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Weeks Following Forced Discharge, LHH Hostages Began Dying

Culpability in 12 Patient Deaths

Asking Hostage Takers to Wait Before Shooting the Hostages: LHH Residents Face Resumption of Mandatory Discharges

by Patrick Monette-Shaw

LHH's Acting-CEO, Roland Pickens, addressed the Health Commission on January 17, 2023. Pickens asserted LHH employees were "*not at fault*" for post-discharge deaths of 12 LHH residents evicted from LHH in June and July. The state surveyors' "Class B" citations suggest otherwise.

It's understandable Laguna Honda Hospital (LHH) wants to avoid culpability when patients die, but as with everything else in life actions have consequences, sometimes grave.

As the *Westside Observer* reported earlier this January, LHH's chaotic and negligent discharge processes of residents from the facility last summer resulted in State "Class B" citations issued on December 20 totalling $36,000 in fines from the California Department of Public Health (CDPH) over LHH's role in the post-discharge deaths of 12 of its residents. The average age of the 12 people was 81.25.

> **"It's understandable LHH wants to avoid culpability when patients die, but as with everything else in life actions have consequences, sometimes grave."**

We initially reported the deaths involved 57 residents discharged before mandatory transfers were halted on July 28. But on reflection, those deaths occurred among the first 41 of the 57 residents discharged through July 17. The 12 deaths represented 29.3% — nearly a third — of the 41 discharges. Two of the residents died within 11 days of discharge, and one resident died 67 days post-discharge. The deaths averaged 29.5 days following their dates of discharge.

Certainly, CDPH and the Centers for Medicare and Medicaid [Medi-Cal] Services (CMS) bear some accountability in the patients' deaths because it had been CMS and CDPH that had insisted LHH engage in mandatory, involuntary forced discharges required by the initial "*Closure Plan*" LHH was forced into accepting. LHH had wanted an 18-month period in which to safely discharge its residents while concurrently applying to regain its certification CMS had stripped from the facility in April 2022. But CMS wouldn't budge and gave LHH an extension of just four months to discharge its frail residents.

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>
> **Dr. Derek Kerr published an *Observer* article on August 2 noting that CMS had expressed concern over LHH's role in the deaths."**

So, CMS and CPDH share some culpability for the LHH residents who died in short order following their forced evictions. But CMS isn't the only culprit.

Long before we belatedly learned in January 2023 that 12 people discharged from LHH had died, my esteemed *Westside Observer* colleague, Dr. Derek Kerr, published an *Observer* article on August 2, noting that CMS had expressed concern over LHH's role in the deaths. At the time, only 4 of the 12 deaths were known publicly when Kerr reported CMS had released a statement on July 28 that read LHH was "*required to perform thorough and adequate medical assessments of every resident before a transfer or discharge … .*"

> **"LHH has tried ever since to disavow, or minimize, its potential culpability for the patients' deaths."**

The discharges were temporarily "*paused*" on July 28 following public outcry after reports of the first four deaths surfaced.

Despite CMS' statement, LHH has tried ever since to disavow, or minimize, its potential culpability for the patients' deaths. During San Francisco's full Health Commission meeting on January 17, 2023 LHH's acting CEO, Roland Pickens stated, in part, (at 37:50 on videotape):

> "*It's important to note that while CDPH issued these citations [against] Laguna Honda, and we take them seriously and have submitted a Plan of Correction to CDPH, we do not agree with all of the allegations that were stated in those citations and we have started the Appeals process to appeal those citations while we further evaluate the cases. It's important that we take a little time to acknowledge and recognize the impact of those citations on our staff, our residents, and the families at Laguna Honda. Again, because none of us had wanted to initiate those transfers, it was very challenging and so we are working hard to, again, through our advocacy and our request to CMS, that we don't have to resume transfers. So, we want to let our staff know* ***by no means are we feeling bad. They weren't at fault in any of those cases***."

Pickens also asserted on January 17 that CDPH had not found LHH had caused "*serious harm*" to the residents, or that LHH was the direct, proximate cause of any of the residents' deaths.

