audit or investigation of BA, in accordance with 42 U.S.C. Section 17934(c).

g. Business Associate's Subcontractors and Agents. BA shall ensure that any agents and subcontractors that create, receive, maintain or transmit Protected Information on behalf of BA, agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI and implement the safeguards required by paragraph 2.f. above with respect to Electronic PHI [45 C.F.R. Section 164.504(e)(2) through (e)(5); 45 C.F.R. Section 164.308(b)]. BA shall mitigate the effects of any such violation.

h. Accounting of Disclosures. Within ten (10) calendar days of a request by CE for an accounting of disclosures of Protected Information or upon any disclosure of Protected Information for which CE is required to account to an individual, BA and its agents and subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.528, and the HITECH Act, including but not limited to 42 U.S.C. Section 17935 (c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents and subcontractors for at least seven (7) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an Electronic Health Record. At a minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure [45 C.F.R. 164.528(b)(2)]. If an individual or an individual's representative submits a request for an accounting directly to BA or its agents or subcontractors, BA shall forward the request to CE in writing within five (5) calendar days.

i. Access to Protected Information. BA shall make Protected Information maintained by BA or its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within (5) days of request by CE to enable CE to fulfill its obligations under state law [Health and Safety Code Section 123110] and the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524 [45 C.F.R. Section 164.504(e)(2)(ii)(E)]. If BA maintains Protected Information in electronic format, BA shall provide such information in electronic format as necessary to enable CE to fulfill its obligations under the HITECH Act and HIPAA Regulations, including, but not limited to, 42 U.S.C. Section 17935(e) and 45 C.F.R. 164.524.

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j. Amendment of Protected Information. Within ten (10) days of a request by CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA and its agents and subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment or other documentation to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R Section 164.526. If an individual requests an amendment of Protected Information directly from BA or its agents or subcontractors, BA must notify CE in writing within five (5) days of the request and of any approval or denial of amendment of Protected Information maintained by BA or its agents or subcontractors [45 C.F.R. Section 164.504(e)(2)(ii)(F)].

k. Governmental Access to Records. BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining BA's compliance with HIPAA [45 C.F.R. Section 164.504(e)(2)(ii)(I)]. BA shall provide CE a copy of any Protected Information and other documents and records that BA provides to the Secretary concurrently with providing such Protected Information to the Secretary.

l. Minimum Necessary. BA, its agents and subcontractors shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the intended purpose of such use, disclosure, or request. [42 U.S.C. Section 17935(b); 45 C.F.R. Section 164.514(d)]. BA understands and agrees that the definition of "minimum necessary" is in flux and shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary" to accomplish the intended purpose in accordance with HIPAA and HIPAA Regulations.

m. Data Ownership. BA acknowledges that BA has no ownership rights with respect to the Protected Information.

n. Notification of Breach. BA shall notify CE within 5 calendar days of any breach of Protected Information; any use or disclosure of Protected Information not permitted by the BAA; any Security Incident (except as otherwise provided below) related to Protected Information, and any use or disclosure of data in violation of any applicable federal or state laws by BA or its agents or subcontractors. The notification shall include, to the extent possible, the identification of each individual whose unsecured Protected Information has been, or is reasonably believed by the BA to have been, accessed, acquired, used, or disclosed, as well as any other available information that CE is required to include in notification to the individual, the media, the Secretary, and any other entity under the Breach Notification Rule and any other applicable state or federal laws, including, but not limited, to 45 C.F.R. Section 164.404 through 45 C.F.R. Section 164.408, at the time of the notification required by this paragraph or promptly thereafter as information becomes available. BA shall take (i) prompt corrective action to cure any deficiencies and (ii) any action pertaining to unauthorized uses or disclosures required by applicable federal and state laws. [42 U.S.C. Section 17921; 42 U.S.C. Section 17932; 45 C.F.R. 164.410; 45 C.F.R. Section 164.504(e)(2)(ii)(C); 45 C.F.R. Section 164.308(b)]

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o. Breach Pattern or Practice by Business Associate's Subcontractors and Agents. Pursuant to 42 U.S.C. Section 17934(b) and 45 C.F.R. Section 164.504(e)(1)(iii), if the BA knows of a pattern of activity or practice of a subcontractor or agent that constitutes a material breach or violation of the subcontractor or agent's obligations under the Contract or this BAA, the BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the BA must terminate the contractual arrangement with its subcontractor or agent, if feasible. BA shall provide written notice to CE of any pattern of activity or practice of a subcontractor or agent that BA believes constitutes a material breach or violation of the subcontractor or agent's obligations under the Contract or this BAA within five (5) calendar days of discovery and shall meet with CE to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

3. Termination.

a. Material Breach. A breach by BA of any provision of this BAA, as determined by CE, shall constitute a material breach of the Agreement and this BAA and shall provide grounds for immediate termination of the Agreement and this BAA, any provision in the AGREEMENT to the contrary notwithstanding. [45 C.F.R. Section 164.504(e)(2)(iii).]

b. Judicial or Administrative Proceedings. CE may terminate the Agreement and this BAA, effective immediately, if (i) BA is named as defendant in a criminal proceeding for a violation of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws or (ii) a finding or stipulation that the BA has violated any standard or requirement of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

c. Effect of Termination. Upon termination of the Agreement and this BAA for any reason, BA shall, at the option of CE, return or destroy all Protected Information that BA and its agents and subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections and satisfy the obligations of Section 2 of this BAA to such information, and limit further use and disclosure of such PHI to those purposes that make the return or destruction of the information infeasible [45 C.F.R. Section 164.504(e)(2)(ii)(J)]. If CE elects destruction of the PHI, BA shall certify in writing to CE that such PHI has been destroyed in accordance with the Secretary's guidance regarding proper destruction of PHI. Per the Secretary's guidance, the City will accept destruction of electronic PHI in accordance with the standards enumerated in the NIST SP 800-88, Guidelines for Media Sanitization. The City will accept destruction of PHI contained in paper records by shredding, burning, pulping, or pulverizing the records so that the PHI is rendered unreadable, indecipherable, and otherwise cannot be reconstructed.

d. Civil and Criminal Penalties. BA understands and agrees that it is subject to civil or criminal penalties applicable to BA for unauthorized use, access or disclosure or Protected Information in accordance with the HIPAA Regulations and the HITECH Act including, but not limited to, 42 U.S.C. 17934 (c).

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e. Disclaimer. CE makes no warranty or representation that compliance by BA with this BAA, HIPAA, the HITECH Act, or the HIPAA Regulations or corresponding California law provisions will be adequate or satisfactory for BA's own purposes. BA is solely responsible for all decisions made by BA regarding the safeguarding of PHI.

4. Amendment to Comply with Law.

The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Agreement or this BAA may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable state or federal laws relating to the security or confidentiality of PHI. The parties understand and agree that CE must receive satisfactory written assurance from BA that BA will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the updated standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable state or federal laws. CE may terminate the Agreement upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Agreement or this BAA when requested by CE pursuant to this section or (ii) BA does not enter into an amendment to the Agreement or this BAA providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

5. Reimbursement for Fines or Penalties.

In the event that CE pays a fine to a state or federal regulatory agency, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible access, use or disclosure of PHI by BA or its subcontractors or agents, then BA shall reimburse CE in the amount of such fine or penalties or damages within thirty (30) calendar days from City's written notice to BA of such fines, penalties or damages.

Attachment 1 – SFDPH Privacy Attestation, version 06-07-2017
Attachment 2 – SFDPH Data Security Attestation, version 06-07-2017

Office of Compliance and Privacy Affairs
San Francisco Department of Public Health
101 Grove Street, Room 330, San Francisco, CA 94102
Email: compliance.privacy@sfdph.org
Hotline (Toll-Free): 1-855-729-6040

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DEPARTMENT OF PUBLIC HEALTH CONTRACTOR
FEE FOR SERVICE STATEMENT OF DELIVERABLES AND INVOICE

CONTRACTOR: Health Services Advisory Group, Inc.
Address: 3133 E. Camelback Rd., Suite 140
Phoenix, Arizona 85016

Telephone:
FAX:

CONTRACT TERM: **11/8/2022 - 12/31/2023**

CONTRACT NAME: **Laguna Honda Re-Application Project**

PROGRAM EXHIBIT: **Appendix A-1 / B-1**

Control Number

Contract Purchase Order PO No.

Fund Source:

Invoicing Period:

Invoice Number:

Deliverables	Total contracted UOS (hours)	UOS Delivered THIS PERIOD	UNIT RATE Per Hour	AMOUNT DUE	UOS Delivered TO DATE	% OF TOTAL	Remaining Units to be Delivered
Root Cause Analysis & Action Plan Development							
QIE Subject Matter Experts	1,560		$420.00				
Compliance Monitoring							
QIE Subject Matter Experts	3,120		$420.00				
Infection Preventionist			$341.00				
Quality Improvement Specialist			$341.00				
Senior Data Scientist			$289.00				
Data Coordinator	520		$167.00				
Project Coordinator	520		$167.00				
Expenses including General and Administrative (29.15% of Travel)	Billed Actual (Appendix G)						

TOTAL EXPENSES	
LESS: Initial Operational Cost Advance Recovery	
Other Adjustments:	
REIMBURSEMENT	

NOTES:

See Appendix B-1 for details

I certify that the information provided above is, to the best of my knowledge, complete and accurate; the amount requested for reimbursement is in accordance with the contract approved for services provided under the provision of that contract. Full justification and backup records for those claims are maintained in our office at the address indicated.

Signature: _____ Date: _____

Title: _____

Send to: SFDPH/LHH
375 Laguna Honda Blvd.
San Francisco, CA 94116
Attn: Baljeet Sangha

SFDPH/LHH Authorization For Payment:

By: _____ Date: _____
Baljeet Sangha

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Appendix G
Travel and Expense Policy

General

Before traveling to City's facilities, Contractor must receive written authorization from City for the travel as provided in the Agreement. Contractor will complete a travel authorization form which, unless agreed otherwise, will include the on-site dates for the personnel and an estimate for all expenses (including expected airfare). At City's option, City may approve a blanket travel authorization rather than an individual travel authorization for each trip. A blanket travel authorization includes a range of trips, reducing the number of travel authorizations submitted to City for approval.

Air Travel

Airfare must be booked for economy/coach class only. Business or First Class is not reimbursable. Optional upgrades are not reimbursable. Contractor will choose the most cost effective flight that otherwise satisfies its booking criteria (e.g., no double connections, fits any reasonable time constraints). If a charter would be of equal cost to or less expensive than commercial airfare due to the number of traveling staff, Contractor may use a charter.

Contractor will use reasonable efforts, where possible, to purchase air tickets at minimum 2 weeks in advance to take advantage of the most economical fares available. You have informed Contractor that You intend to seek approval in writing by the Program Manager or his or her designee if a travel authorization referenced above includes estimated airfare in excess of $500 round trip.

If airline charges for checked luggage, only the cost of the first checked bag is reimbursable. Additional baggage check-in costs will be reimbursed with justification explaining the business need for extra luggage.

Ground Transportation from Airport to Work Site or to Hotel

Public transportation, shuttle, taxi, or ridesharing (e.g., Uber or Lyft) is preferred as the primary mode of transportation. Public transportation between worksites is reimbursed based upon need.

City will reimburse Contractor for actual tolls, parking fees, a standard amount for mileage to and from the outbound airport, airport shuttle service, public transportation fees and taxi or similar (e.g., Uber, Lyft) fares. Personal car mileage is based on the IRS set rate; fuel is not reimbursed for personal car usage. Contractor will instruct its staff to generally use taxi or similar services or public transit, rather than rental cars. Where applicable, Contractor will normally rent cars from a national car rental chain to take advantage of its national discounted rates whenever feasible. Generally, Contractor rents cars that will comfortably accommodate 3 or 4 employees with luggage and laptop computers rather than renting vehicles for each employee. Contractor employees will make reasonable efforts to refuel rental cars prior to returning the cars.

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Personal Vehicles:
The following information should be included in reimbursement request submitted by the traveler to Contractor, except with respect to use of a personal vehicle to travel from the traveler's home or office to airport:

1. Business purpose for use of vehicle
2. Starting point (e.g., worksite or home, whichever is the closer of the two) and the destination
3. Vehicle make, model, and license number
4. Odometer reading, beginning and ending, or a printout from an automated mapping program (e.g., Google Maps) showing the route and mileage

Rental Cars:
The travel reimbursement policy with regards to use of a rental car is as follows:

1. Cost of rental car used for work performed under the Agreement is reimbursable if it was pre-approved by the Program Manager or his or her designee as part of the travel authorization process described above. The pre-approval is required to be documented in writing, and must include:
    a. the car rental amount and estimate of other related expenses such as parking and fuel, and
    b. justification why other forms of transportation are not appropriate, why a rental car is necessary, and how a rental car is the most economical and efficient/practical
2. All passengers traveling in a rental vehicle must be performing work under the Agreement.
    a. Car rental is limited to standard compact size vehicle. Midsize vehicle is reimbursable if use is for three people or more, justification provided, and pre-approved in writing by the Program Manager or his or her designee as part of the travel authorization process described above
    b. Pre-paid fuel for re-filling the gas tank on the rental car is not reimbursable. Employees must submit to Contractor fuel receipt for actual usage
3. Carpooling and ridesharing is required. Members travelling in the car must be provided in writing on the face of the receipt when submitting expenses to Contractor. No less than three contractors per car is permitted.