"Pickens testified: '*So, we want to let our staff know* by no means are we feeling bad. They weren't at fault *in any of those cases*'."

Following Pickens' presentation on January 17, Dr. Teresa ("Terry") Palmer, a noted geriatrician who formerly worked at Laguna Honda Hospital, testified during public comment by saying, in part (at 44:50 on videotape):

> "*The lack of experience on the part of Laguna Honda administration led to panicky discharges by* [LHH] *staff* [who were] *fearing for their jobs if they did not obey* [orders to discharge residents]. … *In nursing homes, a discharge to another nursing home is relatively infrequent and more complicated than discharge to* [an] *acute* [care hospital] *because you're handing over the care of a person's whole life to the nursing home. It's pretty amazing the CDPH found that this wasn't a proximal cause of death. In most* [of the 12] *cases, it clearly was* [a proximate cause]. …
>
> "*I think that because CDPH was itself complicit in [giving] bad advice and bad management they* [only] *slapped* [LHH's] *hand, instead of doing the serious citations that should have happened* [in cases of patient deaths]. *Now what we need is not to repeat this exercise* [in dangerous discharges]. *I think it could be very expensive for the City in terms of litigation if this exercise in cruelty does recur* [should mandatory discharges resume on February 2]."

"Pickens also asserted CDPH had not found LHH had caused '*serious harm*' to the residents, or that LHH was the direct, proximate cause of any of the residents' deaths.

Dr. Palmer testified: '*It's pretty amazing the CDPH found that this wasn't a proximal cause of death. In most* [of the 12] *cases, it clearly was*."

After taking public comment on Pickens' presentation on January 17, Health Commissioner Laurie Green — herself an MD — stated that she had read "*quite a few of the transfer reports*" (apparently unable to bring herself to say the word "*citations*"). It's unclear how many of the combined 84 pages across the 12 citations Green had read. She asked Pickens what impact the citations may have had (if any) on CMS' decision about the *Closure* plan.

Pickens responded saying that because LHH had been subjected to only a four-month discharge period that "*we then had to pause the discharges because of the* Settlement Agreement." Pickens had his dates backwards. CMS had "*paused*" the discharges on July 28, but the tentative *Settlement Agreement* didn't even surface until October 12. He was deflecting and didn't really answer Green's question.

"'*If it's not documented in the [patient's] chart, then it didn't happen*.'

Commissioner Green should have realized State surveyors were quite concerned in the 12 citations about missing documentation in patient charts."

As for the generic patient care plans not individualized for a given patient when not missing entirely, surely Green must have recalled the old adage used in most healthcare settings "*If it's not documented in the* [patient's] *chart, then it didn't happen*." She should have realized State surveyors were quite concerned in the 12 citations about missing documentation in patient charts, for which there is no excuse.

There were a number of errors in Pickens' presentation.

First, Pickens' "*Plan of Correction*" in itself borders on being a posthumous insult to the 12 people who died as a result of LHH's failures to conduct *adequate medical assessments*. After all, there's no way to *correct* someone's death after-the-fact, given that raising Lazarus from the dead is a myth even though it was passed off as being a biblical "*miracle*."

> **"Deficiencies in the 12 LHH citations weren't mere allegations, as Pickens asserted. The citations appear to have been based on substantiated facts, even though LHH may not agree with them."**

As well, like many other documents involving the scandal occurring at LHH, the *Plan of Correction* Pickens may have been referring to hasn't been released as a public document and is being hidden, so there's no way of knowing what corrective actions (if any) LHH and Pickens may belatedly be putting in place to prevent a recurrence. One wonder what LHH proposed in the *Plan of Corrections* to *right the ship*, and whether CDPH accepted the proposed corrections.

Second, it appears the deficiencies in the 12 LHH citations weren't mere *allegations*, as Pickens wrongly asserted. The citations appear to have been based on substantiated facts, even though LHH may not agree with them.

Third, LHH missed the 15-day period in which to appeal. The citations posted on CDPH's *Cal Health Find* web page reports LHH had not appealed any of the 12 "Class B" citations, which were issued on December 20. The 15-day window to appeal stipulated in California's Health and Safety Code §1428 had long ended by the time Pickens asserted on January 17 LHH was still hoping to appeal. As LHH's acting CEO since June of 2022, Pickens should have known about §1428, or someone — say, one of the Health Commissioners — should have told him about it.

> **"Pickens' assertion to the Commission on January 17 that LHH employees were '*not at fault*' for the post-discharge deaths of residents evicted from LHH is misguided, at best, whether or not LHH feels badly."**

Fourth, Pickens' assertion before the Commission on January 17 that LHH employees were "*not at fault*" for the post-discharge deaths of residents evicted from LHH is misguided, at best, whether or not LHH feels badly.

"*Gaslighting*" may be an overused term, but it seems to apply to Roland Pickens who seemed to be gaslighting the Health Commission — and members of the public — on January 17 by using deliberate misinformation and excuses masquerading as senior management claims to make us doubt perceptions of whether LHH is making real progress to save LHH.

Pickens has done this before, and he is known to play a bit loose with the facts, calling into question his veracity. It would be so much better if he just admitted LHH had made mistakes that led to being slapped with the 12 citations.

There is no such thing as "no-fault discharges" — for CMS, for CDPH, or for Laguna Honda Hospital itself — just as there is no such thing as "*no-fault accident*" liability, or "*no fault divorces*," which are legal escape hatches. The responsibility of the deaths post-discharge is a shared responsibility, no matter how much LHH may want to avoid finger-pointing or escape being found to have been at fault.

The Patients, By the Numbers

On January 12, the *California Advocates for Nursing Home Reform* (CANHR) issued a press release noting CDPH had issued fines totalling $36,000 against LHH. Among other key points raised, the press release noted "*Laguna Honda selected extremely disabled, sick, and dependent residents for eviction, who were known to be at high risk for transfer trauma*."

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CANHR's Executive Director, Patricia McGinnis, was quoted as saying "*CDPH must not be allowed to whitewash the deaths of these vulnerable residents and its own role in them*."

Unfortunately, it's not just CDPH trying to whitewash the post-discharge patient deaths. LHH and San Francisco's Department of Public Health (SFDPH) and San Francisco's Health Commission are also trying desperately to whitewash the deaths. Pickens' assertion on January 17 that LHH staff are *not at fault* — implying the facility bore no culpability in the deaths that ensued — is proof LHH has reverted to using its revisionist history whitewashing paint brush.

CANHR's press release was absolutely correct: The 12 patients who rapidly died following discharge were selected by Laguna Honda — not by CDPH. That was on LHH.

LHH chose to finger extremely disabled, sick, and dependent residents for eviction. LHH knew those residents were at high risk for transfer trauma. The discharges occurred between June 10 and July 17, and the deaths happened between July 1 and September 9, with 9 of the deaths occurring by July 30.

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CANHR was right: LHH's residents held hostage and evicted were extremely medically fragile. Here's a snapshot of the residents, gleaned from details in narrative in 84 pages across the 12 citations CDPH released and made public. [**Note:** For your convenience, links to the citations can be found here.]

Table 1: Snapshot of the 12 LHH Residents Who Died Post-Discharge

	State Penalty Number and Enforcement Action Narrative	Patient #	Age	Gender	Transfer Date	Date Died	# of days Before Died	Type of Receiving Facility
1	220018216	3	84	Male	6/10/2022	7/16/2022	36	SNF
2	220018217	11	95	Female	6/23/2022	7/9/2022	16	SNF
3	220018218	24	93	Female	7/5/2022	7/24/2022	19	SNF
4	220018220	17	71	Male	6/30/2022	8/24/2022	55	SNF
5	220018221	5	100	Female	6/10/2022	7/7/2022	27	SNF
6	220018223	38	77	Male	6/17/2022	7/30/2022	43	SNF
7	220018224	39	79	Male	7/8/2022	7/25/2022	17	SNF
8	220018225	7	79	Male	6/21/2022	7/1/2022	10	SNF
9	220018226	31	68	Female	7/13/2022	7/24/2022	11	SNF
10	220018227	2	79	Male	6/10/2022			SNF
11	220018228	53	63	Male	6/23/2022	7/17/2022	24	Medical Respite
12	220018229	21	87	Female	7/1/2022	9/6/2022	67	SNF
		Average:	**81.25**				**29.55**	

Source: California Department of Public Health (CDPH) *Cal Health Find* database citations; downloaded on 1/11/2023.