Information regarding public transportation
The following resources are presented as a guide, please check the applicable website for the most up-to-date information. Contractor will book its own travel.

SF MUNI

1. Plan your trip: https://www.sfmta.com/
2. System Map: https://www.sfmta.com/maps/muni-system-map
3. Schedules: http://511.org/transit/schedules-agency-info/agency/363/schedules

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BART

1. Plan your Trip: https://www.bart.gov/
2. System Map: http://www.bart.gov/stations
3. Schedules: http://511.org/transit/schedules-agency-info/agency/354/schedules

City has informed Contractor that parking is not available at most City worksites. Parking is reimbursable, however Contractor will instruct its staff that they should generally use other forms of transportation that do not require parking at City's facilities. To request reimbursement for garage parking, Contractor staff will provide Contractor with a receipt showing the parking fee paid, subject to the Documentation of Travel Expenses requirements set forth below.

Meals and Hotels

City will reimburse Contractor a flat fee per traveler per day for meals, hotels, and non-ground transport incidental expenses at the "per diem" CONUS rate as published by the General Services Administration for San Francisco (using zip code 94102).
https://www.gsa.gov/travel-resources

Conus Check-in

If, following the Effective Date either party has concerns about the CONUS rate referenced above (whether because it is perceived as too far above or below actual typical hotel and meal costs), such party will escalate its concerns and the parties will discuss whether this provision of the Agreement should be modified through a Revision to the Program Budget to address any shortfall with the CONUS rate or to authorize payment above the published CONUS rate.

Non-Reimbursable Expenses

1. Hotel movies
2. Internet access solely for personal purposes
3. Entertainment
4. Sightseeing
5. Tips above 20%
6. Optional airline upgrades
7. Alcoholic beverages
8. Child or pet care
9. Damages to contractor's personal vehicle
10. Lost or stolen funds or personal property
11. Parking/moving violation tickets or other penalties for infractions of any law, repair of automobile and towing charges
12. Travel insurance or rental car insurance offered by rental car companies
13. Insurance in connection with personal automobiles
14. Hotel health club memberships
15. Laundry service (unless contractor is on site for six consecutive days of work or more)

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16. Personal services and personal supplies
17. Any expense which is not bona fide for federal income tax purposes
18. Cancelled travel tickets and change / cancellation costs (where the cancellation was reasonably avoidable)

Documentation of Travel Expenses

Contractor travelers generally are required to provide Contractor with receipts for their travel expenses. On the occasion a receipt is lost or misplaced, Contractor's accounting department will obtain documentation from the traveler for the applicable expenses. Contractor's accounting department will monitor these instances to help keep them to a minimum.

Sharing Expenses with Other Organizations

Occasionally, it may be possible to combine travel to City's site with travel to or from another Contractor customer site, and in such case, expenses can be shared with the other organizations. Contractor employees are responsible for seeking reimbursement for expenses payable by others. If a Contractor employee is taking a trip payable jointly by City and another entity, City will reimburse City's share of the actual expenses necessary for City's business in accordance with this Travel Policy. In no case may the reimbursement to the Contractor employee from all sources exceed the total expenses incurred by the employee.

Allowable General and Administrative Charge: 29.15% of travel expenses as specified in Appendix B-1.

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Former CMS Certification Number: 55-5020

SETTLEMENT AND SYSTEMS IMPROVEMENT AGREEMENT

This Settlement Agreement and Systems Improvement Agreement (the "Agreement") is made between (i) the City and County of San Francisco ("City"), acting by and through its Department of Public Health, which has administrative jurisdiction over and operates the Laguna Honda Hospital & Rehabilitation Center D/P SNF ("LHH"), (ii) the California Department of Public Health ("CDPH"), and (iii) the United States Department of Health & Human Services ("DHHS"), Centers for Medicare & Medicaid Services ("CMS") (collectively, the "Parties"). This Agreement is being executed and implemented: (1) to temporarily continue federal funding for LHH while LHH follows a revised closure plan; (2) to ensure LHH's substantial compliance with the statutory requirements in sections 1819 and 1919 of the Social Security Act (the "Act") (42 U.S.C. §§ 42 U.S.C. 1395i–3 and 1396r, respectively) and the applicable regulatory requirements found at 42 C.F.R. Part 483, Subpart B (and other applicable statutory and regulatory requirements) during its enaction of its closure plan; (3) to facilitate quality system improvements at LHH including personnel and resource investments; and (4) to safeguard the health and safety of the residents of LHH while LHH pursues Medicare and Medicaid recertification.

Recitals

A. ***Whereas***, LHH is a hospital that was certified as a distinct part Skilled Nursing Facility ("SNF") and a Nursing Facility ("NF"), as those terms are defined by 42 C.F.R. § 488.301, and seeks to be recertified as a SNF in the Medicare program and as a NF in the Medicaid program. LHH has operated as a public nursing facility for 156 years and is one of the largest public skilled nursing facilities in the country; it provides care for medically fragile residents, many of whom are economically disadvantaged. LHH had Medicare and Medicaid provider agreements for its distinct part SNF until they were terminated by CMS on April 14, 2022. To receive federal funding, LHH is required to comply with federal regulations, including, without limitation, the regulatory requirements found at 42 C.F.R. Part 483, Subpart B, in order to receive federal funding. LHH is currently planning to seek recertification and new Medicare and Medicaid provider agreements for its SNF.

B. ***Whereas***, CDPH is the State Survey Agency, as the term is defined by 42 C.F.R. § 488.1, that performs survey and review functions pursuant to an agreement with CMS and Sections 1864, 1819(g), and 1919(g) of the Act.

C. ***Whereas***, the DHHS requires SNFs and NFs participating in the Medicare and Medicaid programs to be in substantial compliance with applicable federal participation requirements and has delegated to CMS the responsibility for verifying that SNFs and NFs achieve and sustain compliance with federal participation requirements. To verify compliance, CMS acts directly or through the State Survey Agency, CDPH, to survey LHH periodically for compliance with the federal participation requirements.

D. ***Whereas,*** between October 14, 2021, and April 13, 2022, CDPH completed 11 surveys of LHH that concluded that the facility was non-compliant with some of the applicable federal

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requirements for nursing homes participating in the Medicare program under Title XVIII of the Act. *See* 42 C.F.R. Part 483, Subpart B. CDPH completed those surveys and issued Statements of Deficiencies ("SODs") for them on Form CMS-2567s with the respective exit dates of: (1) October 14, 2021; (2) October 15, 2021; (3) November 5, 2021; (4) December 21, 2021; (5) December 28, 2021; (6) January 13, 2022; (7) January 21, 2022; (8) February 3, 2022; (9) March 28, 2022; (10) March 30, 2022; and (11) April 13, 2022.

E. ***Whereas***, the SODs in the above-mentioned 11 surveys of LHH identified 26 total regulatory deficiency citations and set forth the bases of CMS's conclusion that LHH failed to substantially comply with the applicable Medicare and Medicaid regulations.

F. ***Whereas,*** CMS issued enforcement letters based on CMS's factual findings and conclusions of law about LHH's substantial noncompliance, respectively dated February 24, 2022, and March 30, 2022, which imposed the following remedies against LHH:

- A Denial of Payment for New Admissions ("DPNA") from January 14, 2022, through April 13, 2022;
- Termination of LHH's Medicare and Medicaid provider agreements effective April 14, 2022;
- A $2,455.00 per-day Civil Money Penalty ("CMP") from October 14, 2021, through January 20, 2022;
- A $550.00 per-day CMP from January 21, 2022, through February 2, 2022;
- A $1,640.00 per-day CMP from February 3, 2022, through March 21, 2022;
- A $10,195.00 per-day CMP from March 22, 2022, through March 26, 2022; and
- A $1,640.00 per-day CMP from March 27, 2022, through April 13, 2022.

The total sum of CMPs imposed against LHH for the 11 above-mentioned surveys was $407,770.00.

G. ***Whereas,*** pursuant to 42 C.F.R. Part 498, Subpart D, on February 15, 2022; April 25, 2022; and May 28, 2022; LHH appealed the remedies, including its termination, imposed in CMS's letters dated February 24, 2022, and March 30, 2022, in three separate appeals. The U.S. Department of Health and Human Services, Departmental Appeals Board ("DAB"), Civil Remedies Division ("CRD"), docketed LHH's appeals as *Laguna Honda Hospital & Rehabilitation Center D/P SNF (CCN: 55-5020) v. Centers for Medicare & Medicaid Services*, Docket Nos. C-22-327, C-22-478, and C-22-555 respectively. On June 2, 2022, the CRD consolidated all the cases under Docket No. C-22-555.

H. ***Whereas,*** LHH has enacted a closure plan dated May 13, 2022 ("Closure Plan") with the goal of obtaining extended federal funding, and DHHS and CMS exercised their discretionary authority pursuant to 42 C.F.R. § 489.55(b) to make continued payments for residents who are beneficiaries of the Medicare and Medicaid programs and who were admitted to LHH prior to January 14, 2022, until September 13, 2022, while LHH transferred and discharged its residents. On May 13, 2022, CMS notified LHH that it approved an additional four months of federal funding beyond 30-days from its termination date. On August 15, 2022, CMS approved this federal funding extension for another two months, for a total of six months of extended funding until November 13, 2022.

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I. ***Whereas***, on July 28, 2022, CMS agreed to LHH's request to pause transfers and discharges of LHH residents to ensure that safety and planning precautions were taken while the Closure Plan was enacted.

J. ***Whereas***, on August 3, 2022, the City, which is LHH's owner and operator, filed a Complaint against DHHS and Xavier Becerra, Secretary of DHHS, docketed in the United States District Court, Northern District of California, *City and County of San Francisco v. U.S. Department of Health and Human Services et al.,* Case No. 3:22-CV-4500.

K. ***Whereas***, on August 3, 2022, certain LHH residents, a resident conservator, and a resident guardian, filed a putative class action Complaint against Chiquita Brooks-LaSure, Administrator for CMS; Xavier Becerra, Secretary of DHHS; CDPH; and Tomás Aragón, Director of CDPH, docketed in the United States District Court, Northern District of California, *D.B. et al. v. Brooks-LaSure et al.*, Case No. 3:22-CV-4501.

L. ***Whereas***, LHH has made to CMS a continued commitment to make substantial improvements and to make substantive personnel and resource investments, in order to meet federal nursing home Medicare and Medicaid participation requirements at 42 C.F.R. Part 483, Subpart B and improve systems of care so that LHH is able to achieve and maintain substantial compliance with all federal nursing home requirements consistently over time and while following a revised closure plan ("Revised Closure Plan").

M. ***Whereas,*** the Parties intend to ensure that LHH provides quality services to residents that meet regulatory requirements at all times. The Parties agree that they are coming together in the spirit of mutual cooperation for the purposes of improving the care for residents and that each Party will work to prioritize the health, safety, and wellbeing of LHH residents in implementing the terms of this Agreement.

N. ***Whereas,*** CMS has agreed to consider a proposed plan to facilitate ongoing substantial compliance with federal nursing home requirements at LHH while LHH follows its Revised Closure Plan and applies for a new certification.

O. ***Whereas***, the Parties recognize concerns raised about protecting residents' rights, minimizing resident transfer trauma, and ensuring the safety and well-being of residents who may be transferred or discharged from LHH pursuant to a Revised Closure Plan.

P. ***Whereas***, LHH intends to reapply, and is working on reapplying for Medicare and Medicaid certification as soon as it is able to achieve and demonstrate sustained compliance with the Medicare and Medicaid program's Long Term Care Facility participation requirements at 42 C.F.R. Part 483, Subpart B. LHH wishes to avoid the need for any future transfers or discharges mandated by CMS, so long as LHH is working to achieve substantial compliance and recertification.

Q. ***Whereas,*** in view of (i) the Parties' shared goal to work together to prioritize the safety of the residents, (ii) LHH's pledge to correct its deficiencies cited in the above-mentioned 11 surveys, (iii) the unique and vulnerable population LHH serves, and (iv) LHH's large resident population, CMS has decided to extend the time period for transfers/discharges in the approved Closure Plan to provide for a more prolonged schedule for assessment and transfer process over the course of the time contemplated by this Agreement. Thus, pursuant to the terms of this Agreement, CMS

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decided to exercise its discretionary authority pursuant to 42 C.F.R. § 489.55(b) to provide Medicare and Medicaid funding to LHH after the 30 days provided pursuant to 42 C.F.R. § 489.55(a) past its April 14, 2022, termination, for up to 18 months, which is November 13, 2023, or until otherwise specified by the terms of this Agreement. The conditions of this Agreement enable CMS and CDPH to closely monitor LHH resident well-being and LHH's continuing efforts to achieve and sustain substantial compliance with all the federal participation requirements as LHH relocates and discharges its residents pursuant to its Revised Closure Plan and while LHH simultaneously seeks recertification.

THEREFORE, in consideration of the Recitals stated above in Paragraphs A-Q and the obligations and commitments expressed herein, the Parties agree as follows:

General Terms:

1. **Duration of the Agreement:** This Agreement expires effective November 14, 2023, at 12:01 a.m., Pacific Daylight Time, unless one of the following occurs before that date: (1) the Parties expressly, mutually agree in writing to a different date to terminate this Agreement; (2) CMS terminates the Agreement because of a material breach by LHH of any its obligations under this Agreement, after the notice and cure period and dispute escalation process set forth in this Agreement; or (3) LHH obtains a new Medicare or Medicaid provider agreement.

2. **Extended Payments to LHH:** CMS agrees to exercise its discretionary authority pursuant to 42 C.F.R. § 489.55(b) to extend federal Medicare and Medicaid payments to LHH for a period of time through and including November 13, 2023, in exchange for LHH's compliance with the terms of this Agreement. *See* 42 U.S.C. 1320a-7j(h)(2)(B). Consistent with the Denial of Payment for New Admissions referenced in Paragraph F above, this provision applies only to funding for the care of residents admitted to LHH on or before January 13, 2022.

3. **Termination of this Agreement:** LHH agrees that CMS retains authority to terminate this Agreement, including any Medicare and Medicaid funding provided pursuant to this Agreement, if LHH materially breaches this Agreement, after the notice and dispute escalation process specified in Paragraph 5 of this Agreement is completed. If CMS concludes that LHH has materially breached this Agreement and intends to terminate this Agreement based on that material breach, it shall provide written notice ("Termination Notice"), pursuant to Paragraph 45, and such notice shall include the provision CMS believes LHH has breached, and the conduct from LHH that CMS believes constitutes the breach, and how LHH can attempt to cure the breach. Such notice shall trigger the meet-and-confer and escalation procedures in Paragraph 5 if LHH elects to follow this process, except for termination based on an Immediate Jeopardy finding documented by a monitoring survey completed pursuant to this Agreement as provided in Paragraph 5(h), below, which would only require CMS to provide two days of Termination Notice and not require the meet-and-confer escalation process before ending federal funding, subject to Paragraph 14, below. If CMS elects to terminate this Agreement due to LHH's material breach of this Agreement, it will provide LHH notice of 30 days in writing, in the manner set forth in Paragraph 45, of its decision. This 30-day period will run concurrently with any meet-and-confer and dispute resolution process pursuant to Paragraph 5. Unless CMS agrees for an extension of time in writing, delays in the dispute escalation process under Paragraph 5 will not extend the 30-day notice period or delay the noticed termination. At the end of the 30-day period, absent CMS's written notice stated otherwise, LHH's Medicare and Medicaid funding will be terminated pursuant to the

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Termination Notice. After this notice period, subject to the meet and confer and dispute escalation provisions, LHH will no longer be entitled to any Medicare and Medicaid funding pursuant to this Agreement. LHH acknowledges and agrees that CMS may, pursuant to its discretionary authority at 42 C.F.R. § 489.55(b), provide additional funding even after the effective date it terminates this Agreement for LHH's material breach, and CMS retains sole discretion to determine the duration of any period of additional funding it will provide if LHH materially breaches this Agreement after the notice and cure period and dispute escalation process specified in this Agreement. Circumstances that would constitute LHH's material breach of this Agreement include, but are not limited to the following:

a. CMS determines LHH fails to substantially comply (as that term is defined by 42 C.F.R. § 488.301) with the standards specified in the Requirements for Long Term Care Facilities at 42 C.F.R. Part 483, Subpart B at any time on or after February 13, 2023.

b. LHH fails to participate in the survey process or materially impedes the survey process specified by this Agreement. This includes LHH's failure to provide documents in a reasonable time requested by surveyors performing duties pursuant to this Agreement, and LHH's failure to provide surveyors with access to interviews of staff and residents, to the extent the surveyors are legally entitled under the terms of this Agreement or other legal authority to those documents or that access.

c. CMS determines that Immediate Jeopardy to resident health and safety occurred, as that term is defined by 42 C.F.R. § 488.301.

d. CMS determines that LHH is not progressing toward substantial compliance with federal requirements based on LHH's failure to meet its Action Plan benchmarks at any time after February 13, 2023, as evidenced by the monthly reports described in Paragraphs 8 and 12, or information gathered during monitoring visits.

e. LHH fails to timely provide to CMS, CDPH, or the Facilitator any required material document as set forth by this Agreement or as necessary to carry out the terms of this Agreement, or materially impedes CMS, CDPH, or the Facilitator's access to interviews with staff and residents, to the extent they are legally entitled to those documents or that access under the terms of this Agreement or through other legal authority.

f. LHH fails to timely retain an external expert or unreasonably fails to cooperate materially with an external expert's recommendations to enact an Action Plan.

g. LHH fails to enact the Revised Closure Plan, including failing to appropriately and safely discharge or transfer residents according to the terms of the Revised Closure Plan and failing to honor resident rights during the relocation process.

h. CMS determines that LHH fails to comply with any of the other material terms and conditions of this Agreement.

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4. **No Admissions:** To resolve this matter expeditiously and to avoid the burden or expense of investigation or litigation, the Parties agree to the terms of this Agreement. The promises, obligations, and other terms and conditions set forth in this Agreement constitute the exchange of valuable consideration between the Parties. This Agreement shall not be deemed or construed to be an admission or evidence of any violation of law or regulation or of any liability or wrongdoing on the part of LHH. Nor shall it be deemed or construed to be an admission or evidence that DHHS, CMS, or CDPH violated any law, including as this relates to the City's claims in *City and County of San Francisco v. U.S. Department of Health and Human Services et al.*, Case No. 3:22-CV-4500, and did not have a good faith basis for the initial determinations at issue in the appeal docketed at the consolidated DAB Case No. C-22-555 or any of the survey findings and remedies imposed and discussed above in the Recitals at Paragraphs D, E, and F.

5. **Meet-and-Confer and Dispute Escalation Process**:

   a. Upon receipt of CMS's written Termination Notice sent pursuant to Paragraph 3 and Paragraph 45 or as otherwise provided in this Agreement, above, LHH shall, within 5 calendar days, provide written notice to CMS sent pursuant to Paragraph 456 that it either: (i) accepts CMS's determination, (ii) will attempt to cure the breach, or (iii) disputes CMS's determination ("LHH Response Notice"). The LHH Response Notice must (1) identify any specific legal issues and findings of facts or conclusions with which LHH disagrees; and (2) specify the basis for why LHH contends that the findings and conclusions are incorrect.

   b. If LHH wishes to cure the breach, the LHH Response Notice shall include LHH's showing that it has cured or will cure the breach and any relevant supporting documentation. CMS retains discretion whether to accept any proposed cure and whether to proceed with termination of this Agreement.

   c. If CMS, upon receipt of the LHH Response Notice, still intends to terminate this Agreement, the Parties shall meet-and-confer within 5 calendar days of CMS's receipt of LHH's Response Notice. At the end of this meet-and-confer, CMS will provide written notice whether the dispute resolution was successful.

   d. If any issues are not resolved by the end of the above meet-and-confer process, the Parties agree that representatives from the San Francisco City Attorney's Office and the HHS Office of the General Counsel will confer within 10 calendar days of CMS's receipt of LHH's Response Notice in an attempt to address the outstanding dispute. Notwithstanding the foregoing, the representatives from the San Francisco City Attorney's Office and the HHS Office of the General Counsel may meet-and-confer concurrently with the meet-and-confer process in Paragraph 5(c), above.

   e. If the representatives from the San Francisco City Attorney's Office and the HHS Office of the General Counsel are unsuccessful in resolving all remaining issues, the Director of CMS's Center for Clinical Standards & Quality or the Director's designee and the San Francisco Director of Health or the Director's Designee shall have 10 calendar days to confer in an attempt to resolve the outstanding dispute.

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f. Any time period set forth in Paragraphs 5(a)-(e) above may be extended by mutual written agreement of LHH and CMS.

g. If, after the process outlined in Paragraphs 5(a)-(e) above does not resolve all remaining disputes, then CMS may terminate this Agreement, including any Medicare and Medicaid funding provided pursuant to this Agreement. After termination of this Agreement, LHH may, without limiting its other rights or remedies at law or in equity, file a lawsuit to enforce the terms of this Agreement pursuant to Paragraph 55, below.

h. In the event that CMS's Termination Notice is based on CMS's determination that LHH violated the federal regulations at an Immediate Jeopardy level, CMS may, in its discretion terminate this Agreement after two days from providing LHH with Termination Notice, subject to paragraph 14 below, regardless of whether all of the steps set forth in Paragraphs 5(a)-(e) have been completed.

System Improvements:

6. **Plan of Correction ("POC"):** LHH will submit acceptable POCs for the surveys listed in Recitals Paragraph D, except for the POCs that CDPH or CMS already accepted, by October 15, 2022. For any new federal deficiencies identified after April 13, 2022, LHH must submit any required POC within 10 days of receipt of the SOD(s), identifying the deficiency. For a POC to be acceptable, it must address all of the required elements specified in Chapter 7304 of the State Operations Manual. LHH must obtain approval of the POCs from CDPH or CMS. CDPH and CMS will not unreasonably withhold approval. The Parties agree that failure to submit an acceptable POC within 10 days of receipt of the SOD(s), or by October 15, 2022 for any outstanding POCs required, may result in CMS terminating the Agreement and discontinuing federal funding, subject to the meet-and-confer and dispute escalation procedures set forth in Paragraph 5, above. CDPH and CMS will make reasonable efforts to timely respond to any POC submitted by LHH. If CDPH rejects the POC, CDPH will state in writing the element(s) of the POC that are unacceptable and the reason(s)/bases(es) for the unacceptability of the POC. LHH will have a reasonable amount of time to address the issues raised by CDPH in a corrected POC. If CMS promulgates new regulations contrary to previously approved POCs, those new regulations will control over any existing POC. LHH will have a reasonable amount of time to change practices in accordance with any newly issued rules that are contrary to approved POCs.

7. **Closure Plan:** During the term of this Agreement, LHH will continue conducting thorough individual assessments of residents for the purpose of determining appropriateness of transfer or discharge as specified in LHH's Revised Closure Plan, subject to the terms and conditions of this Agreement, and will provide safe and orderly discharges for residents that request to leave. Nothing in this Agreement or the Revised Closure Plan precludes LHH residents from being transferred or discharged from LHH of their own volition or for reasons unrelated to the Revised Closure Plan. In the event of any conflict between the Revised Closure Plan and this Agreement, the terms of this Agreement will prevail. LHH will update its Revised Closure Plan accordingly if actions taken pursuant to this Agreement necessitate altering the timeline or other terms of the Revised Closure Plan, including if CMS terminates this Agreement or pauses the period of time for LHH to transfer and discharge residents pursuant to this Agreement. LHH will

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not admit new residents unless LHH obtains Medicare or Medicaid certification. CDPH's and LHH's responsibilities pursuant to the Revised Closure Plan to transfer and discharge LHH residents will be resumed on February 2, 2023, unless CMS provides notice in writing providing that LHH resident transfer and discharges may be resumed at a later date. If LHH is complying with its obligations under this Agreement, CMS will consider whether LHH may be provided federal payment if LHH adjusts the timeline for implementing the Revised Closure Plan, including permitting a pause on the transfer or discharge of residents pursuant to the Revised Closure Plan, as specified in Paragraph 14, below, and coterminous with the duration of this Agreement.

8. Federal Facilitator: LHH agrees to permit CMS to appoint or continue the placement of the current on-site facilitator ("Facilitator") to monitor LHH, including its progress in enacting the Revised Closure Plan, resident transfers and discharges, the terms of this Agreement, and progress towards achieving and maintaining substantial compliance with the applicable Medicare and Medicaid participation regulations. If CMS appoints a new Facilitator pursuant to this Agreement, CMS will provide five days written notice to LHH, identifying and describing the qualifications of the new Facilitator. CMS will not appoint any individual from CDPH who conducted a survey of LHH since January 1, 2022, as the new Facilitator. If LHH objects to CMS's appointment of a specific individual to act as Facilitator, LHH may elect to follow the 30-day, Meet-and-Confer and Dispute Escalation Process in Paragraph 5 in attempt to resolve its objection. CMS will provide reasonable consideration to LHH's objection, but if the LHH and CMS cannot agree to a specific individual to act as the Facilitator at the end of the Dispute Escalation Process, CMS's appointment of a Facilitator will prevail. CMS's newly appointed Facilitator will remain in their appointed position while the Meet-and-Confer Dispute Escalation Process occurs. The parties acknowledge and agree that the Facilitator will perform the services described in the Facilitator Scope of Work. The Parties may modify the Scope of Work by written mutual agreement in which case the revised Scope of Work shall control over this Paragraph. LHH will reasonably cooperate with and provide information to the Facilitator, including, but not limited to, promptly providing all requested documents directly to the Facilitator by the end of the next business day and making LHH staff available for confidential interviews with the Facilitator as soon as practicable, but no later than one calendar day if the requested LHH employee is on duty. If an LHH staff member is out on leave, LHH agrees, to the extent permitted by applicable law, to make reasonable attempts to have the LHH staff member available for an interview by the Facilitator as soon as reasonably practicable. The information the Facilitator may request includes, but is not limited to, documents about proposed, pending, and completed transfers and discharges of current and former residents including: independent and full access to facility policies and access to records, confidential communications with residents, and physical access within the facility. These records include the Facilitator's access to: (1) physician assessments and communications, (2) physician discharge orders, (3) notifications to patients and the facility, (4) residents' vital signs measured within the 72-hours before a discharge or transfer, (5) resident laboratory results, (6) nursing assessments documenting resident status and transfer plans, (7) resident discharge or transfer care plans, (8) social services' communications with residents and family, (9) resident medication lists, (10) resident transfer forms, (11) resident medication reconciliation records including Medical Administration Records ("MAR") and Treatment Administration Records ("TAR"), (12) records about the use of medical equipment, and (13) facility communication with residents. The Facilitator will make monthly reports to CMS and CDPH that include: (1) dates, times, and duration of each visit by the Facilitator; (2) summary of observations made during the visits; (3) summary of any interviews conducted and with whom; (4) summary of any records reviewed; (5)

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any quality concerns identified; (6) any complaints received by the Facilitator; (7) assessment of adequacy of staffing; (8) progress or lack thereof made on each item of the LHH's Action Plan; and (9) detailed information about all residents who have been or imminently will be discharged or transferred from LHH. LHH agrees to permit the Facilitator to perform the terms of this Agreement, including permitting the Facilitator to access the facility, conduct interviews, and review records. Any complaints received by the Facilitator will be forwarded to LHH, CDPH, and CMS. LHH acknowledges and agrees that, if requested by CMS, the Facilitator may provide to CMS any documents that the Facilitator has obtained from the facility pursuant to this Agreement. CMS will be responsible for the Facilitator's compensation. CMS accepts all responsibility and applicable obligations related to any unauthorized access or disclosure caused by or resulting from Facilitator's action or inaction with respect to any LHH patient health information received from LHH. CMS affirms that the Facilitator is a person or entity acting under a grant of authority from or contract with CMS with regards to CMS's activities as a health oversight agency within the meaning of the HIPAA Privacy Rule regulations at 45 C.F.R. §§ 164.512(d), 164.501.