- One of the residents was 100, 2 were in their 90's, 2 were in their 80's, 5 were in their 70's , and 2 were in their 60's. All 12 were frail elderly patients. Again, their average age was 81.2.
- 7 were male and 5 were female.
- A 100-year-old woman had dementia and was on palliative end-of-life care. The citation noted her records stated she was not to be transferred to an acute-care hospital, had a do-not-resuscitate (DNR) order, and was not appropriate for discharge. She was fingered for discharge to another SNF anyway, and survived the transfer trauma for 27 days before she expired.
- 10 of the 12 were noted to have various types of dementias, Alzheimer's, or a traumatic brain injury.
- At least 10 of the 12 patients had been identified by LHH's own staff as being at high risk for transfer trauma. They were discharged anyway, despite the known risks transfer trauma is often deadly.
- 1 had endured a hemorrhagic stroke.
- 1 had laryngeal cancer, along with HIV/AIDS and a substance use disorder, and was discharged to a medical respite homeless shelter where he was subsequently found dead sitting on a toilet.
- One of the most appalling discharges was a conserved 68-year-old woman with dementia who was knowingly transferred to a skilled nursing facility (SNF) that was in the middle of a COVID outbreak. She contracted COVID eight days after she arrived at the receiving facility and died three days later. Why did LHH knowingly transfer her to a SNF that LHH knew beforehand was having a COVID outbreak?

"At least 10 of the 12 patients had been identified by LHH's own staff as being at high risk for transfer trauma. They were discharged anyway, despite the known risks transfer trauma is often deadly."

Contributory Factors by LHH Staff

While Pickens wants to avoid saying LHH or its staff were at fault, other key points gleaned from narratives in the citations point to errors — or at a minimum, lapses in judgement — selecting which frail residents LHH fingered for discharge. CDPH surveyors noted:

> **"At least 8 of the 12 patients were discharged without individualized care plans.**
>
> **At least six of the 12 patients didn't have the required MD-to-MD or RN-to-RN handoffs on the day of transfer from LHH to the receiving facility."**

- At least 8 of the 12 patients were discharged without individualized care plans.
- LHH failed to develop and implement a discharge care plan for at least one of the patients.
- At least one of the patients did not have a care plan specific to transfer trauma.
- The majority of the patients did not have a separate assessment of their risk of transfer trauma.
- At least three of the patients did not have the required RN-to-RN handoffs on the day of transfer from LHH to the receiving facility.
- At least three of the patients did not have the required MD-to-MD handoffs on the day of transfer from LHH to the receiving facility.

All of that was clearly on LHH's staff. It's not known if Pickens addressed these errors in his *Plan of Correction* responding to CDPH's citations. But narrative in the 12 citations point to several other problems of concern.

Statements Attributed to LHH Staff

Although not named by name, statements made by LHH staff members to CDPH's surveyors were attributed to their positions or roles at LHH.

> **"TC #1 stated '*They* [staff] *do not need to do* [patient] *reassessment[s] because they pursued discharge[s] to SNF level* [of care].' That's absurd. *All discharges* and transfers require re-assessment."**

Several statements attributed to "Transfer Coordinators" (TC) are disturbing. One TC explained "*that LHH's Medical Social Services Discharge 'Patient Assessment Form' was a template meant for patients to be discharged to the community*." Didn't that Coordinator realize the patients were being discharged to other skilled nursing facilities, not to the "community"?

TC #1 stated "*They* [staff] *do not need to do* [patient] *reassessment[s] because they pursued discharge[s] to SNF level* [of care]." That's absurd. All discharges and patient transfers require re-assessment. Transfer Coordinators should have known this, or they shouldn't have been coordinating transfers not knowing Federal discharge requirements.