9. **Quality Improvement Expert(s):** LHH will contractually engage one or more external quality improvement experts ("QIEs") experienced in quality improvement specific to SNF and NF services to assist in carrying out the actions described in this Agreement. LHH may continue to contractually engage the services of a QIE that it already has recently contractually engaged, provided that expert meets the terms of this Agreement. No one who currently or in the past 24 months has been an employee of LHH or has any other conflict of interest under applicable laws, may act as a QIE pursuant to this Agreement. If LHH believes that successful performance of this Agreement requires using a person who may have a conflict of interest as a QIE, then LHH will provide CMS with the following information in writing: the name of the individual with the conflict of interest; an explanation of the nature and scope of the conflict; an explanation of why LHH cannot obtain this person's skills or expertise from another source; and an explanation of the steps LHH will take to monitor and mitigate the conflict of interest.

a. If CMS has not already approved LHH's proposed QIE(s) before the implementation of this Agreement, then: by October 15, 2022, LHH will submit to CMS and CDPH the curriculum vitae ("CV") for each QIE it proposes to retain, or has already retained, along with scope of work information, and proposed start and end dates; and by October 25, 2022 CMS, after consulting with CDPH, if CMS so chooses, will determine whether a proposed QIE is qualified to perform the tasks required by this Agreement for which LHH proposes to use the QIE and inform LHH. CMS may seek the opinion of CDPH before making its determination.

b. CMS will inform LHH in writing, sent by e-mail under Paragraph 45, of its decision whether to approve the QIE(s) LHH proposes. Such approval may not be unreasonably withheld. But if CMS does withhold approval of a QIE, then LHH will propose alternate candidates for CMS's approval within 10 business days.

c. If LHH proposes to change its QIE at any point during the term of this Agreement, any proposed substitute QIE must be submitted to CMS and CDPH for approval consistent with Paragraphs 9(a) and 9(b) above. CMS must provide written approval for dismissing the services of a QIE that it previously accepted pursuant to this Agreement.

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d. LHH will be responsible for payment for the services of the QIE(s). LHH must enter into a contract with an approved external QIE as soon as possible and no later than November 4, 2022. LHH shall provide a copy of its contract(s) with the approved external QIE(s) to CMS and CDPH via electronic mail to ROSFEnforcements@cms.hhs.gov; yvonne.pon@cms.hhs.gov; stephanie.magill@cms.hhs.gov; cassie.dunham@cdph.ca.gov; susan.fanelli@cdph.ca.gov

e. LHH will sign a business associate agreement with the external QIE(s) described in this Agreement that requires compliance with HIPAA.

10. Root Cause Analysis: LHH will direct the external QIE(s) to perform a "Root Cause Analysis" to determine the factors that resulted in CMS concluding that LHH violated a federal regulation and to ensure long-term substantial compliance in the future with federal participation requirements at 42 C.F.R. Part 483, Subpart B. As part of the Root Cause Analysis, the external QIE(s) will identify and define problems; investigate and collect supporting information; and analyze and identify the root causes of each identified problem. The Root Cause Analysis will specifically address, but is not limited to, all deficiencies identified during the surveys identified in Recitals Paragraphs D and E above and all deficiencies that were discovered and disclosed to LHH by CDPH, CMS, or a contract surveyor after those surveys.

a. The Root Cause Analysis will specifically address:

- The adequacy and competency of LHH staffing and the provision of quality of care and quality of life for LHH's residents in compliance with 42 C.F.R. § 483.35(a)(3)(4)(c) (F726).

- Training of all LHH staff regarding the identification of contraband and the systems in place to ensure resident safety with regards to contraband in compliance with 42 C.F.R. § 483.35(a)(3)(4)(c) (F726).

- Ensuring that all LHH residents receive appropriate and sufficient supervision and that LHH implements appropriate interventions to keep LHH residents safe from accident hazards, including illegal drug use, illegal drug possession, and other contraband possession in compliance with 42 C.F.R. § 483.25(d)(1)(2) (F689). Such interventions must include both facility-wide interventions and appropriate, individualized interventions for each affected resident. To address compliance with this regulation, LHH should review and implement improvements consistent with CMS's guidance to the state survey agencies set forth in the Advanced Copy of Appendix PP of the State Operations Manual ("SOM") expected to be published on October 24, 2022 related to the prevention of accidents for individuals with substance use disorders. If the SOM is further revised or modified at any time during the term of this Agreement, LHH agrees and understands that the most recent revised or modified version is CMS's current guidance to the state survey agencies. To

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the extent there is any conflict between the SOM and 42 C.F.R. § 483.25(d)(1)(2), LHH acknowledges and agrees that the regulation prevails as the instructive term for this Agreement.

- Ensuring that each resident is free from abuse, neglect, misappropriation of resident property, and exploitation in compliance with 42 C.F.R. § 483.12(a)(1) (F600).

- Ensuring that residents only self-administer medications if the interdisciplinary team determines the practice is clinically appropriate in compliance with 42 C.F.R. § 483.10(c)(7) (F554).

- Developing comprehensive care plans and completing comprehensive assessments of all residents in compliance with 42 C.F.R. § 483.21(b)(2)(i)-(iii) (F657) and ensuring that all care plans meet professional standards of quality in compliance with 42 C.F.R. § 483.21(b)(3)(i) (F658).

- Ensuring that residents admitted to LHH with limited ranges of motion receive appropriate treatment and services to increase their range of motion or prevent further decrease in their range of motion in compliance with 42 C.F.R. § 483.25(c)(1)-(3) (F688).

- Ensuring that residents who need respiratory care are provided such care consistent with professional standards of practice, a comprehensive person-centered care plan, and the residents' goals and preferences in compliance with 42 C.F.R. § 483.25(i) (F695).

- Ensuring that pain management is provided to residents who require those services consistent with the professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences in compliance in compliance with 42 C.F.R. § 483.25(k) (F697).

- Labeling drugs and biologicals used in the facility in accordance with currently accepted professional principles, including appropriate accessory and cautionary instructions, and the expiration date when applicable in compliance with 42 C.F.R. § 483.45(g)(h)(1)(2) (F761).

- Establishing and maintaining an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections in compliance with 42 C.F.R. § 483.80(a)(1)(2)(4)(e)(f) (F880).

- Ensuring that residents are provided the right to a dignified existence, self-determination, and communication with and access to persons and services

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inside and outside the facility in compliance with 42 C.F.R. § 483.10(a)(1)(2)(b)(1)(2) (F550).

- Ensuring that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care in compliance with 42 C.F.R. § 483.24 (F675).

- Ensuring that each resident receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices in compliance with 42 C.F.R. § 483.25 (F684).

- Providing routine and emergency drugs and biologicals to residents, or obtaining them under an agreement, and ensuring that pharmaceutical services are provided to each resident that meets their individual needs in compliance with 42 C.F.R. § 483.45 (F755).

- Ensuring that, based on a comprehensive assessment, residents who use psychotropic drugs receive gradual dose reductions, and behavior interventions, unless clinically contraindicated, in an effort to discontinue these drugs in compliance with 42 C.F.R. § 483.45(e)(2) (F756).

- Developing, implementing, and maintaining an effective, comprehensive, data-driven quality assurance performance improvement program that focuses on indicators of the outcomes of care and quality of life and that is accountable to the governing body in compliance with 42 C.F.R. § 483.75 (F865).

- Ensuring that the facility is designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public and in compliance with 42 C.F.R. § 483.90.

- Complying with all applicable Federal, State, and local emergency preparedness requirements, and establishing and maintaining an emergency preparedness program in compliance with 42 C.F.R. § 483.73.

- Ensuring that each resident receives the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, including but not limited to providing prevention and treatment for mental and substance use disorders in compliance with 42 C.F.R. § 483.40 (F740).

- Ensuring each resident is provided nourishing, palatable, and well-balanced diet that meets the individual's daily nutritional and special dietary needs, taking into consideration the preferences of each resident in compliance with 42 C.F.R. § 483.60 (F800).

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b. **Report and Recommendations:** The external QIE(s) will provide a report on the results of the analyses required by this Agreement, as set forth in the preceding paragraphs (the "Report"). The Report must include a list of recommendations for changes and improvements necessary for LHH to achieve and maintain compliance with applicable federal participation requirements. Once the Report and recommendations are approved by CMS, these recommendations shall form the basis for the plan to implement the recommendations and necessary improvements (the "Action Plan"), as provided in Paragraph 11.

c. **Delivery of Report:** The QIE(s) will submit the Report in writing to CMS and CDPH as soon as possible but no later than December 1, 2022. CMS may require the external QIE(s) to revise the Root Cause Analysis, at LHH's expense, before CMS will approve it. Such approval may not be unreasonably withheld and CMS will promptly provide a response to the Report after acknowledging receipt of the Report. If CMS does not provide a written response by December 11, 2022, after acknowledging receipt of the Report, the Report will be deemed approved.

11. Action Plan: The external QIE(s) will assist LHH in developing an Action Plan to respond to the findings of the Root Cause Analysis. LHH will be responsible for payment for the creation and implementation of the Action Plan. As soon as possible, but no later than January 6, 2023, LHH will submit the Action Plan to CMS and CDPH for review and approval. The Action Plan will include improvement solutions identified in the Root Cause Analysis. All elements of the Action Plan shall be incorporated into LHH's quality assurance program.

a. The Action Plan must, at a minimum:

i. Be fully implemented by May 13, 2023;

ii. Identify the actions LHH must take to correct all problems identified in the Root Cause Analysis; and

iii. Establish a timeline of activities ("the Timeline"), including a detailed list of milestones and completion dates for each corrective action.

b. CMS will have final approval of the proposed Action Plan, and CMS may require the external QIE(s) or LHH to revise the Action Plan, at LHH's expense, before CMS will accept it. Initial comments from CMS must be provided January 17, 2023 or the Action Plan will be deemed approved. The QIE or LHH shall provide any revisions to the Action Plan requested by CMS within ten business days of receipt of CMS's revision request, unless CMS in writing allows the QIE and LHH additional time to submit revisions. CMS shall provide a response to all revisions of such Action Plan within ten business days of receipt of the written submittal by LHH. Once CMS has approved the Action Plan, LHH will cooperate with the external QIE(s) to promptly implement the Action Plan. If the Parties cannot agree on an Action Plan that CMS approves, CMS may elect to terminate this Agreement and discontinue discretionary federal funding to LHH, subject to the meet-and-confer and dispute escalation procedures set forth in Paragraph 5, above.

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c. If LHH refuses to implement any material aspect of the Action Plan without good cause, as determined by CMS, it shall be considered in material breach of this Agreement. Such breach shall be grounds for CMS to terminate the Agreement and to discontinue discretionary federal funding to LHH, subject to the meet-and-confer and dispute escalation procedures set forth in Paragraph 5, above.

12. Monitoring and Reporting: After the Action Plan has been approved, the external QIE(s) will provide a monthly written report to CMS by the 10th calendar day of each month and will contemporaneously send copies of the reports to the CDPH and LHH.

a. The reports will include, but are not limited to, the following information:

i. Dates and times of the visits by the external QIE(s);
ii. Summary of observations made during the visits;
iii. Summary of any interviews conducted and with whom;
iv. Summary of any records reviewed;
v. Any quality concerns identified;
vi. Any complaints related to resident health and safety received and reviewed by the QIE;
vii. Number and description of complaints received by LHH from any source;
viii. Number and description of incidents reported to CDPH;
ix. Assessment of LHH in meeting established goals outlined in the Action Plan;
x. Obstacles on each item of LHH's Action Plan and proposed solutions to those barriers; and
xi. Summary of any proposed or enacted transfers and discharges.

b. At CMS's discretion, these reports may be followed by face-to-face, video conference, or telephone conference discussions between the external QIE(s) and CMS. Any such discussions will be confidential between CMS and the external QIE(s). The QIE may disclose any concerns or challenges that the QIE(s) identified and disclosed to CMS, directly to LHH.

c. If LHH fails to provide reports, documents, or information identified in the Agreement to the QIE(s), CMS, or CDPH, or if CMS determines that LHH is not adequately progressing toward full compliance with federal participation requirements by not complying with its Action Plan, CMS may find a material breach of this Agreement. Such breach shall be grounds for CMS to exercise its discretion to terminate this Agreement and to discontinue federal funding to LHH, subject to the meet-and-confer and dispute escalation procedures in Paragraph 5, above.

13. CMS May Share Information with the External QIE(s) and Facilitator: CMS may provide the external QIE(s) and Facilitator with information acquired during the course of this Agreement that may be relevant to developing or implementing the Action Plan.

14. Monitoring Surveys: LHH will be subject to onsite, federal surveys at least once every 90 days (about every three months) after October 10, 2022 to assess LHH's compliance with the

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Medicare and Medicaid nursing home care requirements at 42 C.F.R. 483, Subpart B and all other federal requirements. Monitoring surveys will be conducted either by CDPH, CMS, or a private contracting survey entity that CMS approves in writing. CMS retains authority to determine who will conduct the surveys. These surveys will be unannounced and may be performed at any time and without any limit to how many surveys that CDPH and CMS may conduct. These surveys will provide feedback as to the level and degree of compliance that LHH may have achieved. For any survey findings identified at Level 2 or above (i.e., a finding of potential for more than minimal harm, actual harm, or immediate jeopardy), LHH will engage its external QIE(s) to develop a new Root Cause Analysis to identify why noncompliance was cited and develop an updated Action Plan to address those findings. For any survey findings identified as "Immediate Jeopardy" (as that term is defined in 42 C.F.R. § 488.1), LHH agrees to provide and implement a removal/action plan and take immediate action, consistent with Appendix Q of the SOM, in which case CMS will consider whether the Immediate Jeopardy finding has been removed. If CMS determines LHH has removed the Immediate Jeopardy finding, the Immediate Jeopardy termination procedure in 5(h) shall not apply. LHH must make measurable and demonstrated progress towards compliance with Medicare nursing home requirements and the Action Plan in accordance with this Agreement. LHH's failure to achieve substantial compliance by February 13, 2023, which would be signified by a survey with Level 2 or higher findings (federal deficiencies with potential for more than minimal harm, actual harm, or Immediate Jeopardy), may result in CMS terminating this Agreement, discontinuing extended funding, and/or requiring LHH to accelerate the effective and orderly transfer or discharge of remaining residents by a date to be determined by CMS, subject to the meet-and-confer and dispute escalation procedures in Paragraph 5, above. Conversely, if CMS and CDH determine that LHH has achieved and maintained substantial compliance with all federal requirements based on these monitoring surveys, CMS will consider whether LHH may adjust the timeline for implementing the Closure Plan, including permitting a pause on the transfer or discharge of residents pursuant to the Closure Plan until the results of the next monitoring survey. At any time after December 1, 2022, LHH may submit a written request for CMS participate in the meet-and-confer and dispute escalation procedures in Paragraph 5, above to determine whether an extended pause on transfers or discharges is appropriate. In such a written request, LHH will explain the basis(es) why it contends that it is appropriate under 42 C.F.R. § 489.55(b) for the HHS Secretary to continue funding under this Agreement, and include any supporting documentation LHH wishes CMS to consider. CMS is not obligated by this Agreement to participate in the Paragraph 5 meet-and-confer and dispute escalation process to hear LHH's request to adjust the Closure Plan timeline, including pausing transfers or discharges, but will consider LHH's request.

15. Complaint Surveys: LHH acknowledges and agrees that CMS will continue to conduct, or to have CMS federal survey contractors or CDPH conduct on its behalf, unannounced complaint and entity reported event investigations at LHH in accordance with State and Federal law during the term of this Agreement. All surveys performed pursuant to this Agreement will be conducted with confidentiality of resident and staff interviews, and LHH will provide full access to policies and records, as well as providing surveyors full access to interviews of residents and staff, to maintain the integrity of the survey process. Neither this paragraph nor any term in this Agreement precludes CDPH or other state regulatory agencies from investigating complaints or incidents under its state licensure authority.

16. Staffing: Consistent with its obligations under 42 C.F.R. Part 483, Subpart B, LHH will ensure adequate staffing in all disciplines and areas to protect the health and safety of the residents

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residing there. Professional staff will, as necessary: (a) engage in direct service delivery (i.e., provide assessments, therapy, consultations, referrals); (b) participate in Interdisciplinary Team Meetings; and (c) provide training and technical support to LHH staff (i.e., train and monitor effectiveness of program plans developed by professional staff but implemented by non-professional staff).

17. **Responsibility for Compliance and Expenses:** LHH acknowledges that it is solely responsible for achieving and maintaining compliance with all applicable Medicare and Medicaid participation requirements and is solely responsible for the expenses of: hiring of independent QIE(s); conducting the Root Cause Analysis; preparing and implementing the Action Plan; and the monitoring activities specified in this Agreement.

18. **New Certification Application(s):** This Agreement does not preclude LHH from applying to CMS or the State Medicaid Agency for a new certification and provider agreement as a SNF Medicare and/or NF Medicaid participant at any time during the duration of this Agreement. CMS and CDPH recognize that LHH has maintained an interest in reapplying to the Medicare and Medicaid programs. Although this Agreement acknowledges that LHH may reapply to the Medicare and Medicaid programs, it provides no affirmative assurances about LHH's readmission to either program based on any provision in this Agreement. Likewise, in the event that LHH reapplies to the Medicare and/or Medicaid programs during the course of this Agreement, those applications in no way change or limit LHH's responsibilities herein to enact its Closure Plan and safely discharge and transfer residents pursuant to its Closure Plan. CMS and CDPH may use the successful results of any monitoring survey conducted pursuant to this Agreement as part of the recertification surveys in connection with LHH's application for a new Medicare or Medicare provider agreement. For the term of this Agreement, CDPH agrees that a Chief Deputy Director, Deputy Director or Branch Chief from CDPH, or CMS federal reviewer will review the survey results related to LHH's application for certification, if those results find deficiencies that preclude certification.

CDPH agrees to do the following on behalf of CMS:

19. **Cooperation with CMS:** CDPH agrees to cooperate with CMS and help CMS, as its State Survey Agency acting on behalf of CMS, enforce LHH's responsibilities set forth by this Agreement.

20. **Root Cause Analysis and Action Plan Contractors:** CDPH agrees to collaborate with CMS to review LHH's proposed external QIE(s), the external QIE's Root Cause Analysis, and the external QIE's Action Plan, and further collaborate with CMS to assess whether LHH's progress as to these actions comply with the terms of this Agreement.

21. **On-Site External Quality Improvement Monitoring Expert or Organization:** CDPH agrees to cooperate with CMS to review the qualifications of LHH's proposed external QIE(s) and continue to assess LHH's QIE's success in carrying out the terms of this Agreement.

22. **Review of Monitoring Reports:** CDPH will, in conjunction with CMS, review the QIE's monthly reports and the Facilitator's monthly reports and act in accordance with this

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Agreement and its other legal responsibilities in response to any quality concerns identified in those reports.

23. Surveys and Complaint Investigations: CDPH agrees to conduct state complaint survey investigations of complaints and facility reported incidents at LHH for the duration of this Agreement based on applicable state statutes (Title 22, Health and Safety Code, etc.) as required by state law, and all federal regulatory requirements incorporated by state law, and any subsequent required re-visits to such surveys and share these findings with CMS. CDPH will continue to survey LHH pursuant to its licensure and other state authorities, which are additional and separate regulatory activities that will continue, in addition to the survey obligations required by this Agreement, including the surveys specified in Paragraphs 14 and 15 above. CDPH agrees to conduct all surveys fairly and reasonably, and that a Chief Deputy Director, Deputy Director or Branch Chief from CDPH, or a CMS federal surveyor will review the survey results of any surveys specified in this Agreement that results in a substantial noncompliance finding of actual harm or an Immediate Jeopardy.

The Parties further agree:

24. Discharges and Transfers: In the event that discharges and transfers resume under this Agreement, the State will comply with 42 C.F.R. § 488.426(b) and LHH will comply with 42 C.F.R. § 483.70(l).

25. Survey Authority: Notwithstanding any provision of this Agreement, including but not limited to Paragraphs 14 and 15 above, CMS has authority, as does the CDPH, as the State Survey Agency, under its Section 1864 Agreement, to investigate complaints or otherwise evaluate LHH's compliance with federal participation requirements.

26. Resolve Past Complaints: CMS and CDPH agree to not use the survey results of any complaint surveys of LHH that document noncompliance before or were submitted before July 1, 2022 as a basis to terminate this Agreement. This Paragraph does not limit CMS or CDPH's action based on noncompliance that began or occurred prior to July 1, 2022 that remains ongoing after that date.

27. Requirements of 42 C.F.R. Part 483, Subpart B apply: LHH affirms its obligation to comply with all applicable laws, regulations, and requirements, including without limitation, the participation requirements at 42 C.F.R. Part 483, Subpart B.

28. CMS is Not Required to Provide Technical Assistance: This Agreement does not require CMS to provide LHH or its external expert(s) with technical advice or resources for meeting LHH's obligations under this Agreement and federal law.

29. CMP Payment: Pursuant to the authority at sections 1819(h)(2)(B) and 1128A(f) of the Social Security Act (and 42 C.F.R. § 488.444), and based on further review and consideration, CMS exercises its discretion and agrees to accept the amount of $203,885 as payment in full for the CMP imposed for the noncompliance described in Recitals Paragraphs D, E, and F.

30. DPNA Duration: The Denial of Payment for New Admissions discussed in Recitals Paragraph F will continue through the duration of this Agreement. This Agreement does not limit

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CMS and CDPH's authority to impose any new or subsequent DPNA if LHH obtains recertification for any reason authorized under federal law.

31. No Changes to the SODs: CMS will not make any changes to the Statement of Deficiencies for any of the 11 surveys described in Recitals Paragraphs D and E, including to any regulatory citations or their respective scope-and-severity levels.

32. CMP Payment Instructions: As provided in Paragraph 29 above, LHH agrees to pay a total CMP amount of $203,885 and CMS agrees to accept this amount as full payment of the CMPs referenced in Recitals Paragraph F. The CMP payment owed by LHH is due within ten (10) calendar days of this Agreement being executed by both parties. The CMP payment should be made directly through the CMP Pay.gov portal: https://www.pay.gov/public/form/start/998675240. To process the payment via Pay.gov, LHH acknowledges that it will need to provide its CMS Certification No: 55-5020 and the CMP Case Number: 2022-09-LTC-458. LHH agrees to send a copy of its payment receipt from the CMP Pay.gov portal to the CMS San Francisco Office at ROSFEnforcements@cms.hhs.gov with the **Subject Line: CMP No. 2022-09-LTC-458; ATTN: Yvonne Pon**.

33. Failure to Timely Pay CMP: LHH further agrees that if it fails to submit the CMP payment referenced in Paragraph 29 within the specified time period, per 45 C.F.R. § 405.378, the entire unpaid amount of the CMP, plus interest (*see* 45 C.F.R. § 30.18(b)(1)) at the Federal Treasury rate in effect at the time of default (currently set at 8.75% per annum, but subject to change quarterly per 45 C.F.R. § 405.378(d)(1)(i)), will be deducted from any sum[s] then or later owing to LHH by Medicare, Medicaid, or any other federal government entities, agents, or programs until the CMP (including interest) is paid in full, in accordance with 42 C.F.R. § 488.442(c) and (d) or by any other means available under law for collection of debts due to the United States or its agencies. *See also* 42 C.F.R. § 405.378. LHH accepts that it may not receive any additional notice before these deductions will begin.

34. In the Event of Bankruptcy Proceedings: In the event that LHH commences, or is involuntarily placed in, a bankruptcy or reorganization proceeding under Title 11 of the United States Code, LHH agrees not to contest or oppose any motion filed by the United States or CMS seeking relief from or modification of the automatic stay, 11 U.S.C. § 362. LHH expressly acknowledges that this waiver of any rights it may have under the automatic stay is in consideration for final settlement of all issues and disputes between the parties in the proceedings identified above. LHH further agrees that the CMP payable under the Agreement is non-dischargeable in bankruptcy by virtue of 11 U.S.C. § 523(a)(7) as a "fine, penalty, or forfeiture payable to and for the benefit of a governmental unit" that "is not compensation for actual pecuniary loss."

35. Instructions to Not Send CMP to CMS's San Francisco Office: LHH further agrees not to send its CMP payment check to the CMS San Francisco Office. LHH acknowledges that if it sends its CMP payment other than as specified in Paragraph 32 above, its payment may be considered late and offset may be initiated and/or interest may be imposed.