LHH's TC 1 and TC 2 stated that they were aware of a COVID-19 outbreak at the receiving facility when they discussed resident placement in that facility and when they transferred Patient 31 to that receiving facility. Patient 31 was the conserved resident with dementia subsequently diagnosed with COVID-19 infection at the receiving facility on July 21 eight days after her transfer, and who died three days later.

> **"What a damning admission individualized care plans and other assessments continued to remain a problem at LHH in June and July, after deficiencies CMS had levied against LHH in April 2022 when it was decertified had involved multiple instances of the lack of individualized care plans, along with altogether missing care plans."**

A Nurse Manager (NM 2) told State surveyors the transfer trauma care plan was a "*pre-populated*" care plan for all patients. "*NM 2 confirmed the transfer trauma care plan was not specific to Patient 5*." What a damning admission that individualized care plans and other assessments continued to remain a problem at LHH in June and July, after deficiencies that CMS had levied against LHH in April 2022 when it was decertified had involved multiple instances of the lack of individualized care plans, along with altogether missing care plans. Additional statements were made to State surveyors that some of the care plans had been boilerplate forms not tailored to a given patient.

A Social Worker (SW 4) stated, "*Not sure about the discharge care plan. In his* [Patient 17's] *case we think the reason we don't have one, up to* [before] *the recertification* [decertification in April]*, we do not consider him to be as a candidate for discharge*." Discharge plans are required, whether or not a patient had previously been identified for potential discharge, and are required at the point a discharge becomes under way.

A Registered Nurse (RN) 5 stated that Patient 17 was transferred, not discharged. RN 5 stated, "*It's a lateral move. If it's a same* [type of] *facility* [referring to another SNF], there *would be no discharge plan. It's more a transfer with same level of care as opposed to something to lower level of care*." Clearly, that RN didn't understand discharge plans are required whether a lateral move "*discharge*" to another facility (with the patient not expected to return) or a temporary "*transfer*" to another facility (with an expectation the patient might return to LHH).

During the December 2028 surveyor visits regarding the patient deaths, LHH's Chief Nursing Officer (CNO) — thought to have been Terry Dentoni who was brought in from SFGH to serve as LHH's acting CNO — stated, "*If it's not there, it's not there*" ["*it*" referring to no care plan for risk of transfer trauma in a patient's chart]." The CNO's "*It is, what it is*" attitude from a senior member of LHH's leadership team was shocking for being so cavalier regarding missing documentation in a patient's medical records.

"It seems clear that members of the Care Planning Teams, including senior members of LHH's management team, did not understand the policies governing transfer and discharge."

It seems clear that members of the Care Planning Teams including senior members of LHH's management team, did not understand the policies governing transfer and discharge.

Other Staff Culpability

Other narrative regarding patient assessments and care plans made by surveyors resulting in the "Class B" citations were also disturbing. One surveyor noted "*The definition of 'transfer' and 'discharge' indicated in the Discharge Planning policy was not clear to [LHH] staff completing the pre-discharge patient assessments*." A reasonable person would assume that Pickens — as LHH's acting CEO — would have ensured the *Discharge Planning Policy* would have been up to date.

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The citation also noted the *Discharge Planning* policy didn't indicate "*Not Discharge Ready*" meant discharge to the community or lower level of care, not discharges and transfers to another skilled nursing facility.

On January 17, 2023 San Francisco's Health Commission faced the herculean task of reviewing during a single meeting 123 of LHH's policies and procedures engulfing 619 pages. Notably missing from the pile of 123 policies was the *Discharge Planning* policy, which was a grave mistake (no pun intended). That *Discharge* policy cries out for revision.

One LHH staff member told a State surveyor "*Up until the decertification, he was not on* [a] *discharge track*," inferring that a missing discharge assessment was justifiable for a patient who had been discharged and had subsequently died, because prior to LHH's decertification in April he had not been considered a candidate for discharge. That echoed other comments made to State surveys by Social Workers who had said multiple patients that been assessed as not discharge ready, or inappropriate for discharge, even though the patients wound up evicted during the initial *Closure Plan* before it was temporarily paused on July 28.