36. Withdrawal of Appeal: Within five (5) business days after this Agreement is signed by the Parties following approval by ordinance by the San Francisco Board of Supervisors and Mayor of San Francisco, LHH agrees to withdraw its appeal of the certifications/findings of

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noncompliance and resulting remedies, including termination, currently pending before the U.S. Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division docketed as *Laguna Honda Hospital & Rehabilitation Center D/P SNF (CCN: 55-5020) v. Centers for Medicare & Medicaid Services*, Docket No. C-22-555. LHH agrees that it will notify the Administrative Law Judge by electronically filing a letter or motion withdrawing its request for hearing with prejudice in the above-referenced case DAB Docket No. C-22-555 via the Departmental Appeals Board Electronic Filing System website (DAB E-file) at https://dab.efile.hhs.gov. LHH affirms that **it will not send** or communicate the contents of this Agreement to the Administrative Law Judge or the staff attorney.

37. **Dismissal of Complaint**: Within five (5) business days after this Agreement is signed by the Parties following approval by ordinance by the San Francisco Board of Supervisors and Mayor, the City and County of San Francisco agrees to file a Notice of Dismissal pursuant to Federal Rule of Civil Procedure 41(a)(1)(A)(i) to dismiss their lawsuit described in Recitals Paragraphs J above, Case No. 3:22-CV-4500, currently pending in the Northern District of California. The Notice of Dismissal shall dismiss the case with prejudice, including all claims asserted or that could have been asserted in that action. The Notice of Dismissal shall also provide that each party will bear their own attorney's fees, costs, and expenses.

38. **Waiver of appeal rights:** LHH agrees to waive all rights to administratively or judicially challenge in any forum in which the United States, DHHS, CMS, or any component of the federal government, or their officers, employees or agents, is a party or has an interest: (a) the certifications/findings of noncompliance based on CMS's determination that LHH was not in "substantial compliance" with the participation requirements for nursing homes at 42 C.F.R. Part 483, as documented in the Statements of Deficiencies for the 11 surveys referenced in Recitals Paragraphs D and E; (b) all remedies referenced in Recitals Paragraph F including the CMPs imposed as a result of the certifications/findings of noncompliance based on the 11 surveys, as modified by Paragraph 29 above; (c) the April 14, 2022 termination date of LHH's Medicare and Medicaid provider agreements; and (d) any claims related to DHHS and CMS's use and duration of discretionary 42 C.F.R. § 489.55(b) funding and LHH's issuance of the Closure Plan that existed or accrued on or before the date when this Agreement is fully executed by all Parties. LHH further agrees that it shall not file or submit any other action or suit against the United States, DHHS, CMS, or any component of the Federal government, including their officers, employees and agents, in any administrative or judicial forum with respect to the certifications/findings of noncompliance and the corresponding remedies imposed by CMS for the surveys described in Recitals Paragraphs, D, E, and F, as modified by Paragraph 29 above.

39. **Agreement as Basis for Resolution:** This Agreement sets forth the full and complete basis for the resolution by the Parties of all the deficiencies in the 11 surveys described in Recitals Paragraphs D and E above; CMS's remedies imposed on LHH described in Recitals Paragraph F above including but not limited to the CMPs, DPNA, and termination described in those paragraphs; and all issues involving DAB Docket No. C-22-555. This Agreement also sets forth the full and complete basis for the resolution by the Parties of all the City's claims in the lawsuit described in Recitals Paragraphs J above, Case No. 3:22-CV-4500, currently pending in the Northern District of California.

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40. Relation to Federal Authority: The Parties agree nothing in this Agreement is binding on any other component of the United States government nor does it in any way define, limit, or circumscribe Federal civil or criminal authority. The Parties agree that nothing in this Agreement limits, contradicts, or circumscribes CMS's existing authority, enforcement discretion, or activities pursuant to Titles XVIII and XIX of the Social Security Act and its implementing regulations including 42 C.F.R. Parts 430, 431, 441, and 442. The Parties agree that CMS retains all authority and discretion accorded to the Agency pursuant to existing regulations and statutes.

41. Public Disclosure: The Parties recognize that this Agreement may be subject to disclosure in accordance with the Freedom of Information Act ("FOIA") and/or in accordance with all applicable laws and processes. All Parties consent to the public disclosure of this Agreement, and information about this Agreement.

42. Applicability of Federal and State Privacy Laws: The Parties acknowledge that documents, information, and data produced or prepared in accordance with this Agreement may be subject to federal and state privacy laws, including the Privacy Act (5 U.S.C. § 552a), HIPAA, and laws protecting the privacy of medical records, quality assurance, patient safety, peer review, and performance improvement activities, and so may be subject to the limits on disclosure these laws impose. However, nothing in this paragraph shall provide a basis for LHH to withhold from CMS or the CDPH relevant information necessary to confirm LHH's compliance with its Action Plan or with the federal participation requirements more generally. CMS does not consent to be bound by state law or to waive any argument of sovereign immunity available to it, and nothing in this paragraph or this Agreement abridges DHHS's or CMS's sovereign immunity. Further, CMS does not waive any administrative exhaustion defenses and rights that CMS possesses and may later accrue in future enforcement actions.

43. Binding Nature of Agreement: This Agreement shall be final and binding upon the Parties, their successors and assigns, upon execution by the undersigned, who represent and warrant that they are authorized to enter into this Agreement on behalf of the Parties hereto in accordance with Paragraph 56.

44. Change in Ownership: In the event that LHH decides to pursue a Change of Ownership ("CHOW"), it will notify CMS in writing at least 60 days prior to the CHOW with a proposed transition plan that ensures LHH's compliance with the federal participation requirements and the terms of this Agreement. The Parties agree that this Agreement shall be fully disclosed to the prospective owner before it acquires LHH's long term care facility, and before it files a CHOW. CMS reserves the right to terminate this Agreement if a CHOW occurs and the terms of this Agreement are not acceptable to CMS and the new owners. Nothing in this Agreement limits CMS's existing statutory and regulatory authority and discretion to reject or preclude any new ownership's participation in the Medicare and Medicaid programs. As stated above, any new assignee approved by CMS shall be bound by the terms of this Agreement.

45. Contacts for Reporting Requirements: For the purposes of this Agreement, all documents, reports, communications and notices specified in this Agreement shall be forwarded via e-mail to the following representatives:

LHH:

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Laguna Honda Hospital
Attn: Roland Pickens, Interim Chief Executive Officer
375 Laguna Honda Blvd,
San Francisco, CA 94116
Phone: (415) 554-2610
E-Mail: roland.pickens@sfdph.org

San Francisco City Attorney's Office
Attn: Sara Eisenberg, Tara Steeley, and Henry Lifton
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102
Phone: (415) 554-4700
E-Mail: sara.eisenberg@sfcityatty.org; tara.steeley@sfcityatty.org; henry.lifton@sfcityatty.org

California Department of Public Health

Attn: Cassie Dunham
California Department of Public Health
Center for Health Care Quality
1615 Capitol Avenue, MS 3201
Sacramento, California 95814
Phone: 916-440-7360
E-mail: Cassie.Dunham@cdph.ca.gov; Susan.Fanelli@cdph.ca.gov; Heather.Chamizo@cdph.ca.gov

Centers for Medicare & Medicaid Services:

Attn: Stephanie Magill and Yvonne Pon
San Francisco and Seattle Survey & Enforcement Division
Survey & Operations Group
CMS Region IX
90 Seventh Street, Suite 600
San Francisco, California 94103
Phone: (415) 744-3746
E-mail: ROSFEnforcements@cms.hhs.gov; stephanie.magill@cms.hhs.gov; rufus.arther@cms.hhs.gov; yvonne.pon@cms.hhs.gov

46. Complete Agreement: This Agreement contains a complete description of the agreement between the Parties. All material representations, understandings, and promises of the parties are contained in this Agreement.

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47. Voluntary Agreement: The Parties represent that this Agreement is entered into voluntarily, with knowledge of the events described herein and after a reasonable opportunity to consult with legal counsel.

48. Attorney's Fees and Costs: Each Party agrees to bear its own costs, fees, and expenses, including attorney's fees and costs.

49. Modification: Any modifications of this Agreement must be in writing and signed by all the Parties.

50. Execution in Counterparts: This Agreement may be executed in multiple identical counterparts, each of which shall be considered original for all purposes.

51. No Waiver: Failure by CMS to enforce any provision of this Agreement, or CMS's decision to refrain from terminating this Agreement in the event of a breach or failure by LHH or CDPH to meet any condition of this Agreement shall not be deemed a waiver or consent to a subsequent breach or failure.

52. Effective Date of Agreement: The effective date of this Agreement shall be the date that all the Parties sign and deliver this Agreement. The City cannot sign and deliver this Agreement until after the agreement is approved by ordinance by the San Francisco Board of Supervisors and the Mayor of San Francisco, consistent with the City's Charter.

53. Order of Execution: CMS shall be the last party to execute this Agreement. Before CMS executes this Agreement, the City and CDPH shall sign and date this Agreement.

54. Timing: All time periods in this Agreement are to be measured by calendar days unless specified otherwise. If a deadline or date falls on a weekend or State or Federal holiday, the deadline or date is extended to the next business day.

55. Jurisdiction: In the event of a contractual dispute related to this Agreement that has not been resolved after compliance with the meet-and-confer and dispute escalation procedures set forth in Paragraph 5, above, each Party agrees to submit to the jurisdiction of the United States Federal Court for the Northern California District, solely for actions as specified in this Agreement. For the avoidance of doubt, nothing in this Agreement is intended to be construed as a submission by a Party to the general jurisdiction of any court or other tribunal, nor as a submission for any purpose except as specified herein.

56. Authority by Signatories: Each person executing this Agreement in a representative capacity on behalf of one of the Parties warrants that individual is duly authorized to bind the party for which he, she, or they sign.

SIGNED THIS DAY BELOW:

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For LHH:

By: DocuSigned by: Roland Pickens 142006282BEB48B... Date: 11/9/2022 | 1:46:33 PST

Name: Roland Pickens
Title: SFHN DIRECTOR
City and County of San Francisco, acting for and on behalf of Laguna Honda Hospital & Rehabilitation Center D/P SNF

Approved as to form:
David Chiu, City Attorney

By: _____ Date: 11/9/2022

Name: Tara Steeley
Deputy City Attorney

For CDPH:

By: _____ Date: 11/10/22

Name: Cassie Dunham
Title: Deputy Director
The California Department of Public Health

For CMS:

By: Jean C. Ay -S Digitally signed by Jean C. Ay -S Date: 2022.11.09 21:29:26 -05'00' Date: _____

Jean Ay
Director
San Francisco and Seattle Survey & Enforcement Division
Survey & Operations Group
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

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FILE NO. 221102 ORDINANCE NO. 224-22

[Settlement of Lawsuit - U.S. Department of Health and Human Services and Xavier Becerra - City to Pay $203,885 - Sole Source Contract for Quality Improvement Expert - Not to Exceed $3,000,000 - Waiver of Certain Administrative Code Provisions]

Ordinance authorizing settlement of the lawsuit filed by the City and County of San Francisco against U.S. Department of Health and Human Services and Xavier Becerra, Secretary of Health and Human Services for $203,885; and in connection with the settlement agreement, authorizing the Department of Public Health to enter into a contract with a Quality Improvement Expert without engaging in a competitive procurement process, and without adhering to specified contract requirements in the Administrative Code; the lawsuit was filed on August 3, 2022, in the United States District Court for the Northern District of California, Case No. 3:22-cv-4500-WHA; entitled City and County of San Francisco v. U.S. Department of Health and Human Services; Xavier Becerra, Secretary of the Department of Health and Human Services; the lawsuit involves allegations that defendants violated the Administrative Procedure Act and the City's due process rights by deciding to terminate federal funding for Laguna Honda Hospital and Rehabilitation Center before residents could safely be transferred to other facilities and before the City's administrative appeal could be heard.

Be it ordained by the People of the City and County of San Francisco:

Section 1. Pursuant to Charter Section 6.102(5), the Board of Supervisors hereby authorizes the City Attorney to settle the action entitled City and County of San Francisco v. U.S. Department of Health and Human Services; Xavier Becerra, Secretary of the Department of Health and Human Services, filed in the United States District Court for the Northern District of California, Case No. 3:22-cv-4500-WHA by the payment of $203,885 by the City for

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previously assessed civil monetary penalties required to be paid as a condition of the settlement and by the continuation of federal funding by the Centers for Medicare and Medicaid Services (CMS) through November 13, 2023. The lawsuit involves allegations that defendants violated the Administrative Procedure Act and the City's due process rights by deciding to terminate federal funding for Laguna Honda Hospital and Rehabilitation Center before residents could safely be transferred to other facilities and before the City's administrative appeal could be heard.

Section 2. The above-named action was filed in the United States District Court for the Northern District of California on August 3, 2022, and the following parties were named in the lawsuit: plaintiff: the City and County of San Francisco; defendants: the U.S. Department of Health and Human Services, and Xavier Becerra, Secretary of the Department of Health and Human Services.

Section 3. The settlement between the parties requires the City to enter into an agreement with a contractor to serve as a quality improvement expert (QIE). Under the terms of the settlement agreement, CMS must approve the QIE and the QIE must deliver a written report to CMS no later than December 1, 2022. The settlement agreement requires the City to retain a QIE for the duration of the settlement agreement, which is at least through November 13, 2023.

Section 4. The Board of Supervisors hereby authorizes the Department of Public Health to enter into a contract with a QIE selected by CMS in an amount not to exceed $3,000,000, for a term not to exceed one year and 3 months (through December 31, 2023), to provide skilled nursing quality improvement services approved by CMS, as required by the settlement between the parties, without adhering to the requirements of Administrative Code Section 21.1, or any other competitive procurement requirements, Administrative Code Chapter 12B, or Administrative Code Chapter 14B.

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APPROVED AS TO FORM AND RECOMMENDED:

DAVID CHIU
City Attorney

/s/
JULIE VAN NOSTERN
Chief Attorney, Health & Human Services

FUNDS AVAILABLE:

/s/ Michelle Allersma for
BEN ROSENFIELD
Controller

RECOMMENDED:

DEPARTMENT OF PUBLIC HEALTH

/s/
GRANT COLFAX
Director of Health

RECOMMENDED:

/s/
MARK MOREWITZ
Secretary, Health Commission

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City and County of San Francisco
Tails
Ordinance

City Hall
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

File Number: 221102 **Date Passed:** November 08, 2022

Ordinance authorizing settlement of the lawsuit filed by the City and County of San Francisco against U.S. Department of Health and Human Services and Xavier Becerra, Secretary of Health and Human Services for $203,885; and in connection with the settlement agreement, authorizing the Department of Public Health to enter into a contract with a Quality Improvement Expert without engaging in a competitive procurement process, and without adhering to specified contract requirements in the Administrative Code; the lawsuit was filed on August 3, 2022, in the United States District Court for the Northern District of California, Case No. 3:22-cv-4500-WHA; entitled City and County of San Francisco v. U.S. Department of Health and Human Services; Xavier Becerra, Secretary of the Department of Health and Human Services; the lawsuit involves allegations that defendants violated the Administrative Procedure Act and the City's due process rights by deciding to terminate federal funding for Laguna Honda Hospital and Rehabilitation Center before residents could safely be transferred to other facilities and before the City's administrative appeal could be heard.

November 01, 2022 Board of Supervisors - PASSED ON FIRST READING

Ayes: 11 - Chan, Dorsey, Mandelman, Mar, Melgar, Peskin, Preston, Ronen, Safai, Stefani and Walton

November 08, 2022 Board of Supervisors - FINALLY PASSED

Ayes: 11 - Chan, Dorsey, Mandelman, Mar, Melgar, Peskin, Preston, Ronen, Safai, Stefani and Walton

File No. 221102

I hereby certify that the foregoing Ordinance was FINALLY PASSED on 11/8/2022 by the Board of Supervisors of the City and County of San Francisco.

Angela Calvillo
Clerk of the Board

London N. Breed
Mayor

11/9/22

Date Approved

EXHIBIT 15

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: POC09a_2019: Mandated Reporting_DPH50076

DATE: 10-7-2021 **Hospital-Wide Compliance Rate:** 98%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Accounting	17		17	0	17	100%
Activity Therapy	26		26	0	26	100%
Administrative Services	9		9	0	9	100%
Admission & Eligibility	8		8	0	8	100%
Ambulatory Care Telecommunications	19		19	0	19	100%
Cash Management / Finance	4		4	0	4	100%
Clinical Support Services	8		8	0	8	100%
Dietitians	9		9	0	9	100%
Education and Training	9		7	0	7	100%
Equity and Culture	1		1	0	1	100%
Environmental Services	105		105	3	102	97%
Facility Services	27		27	0	27	100%
Health at Home	37		37	0	37	100%
Health Information Services	17		17	0	17	100%
Human Resources	7		7	0	7	100%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Informations Systems	10		10	1	9	90%
LHH Patient Accounting	15		15	0	15	100%
Materials Management	13		13	1	12	92%
Medical Services	28		28	2	26	93%
Nursing	703	3	700	12	688	98%
Nutrition Service	97		97	1	96	99%
Office of Managed Care	5		5	0	5	100%
Payroll	4		4	0	4	100%
Pharmacy	24		24	0	24	100%
Psychiatry	8		8	0	8	100%
Quality Management	7		7	0	7	100%
Rehab Services	18		18	0	18	100%
Sheriff	19		19	1	18	95%
Social Services	19		19	0	19	100%
Vocational Rehab	1		1	0	1	100%
Workplace Safety and Emergency Management	0		0	0	0	-
ZFGH Patient Accounting	46		46	0	46	100%
OVERALL COMPLIANCE	**1320**	**3**	**1315**	**21**	**1294**	**98%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: 2019 Mandatory for All - POC to CA597769: Abuse Attestation

DATE: 5/8/2019 **Hospital-Wide Compliance Rate:** 96%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (Approx)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Accounting	22	0	22	0	22	100%
Activity Therapy	38	1	37	0	37	100%
Admission & Eligibility	11	0	11	0	11	100%
Ambulatory Care Telecommunications	34	2	32	6	26	81%
Clinical Support Services	12	1	11	0	11	100%
Dietitians	12	0	12	0	12	100%
Education and Training	12	1	11	0	11	100%
Executive Staff / Admin Support/IPO	27	0	27	1	26	96%
Environmental Services	105	7	98	1	97	99%
Facility Services	32	0	32	0	32	100%
Health at Home	46	2	44	0	44	100%
Health Information Services	23	0	23	1	22	96%
Human Resources	16	0	16	1	15	94%
Informations Systems	10	0	10	0	10	100%
LHH Patient Accounting	10	0	10	0	10	100%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (Approx)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Materials Management	15	0	15	0	15	100%
Medical Services	27	1	26	1	25	96%
Nursing	790	29	761	48	713	94%
Nutrition Service	114	1	113	4	109	96%
Office of Managed Care	5	0	5	0	5	100%
Payroll	4	0	4	0	4	100%
Pharmacy	28	1	27	1	26	96%
Psychiatry	10	1	9	0	9	100%
Quality Management	14	0	14	0	14	100%
Rehab Services	27	2	25	1	24	96%
Sheriff	25	1	24	1	23	96%
Social Services	21	1	20	0	20	100%
Vocational Rehab	1	0	1	0	1	100%
Workplace Safety and Emergency Management	2	0	2	0	2	100%
ZFGH Patient Accounting	62	1	61	0	61	100%
OVERALL COMPLIANCE	**1555**	**52**	**1503**	**66**	**1437**	**96%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: POC08_2019 Plan of Correction (F600, 610): Mandatory for all staff – Prevention of Abuse and Reporting (DPH50071)

*** Course offered online only, no sign-in sheets generated.*

DATE: 7/22/2019 **Hospital-Wide Compliance Rate:** 87%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Accounting	22	0	22	2	20	91%
Activity Therapy	34	0	34	0	34	100%
Administrative Services	13	2	11	0	11	100%
Admission & Eligibility	10	1	9	0	9	100%
Ambulatory Care Telecommunications	33	1	32	15	17	53%
Clinical Support Services	10	0	10	1	9	90%
Dietitians	11	1	10	0	10	100%
Education and Training	11	1	10	0	10	100%
Environmental Services	116	3	113	40	73	65%
Facility Services	37	0	37	4	33	89%
Health at Home	46	0	46	5	41	89%
Health Information Services	24	1	23	1	22	96%
Human Resources	15	0	15	1	14	93%
Informations Systems	9	0	9	2	7	78%
LHH Patient Accounting	11	0	11	2	9	82%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Materials Management	15	0	15	2	13	87%
Medical Services	45	1	44	8	36	82%
Nursing	778	21	757	78	679	90%
Nutrition Service	100	5	95	26	69	73%
Office of Managed Care	5	0	5	1	4	80%
Payroll	4	0	4	0	4	100%
Pharmacy	29	1	28	3	25	89%
Psychiatry	11	0	11	0	11	100%
Quality Management	14	0	14	1	13	93%
Rehab Services	27	1	26	1	25	96%
Sheriff	24	0	24	3	21	88%
Social Services	22	1	21	0	21	100%
Vocational Rehab	1	0	1	0	1	100%
Workplace Safety and Emergency Management	2	0	2	0	2	100%
ZFGH Patient Accounting	58	0	58	4	54	93%
OVERALL COMPLIANCE	**1537**	**40**	**1497**	**200**	**1297**	**87%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: POC12_2019 Mandatory for All: Skilled Nursing Facility (SNF) Quality of Care Plan of Correction In-Service_DPH50095

DATE: 2/25/2020 @ 0700

Hospital-Wide Compliance Rate: 88%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Accounting	22	1	21	0	21	100%
Activity Therapy	34	0	34	2	32	94%
Administrative Services	16	0	16	0	16	100%
Admission & Eligibility	6	1	5	1	4	80%
Ambulatory Care Telecommunications	31	1	30	0	30	100%
Clinical Support Services	9	1	8	3	5	63%
Dietitians	12	0	12	0	12	100%
Education and Training	9	0	9	1	8	89%
Environmental Services	120	17	103	9	94	91%
Facility Services	32	3	29	0	29	100%
Health Information Services	19	2	17	0	17	100%
Human Resources	12	3	9	2	7	78%
Informations Systems	9	0	9	5	4	44%
LHH Patient Accounting	10	0	10	0	10	100%
Materials Management	15	0	15	3	12	80%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Medical Services	28	0	28	2	26	93%
Nursing	794	22	772	99	673	87%
Nutrition Service	107	5	102	21	81	79%
Office of Managed Care	5	0	5	0	5	100%
Payroll	4	0	4	0	4	100%
Pharmacy	31	0	31	0	31	100%
Psychiatry	12	0	12	1	11	92%
Quality Management	14	1	13	1	12	92%
Rehab Services	28	1	27	1	26	96%
Sheriff	23	0	23	7	16	70%
Social Services	20	0	20	0	20	100%
Workplace Safety and Emergency Management	2	0	2	0	2	100%
ZFGH Patient Accounting	61	2	59	10	49	83%
OVERALL COMPLIANCE	**1485**	**60**	**1425**	**168**	**1257**	**88%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: 2020 Mandatory for All: Abuse Prevention 1_DPH50124

DATE: 8-16-2021 **Hospital-Wide Compliance Rate:** 90%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Accounting	21		21	1	20	95%
Activity Therapy	28	1	27	0	27	100%
Administrative Services	15	1	14	1	13	93%
Admission & Eligibility	8		8	0	8	100%
Ambulatory Care Telecommunications	28	1	27	3	24	89%
Cash Management / Finance	5		5	1	4	80%
Clinical Support Services	9	1	8	3	5	63%
Dietitians	9		9	1	8	89%
Education and Training	7		5	0	5	100%
Equity and Culture	1		1	0	1	100%
Environmental Services	120	4	116	48	68	59%
Facility Services	29	1	28	0	28	100%
Health at Home	40		40	1	39	98%
Health Information Services	19		19	0	19	100%
Human Resources	13		13	8	5	38%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Informations Systems	10		10	7	3	30%
LHH Patient Accounting	16		16	0	16	100%
Materials Management	15		15	3	12	80%
Medical Services	30	4	26	5	21	81%
Nursing	778	1	777	32	745	96%
Nutrition Service	106	3	103	19	84	82%
Office of Managed Care	5		5	0	5	100%
Payroll	5		5	0	5	100%
Pharmacy	26		26	0	26	100%
Psychiatry	11		11	0	11	100%
Quality Management	10	1	9	0	9	100%
Rehab Services	19		19	1	18	95%
Sheriff	19		19	12	7	37%
Social Services	18		18	0	18	100%
Vocational Rehab	1		1	0	1	100%
Workplace Safety and Emergency Management	1		1	0	1	100%
ZFGH Patient Accounting	49		49	0	49	100%
OVERALL COMPLIANCE	**1471**	**18**	**1451**	**146**	**1305**	**90%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: 2021 Mandatory for All: Abuse Prevention 2_DPH50129

DATE: 8-16-2021 **Hospital-Wide Compliance Rate:** 89%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Accounting	21		21	1	20	95%
Activity Therapy	28	1	27	0	27	100%
Administrative Services	15		15	1	14	93%
Admission & Eligibility	8		8	0	8	100%
Ambulatory Care Telecommunications	28	1	27	4	23	85%
Cash Management / Finance	5		5	2	3	60%
Clinical Support Services	9	1	8	4	4	50%
Dietitians	9		9	1	8	89%
Education and Training	7		5	0	5	100%
Equity and Culture	1		1	0	1	100%
Environmental Services	120	4	116	53	63	54%
Facility Services	29	1	28	0	28	100%
Health at Home	40		40	1	39	98%
Health Information Services	19		19	0	19	100%
Human Resources	13		13	8	5	38%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Informations Systems	10		10	7	3	30%
LHH Patient Accounting	16		16	0	16	100%
Materials Management	15		15	3	12	80%
Medical Services	30	4	26	6	20	77%
Nursing	782	2	780	35	745	96%
Nutrition Service	106	4	102	19	83	81%
Office of Managed Care	5		5	0	5	100%
Payroll	5		5	0	5	100%
Pharmacy	26		26	0	26	100%
Psychiatry	11		11	0	11	100%
Quality Management	10		10	0	10	100%
Rehab Services	19		19	1	18	95%
Sheriff	19		19	12	7	37%
Social Services	18		18	0	18	100%
Vocational Rehab	1		1	0	1	100%
Workplace Safety and Emergency Management	1		1	0	1	100%
ZFGH Patient Accounting	49		49	0	49	100%
OVERALL COMPLIANCE	**1475**	**18**	**1455**	**158**	**1297**	**89%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: 2020 Mandatory for All: Residents' Rights_DPH50101