Another surveyor wrote "*Facility* [LHH] *failed to appropriately assess and plan for Patient 38 prior to transfer*." Another observation included "*Failure to perform an assessment of discharge readiness prior to the transfer of Patient 7 after an initial assessment indicated he was not ready for discharge to another facility resulted in Patient 7 not receiving continuity of care*."

A third surveyor wrote: "*The facility* [LHH] *failed to take reasonable steps to transfer Patient 31 safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services for Patient 31*."

A fourth surveyor noted regarding the mandatory RN-to-RN patient handoffs "*Nursing staff failed to report the patient's conditions and care needs to the receiving facility's nursing staff on the day of transfer*."

Given the damning December 2022 CDPH citations, it's shocking that not one of the seven Health Commissioners bothered to ask why the *Discharge Planning Policy* wasn't among the 123 policies they were asked to review. Perhaps they didn't notice that policy was missing in action. After all, the citations had clearly asserted the policy needed clarification, since LHH staff hadn't understood the policy.

"Given the damning December 2022 CDPH citations, it's shocking that not one of the seven Health Commissioners bothered to ask why the '*Discharge Planning Policy*' wasn't among the 123 policies they were asked to review.

As far as that goes, none of the Commissioners asked why the "*LHH Facility Closure Policy*" (subtitled the "*Facility Closure Plan*") was also not included in the 123 policies up for review. After all, the *Facility Closure Policy* — itself embedded in the larger "*LHH Notice of Closure and Patient Transfer and Relocation Plan*" released in early May 2022 — clearly stated that LHH's CEO Roland Pickens himself "***Shall** … ensure that a medical assessment is completed by each patient's attending physician*," mirroring CMS' concern that LHH was "*required to perform thorough and adequate medical assessments of every resident before a transfer or discharge …*".

None of the Commissioners asked why the '*LHH Facility Closure Policy*' was also not included in the 123 policies."

Pickens had been on the hook just as much as the social workers, RN's, and MD's to make sure comprehensive assessments had been completed prior to patient discharges. Contrary to his entreaties on January 17 that staff "*weren't at fault*," Pickens himself was at fault that the comprehensive assessments hadn't been completed.

The Commissioners also didn't ask about the "*Restorative* [Care] *Nursing Program*," Nursing policy D.1.0, which was also missing in action.

What Observers Thought

A community member concerned about the deaths following discharge expressed alarm there had been an anecdotal report that an LHH physician was forced to sign at least one patient's transfer documents in June or July, despite the physician's protests. The physician was reportedly forced by her boss, LHH's then-Chief Medical Officer (CMO), who by September had resigned. The anecdotal report admittedly may be hearsay.

"There had been an anecdotal report that an LHH physician was forced to sign at least one patient's transfer documents in June or July, despite the physician's protests."

That community member was also disturbed by the preponderance of blame layered onto LHH staff in narrative contained in the 12 citations CDPH issued against LHH in December. They felt that if there was any staff member who deserved blame it was LHH's CMO.

That observer thought CDPH was attempting to build a case in its favor given narrative used in the December citations.

It may be true CMS and CDPH set LHH up for failure by instigating and requiring the discharges under the *Closure Plan* in the first place, so CDPH has some culpability for having put LHH is this untenable position to begin with.

Others didn't view narrative in the citations as improperly layering blame on LHH's staff. CDPH surveyors don't appear to have been deliberately trying to build a case in their favor with the narrative included in the citations.

LHH's CMO wasn't the primary, or only, staff member responsible for the 12 citations involving patient deaths post-transfer. If anything, LHH's CEO and the rotten team of SFDPH/SFGH managers brought into to run LHH over the past 20 years carry more responsibility for LHH's mess than does the CMO.

After all, Pickens had admitted to the Health Commission as far back as last August that LHH had been using the wrong regulatory guidelines — for acute-care hospitals — not regulations governing skilled nursing facilities (SNF's). Another astute observer noted: "*The fact that LHH was using the wrong set of rules for running the facility is beyond comprehension. A simple 'Sorry, we didn't notice' isn't a satisfactory explanation. Incompetence is*."