DATE: 5/6/21 **Hospital-Wide Compliance Rate:** 89%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Accounting	18		18	1	17	94%
Activity Therapy	27	1	26	0	26	100%
Administrative Services	14	1	13	0	13	100%
Admission & Eligibility	8		8	0	8	100%
Ambulatory Care Telecommunications	29	2	27	4	23	85%
Cash Management / Finance	5		5	1	4	80%
Clinical Support Services	8	1	7	4	3	43%
Dietitians	9		9	1	8	89%
Education and Training	7		7	0	7	100%
Equity and Culture	1		1	0	1	100%
Environmental Services	112	5	107	47	60	56%
Facility Services	27	1	26	0	26	100%
Health at Home	40		40	2	38	95%
Health Information Services	19		19	0	19	100%
Human Resources	9		9	5	4	44%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Informations Systems	11		11	7	4	36%
LHH Patient Accounting	14		14	0	14	100%
Materials Management	15		15	3	12	80%
Medical Services	28	4	24	7	17	71%
Nursing	771	7	764	53	711	93%
Nutrition Service	104	3	101	15	86	85%
Office of Managed Care	5		5	0	5	100%
Payroll	5		5	0	5	100%
Pharmacy	25		25	0	25	100%
Psychiatry	10		10	0	10	100%
Quality Management	9	1	8	0	8	100%
Rehab Services	19		19	1	18	95%
Sheriff	19		19	11	8	42%
Social Services	18		18	0	18	100%
Vocational Rehab	1		1	0	1	100%
Workplace Safety and Emergency Management	1		1	0	1	100%
ZFGH Patient Accounting	49		49	0	49	100%
OVERALL COMPLIANCE	**1437**	**26**	**1411**	**162**	**1249**	**89%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: 2021 Mandatory for All: Abuse Prevention 1_DPH50217

DATE: 8/12/22 **Hospital-Wide Compliance Rate:** 95%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Accounting	19		19	0	19	100%
Activity Therapy	28		28	0	28	100%
Administrative Services	13		13	0	13	100%
Admission & Eligibility	8		8	0	8	100%
Ambulatory Care Telecommunications	35		35	0	35	100%
Cash Management / Finance	6		6	0	6	100%
Clinical Support Services	9	1	8	1	7	88%
Dietitians	11		11	0	11	100%
Education and Training	8		8	0	8	100%
Equity and Culture	1		1	0	1	100%
Environmental Services	117	9	108	20	88	81%
Facility Services	31		31	0	31	100%
Health at Home	38		38	0	38	100%
Health Information Services	19	1	18	0	18	100%
Human Resources	9		9	3	6	67%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Informations Systems	8		8	0	8	100%
LHH Patient Accounting	17		17	0	17	100%
Materials Management	18		18	2	16	89%
Medical Services	29	1	28	9	19	68%
Nursing	785	11	774	23	751	97%
Nutrition Service	113	4	109	10	99	91%
Office of Managed Care	5		5	0	5	100%
Payroll	5		5	0	5	100%
Pharmacy	26		26	0	26	100%
Psychiatry	10		10	0	10	100%
Quality Management	10		10	0	10	100%
Rehab Services	19		19	0	19	100%
Sheriff	18	1	17	4	13	76%
Social Services	18		18	0	18	100%
Vocational Rehab	1		1	0	1	100%
Workplace Safety and Emergency Management	0		0	0	0	-
ZFGH Patient Accounting	50		50	0	50	100%
OVERALL COMPLIANCE	**1484**	**28**	**1456**	**72**	**1384**	**95%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: 2021 Mandatory for All: Residents' Rights_DPH50203

DATE: 8/12/22 **Hospital-Wide Compliance Rate:** 94%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Accounting	20		20	0	20	100%
Activity Therapy	29		29	0	29	100%
Administrative Services	13	1	12	1	11	92%
Admission & Eligibility	8		8	0	8	100%
Ambulatory Care Telecommunications	32	1	31	0	31	100%
Cash Management / Finance	6		6	0	6	100%
Clinical Support Services	9	1	8	2	6	75%
Dietitians	11		11	0	11	100%
Education and Training	8		8	0	8	100%
Equity and Culture	1		1	0	1	100%
Environmental Services	118	7	111	21	90	81%
Facility Services	30		30	0	30	100%
Health at Home	40	1	39	1	38	97%
Health Information Services	19		19	0	19	100%
Human Resources	9		9	3	6	67%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Informations Systems	8		8	0	8	100%
LHH Patient Accounting	17		17	0	17	100%
Materials Management	17		17	3	14	82%
Medical Services	29	2	27	8	19	70%
Nursing	781	15	766	29	737	96%
Nutrition Service	116	4	112	21	91	81%
Office of Managed Care	5		5	0	5	100%
Payroll	5		5	0	5	100%
Pharmacy	27		27	0	27	100%
Psychiatry	11		11	0	11	100%
Quality Management	10		10	0	10	100%
Rehab Services	19	1	18	0	18	100%
Sheriff	18	1	17	4	13	76%
Social Services	18		18	0	18	100%
Vocational Rehab	1		1	0	1	100%
Workplace Safety and Emergency Management	0		0	0	0	-
ZFGH Patient Accounting	51		51	0	51	100%
OVERALL COMPLIANCE	**1486**	**34**	**1452**	**93**	**1359**	**94%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: 2022 Mandatory for All: Abuse Prevention II_DPH50350

DATE: 07/03/2023 **Hospital-Wide Compliance Rate:** 95%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Accounting	15		15	0	15	100%
Activity Therapy	22		22	1	21	95%
Administrative Services	14		14	1	13	93%
Admission & Eligibility	12		12	0	12	100%
Ambulatory Care Telecommunications	22		22	0	22	100%
Cash Management / Finance	9		9	1	8	89%
Clinical Support Services	8	1	7	0	7	100%
Dietitians	13		13	0	13	100%
Education and Training	11		11	0	11	100%
Equity and Culture	1		1	0	1	100%
Environmental Services	109	12	97	15	82	85%
Facility Services	31		31	0	31	100%
Health at Home	37	1	36	0	36	100%
Health Information Services	20		20	0	20	100%
Human Resources	12	1	11	2	9	82%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Informations Systems	8		8	2	6	75%
IT Procurement	7		7	3	4	57%
LHH Patient Accounting	15		15	0	15	100%
Materials Management	13		13	0	13	100%
Medical Services	31	2	29	5	24	83%
Nursing	731	20	711	16	695	98%
Nutrition Service	98	4	94	23	71	76%
Office of Managed Care	4		4	0	4	100%
Payroll	5		5	0	5	100%
Pharmacy	29		29	0	29	100%
Psychiatry	9		9	0	9	100%
Quality Management	13		13	0	13	100%
Rehab Services	16		16	0	16	100%
Sheriff	27		27	1	26	96%
Social Services	16		16	0	16	100%
Vocational Rehab	1		1	0	1	100%
Volunteer Services	1		1	0	1	100%
Workplace Safety and Emergency Management	0		0	0	0	-
ZFGH Patient Accounting	48		48	0	48	100%
OVERALL COMPLIANCE	**1408**	**41**	**1367**	**70**	**1297**	**95%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: 2022 Mandatory for All: Residents' Rights_DPH50300

DATE: 02/02/23 **Hospital-Wide Compliance Rate:** 95%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Accounting	15		15	0	15	100%
Activity Therapy	24		24	1	23	96%
Administrative Services	7		7	1	6	86%
Admission & Eligibility	10		10	0	10	100%
Ambulatory Care Telecommunications	19		19	0	19	100%
Cash Management / Finance	6		6	1	5	83%
Clinical Support Services	9	1	8	2	6	75%
Dietitians	12		12	0	12	100%
Education and Training	10		10	0	10	100%
Equity and Culture	1		1	0	1	100%
Environmental Services	109	9	100	8	92	92%
Facility Services	28		28	0	28	100%
Health at Home	38		38	0	38	100%
Health Information Services	20		20	0	20	100%
Human Resources	11	1	10	2	8	80%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Informations Systems	8		8	0	8	100%
LHH Patient Accounting	14		14	0	14	100%
Materials Management	14	1	13	1	12	92%
Medical Services	30	1	29	11	18	62%
Nursing	736	14	722	29	693	96%
Nutrition Service	103	4	99	15	84	85%
Office of Managed Care	4		4	0	4	100%
Payroll	4		4	0	4	100%
Pharmacy	27		27	1	26	96%
Psychiatry	11		11	0	11	100%
Quality Management	9		9	0	9	100%
Rehab Services	16		16	0	16	100%
Sheriff	19		19	1	18	95%
Social Services	16		16	0	16	100%
Vocational Rehab	1		1	0	1	100%
Workplace Safety and Emergency Management	1		1	0	1	100%
ZFGH Patient Accounting	45		45	0	45	100%
OVERALL COMPLIANCE	**1377**	**31**	**1346**	**73**	**1273**	**95%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: 2023 Mandatory for All: Abuse Prevention 1_DPH50402_As Needed_Contractors_Registry

DATE: 03/01/2024 **Hospital-Wide Compliance Rate:** 91%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
CLINICAL SUPPORT SERVICES	2	0	2	0	2	100%
EDUCATION AND TRAINING	1	0	1	0	1	100%
FACILITY SERVICES	4	0	4	0	4	100%
MATERIALS MANAGEMENT	1	0	1	0	1	100%
MEDICAL SERVICES	17	3	14	0	14	100%
NURSING	44	6	37	7	30	81%
NUTRITION SERVICES	10	1	9	0	9	100%
PHARMACY	4	0	4	0	4	100%
PSYCHIATRY	2	0	2	0	2	100%
REHAB SERVICES	8	0	8	0	8	100%
Grand Total	**93**	**10**	**82**	**7**	**75**	**91%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: 2023 Mandatory for All: Abuse Prevention II_DPH50426

DATE: 03/01/2024 **Hospital-Wide Compliance Rate:** 82%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
CLINICAL SUPPORT SERVICES	2	0	2	1	1	50%
FACILITY SERVICES	4	1	3	0	3	100%
MATERIALS MANAGEMENT	1	0	1	0	1	100%
MEDICAL SERVICES	17	7	10	3	7	70%
NURSING	59	16	43	9	34	79%
NUTRITION SERVICES	10	1	9	2	7	78%
PHARMACY	4	0	4	0	4	100%
PSYCHIATRY	3	0	3	0	3	100%
REHAB SERVICES	8	0	8	0	8	100%
Grand Total	**108**	**25**	**83**	**15**	**68**	**82%**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

IN-SERVICE COMPLIANCE REPORT

TITLE: 2023 Mandatory for All: Residents' Rights _DPH50396

DATE: 02/02/24 **Hospital-Wide Compliance Rate:** 95%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Accounting	14	0	14	0	14	100%
Activity Therapy	20	0	20	0	20	100%
Administrative Services	13	0	13	1	12	92%
Admission & Eligibility	10	0	10	0	10	100%
Ambulatory Care Telecommunications	13	0	13	1	12	92%
Cash Management / Finance	9	0	9	2	7	78%
Clinical Support Services	7	2	5	1	4	80%
Dietitians	13	0	13	0	13	100%
Education and Training	11	0	11	0	11	100%
Equity and Culture	1	0	1	0	1	100%
Environmental Services	106	14	92	9	83	90%
Facility Services	36	0	36	0	36	100%
Health at Home	35	0	35	0	35	100%
Health Information Services	18	0	18	0	18	100%
Human Resources	8	1	7	0	7	100%

DEPARTMENT	NUMBER OF STAFF ASSIGNED COURSE (APPROX)	NUMBER OF STAFF ON LEAVE	NUMBER OF STAFF AVAILABLE ASSIGNED	NUMBER OF STAFF NOT COMPLETED	NUMBER OF STAFF COMPLETED	ADJUSTED COMPLIANCE RATE (PRESENT STAFF)
Informations Systems	8	0	8	2	6	75%
IT Procurement	4	0	4	2	2	50%
LHH Patient Accounting	13	0	13	0	13	100%
Materials Management	12	0	12	0	12	100%
Medical Services	28	1	27	4	23	85%
Nursing	656	17	639	23	616	96%
Nutrition Service	90	8	82	12	70	85%
Office of Managed Care	5	0	5	0	5	100%
Payroll	5	0	5	0	5	100%
Pharmacy	29	0	29	0	29	100%
Psychiatry	6	0	6	0	6	100%
Quality Management	14	0	14	0	14	100%
Rehab Services	16	0	16	0	16	100%
Sheriff	17	0	17	1	16	94%
Social Services	16	0	16	0	16	100%
Vocational Rehab	1	0	1	0	1	100%
Volunteer Services	1	0	1	0	1	100%
Workplace Safety and Emergency Management	-	-	-	-	-	-
ZFGH Patient Accounting	**44**	**0**	**44**	0	**44**	100%
OVERALL COMPLIANCE	**1279**	**43**	**1236**	**58**	**1178**	**95%**