And when Pickens informed the Health Commission on January 17 that the *Root Cause Analysis* and *Action Plan* had identified hundreds of "improvements" that needed to be made, it was a clear acknowledgement that senior managers had been mismanaging LHH like it was an acute care hospital. How long LHH had been following the wrong regulations isn't known, but it appears to have been long before Pickens was hastily brought in as LHH's acting CEO in June 2022. He had admitted to the Health Commission last August that if they had **not** been following the wrong regulations, LHH may not have been decertified in April.

"When Pickens informed the Health Commission on January 17 that the *Root Cause Analysis* and *Action Plan* had identified hundreds of 'improvements' that needed to be made, it was a clear acknowledgement that senior managers had been mismanaging LHH like it was an acute care hospital."

Yes, CDPH with CMS' blessing shouldn't have put LHH in the mess of requiring mandatory discharges of patients under the *Closure Plan*. But LHH staff — including both senior managers and line staff — carry much of the responsibility for violations of various CMS F-tags, particularly those around failing to develop adequate, individualized care plans. Along with the responsibility of senior LHH managers who had written deficient policies and procedures to begin with.

The surveyors were essentially doing their jobs and rightly identified violations in December that may still need to be remedied.

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Although LHH had posted a job vacancy announcement on-line to recruit for a replacement CMO, LHH's vacancy report for the period ending on December 27 revealed the CMO position apparently remains unfilled. What physician would want to apply for the CMO gig with LHH nowhere near close to becoming re-certified by CMS?

Nonetheless, the narrative in the citations seem to squarely — and fairly — assign culpability to LHH staff who hadn't performed the comprehensive care plan assessments required by federal statutes. As far as that goes, the citations mistakenly avoided naming Pickens himself, giving him a get-out-of-jail-free card after he had been tasked with ensuring the patient assessments ***shall*** have been made.

After writing in my last article that San Francisco's Director of Public Health, Grant Colfax had assembled a new eight-member "*Recertification Strategy*" team paid $2.3 million in salaries (excluding fringe benefits) in the year that ended on June 30, 2022, a reader who formerly worked at LHH, knows many of the LHH managers, and cares deeply as an RN about LHH's residents, reached out writing:

> "*These fools cannot salvage Florence Nightingale's legacy for San Franciscans. These people will continue to earn these salaries whether LHH is saved or not. It is absolutely shameful. … The overall issue is that these people are paid millions, whether they succeed or fail* [in getting LHH recertified]. *That is not acceptable. … They* [have] *no incentive to succeed. LHH may close, but these people will carry on and commit their overpaid incompetency's elsewhere …*"

"Not only do San Franciscans writ large need to be saved from LHH's managers, so do LHH's residents who are being held hostage to decades of mismanagement at LHH."

Amen, brother! Unfortunately, this reader is also absolutely right.

Another observer, who had also worked at Laguna Honda Hospital, wrote:

> "*It goes on and on. The secretiveness, the expensive outsiders brought in to create a plan of correction, the people who are working on this not having the proper credentials … I don't know whether they can be saved from themselves*."

Not only do San Franciscans writ large need to be saved from these LHH managers, so do LHH's residents who are being held hostage to decades of mismanagement at LHH.

Dr. Kerr's August 2 article noted that the initial *LHH Closure Plan* CMS approved in May had indicated "*the medical assessment will include screening patients for risks of transfer trauma*." Apparently, that didn't happen as promised, since despite the inadequate amount of transfer trauma screening reported in CDPH's December citations, patients at risk of trauma were evicted nonetheless. Kerr had asked a rhetorical question about whether LHH made follow-up calls to ensure smooth transfers. Since transfer trauma appears to have contributed to the 12 deaths, Kerr was right that LHH bears some responsibility.

The section on medical ethics in Kerr's article is well worth the read.

CANHR's press release was also right: The patients who died should have been the ***last*** residents to have been evicted. Instead, they went out first — out of sight, out of mind — without follow-up care from LHH staff. CANHR also faulted CDPH, noting the regulatory oversight agency had only issued tiny fines and quietly posted the citations to its website without taking any other actions to alert the public.

"The patients who died should have been the *last* residents to have been evicted. Instead, they went out first — out of sight, out of mind — without follow-up care from LHH staff."

Resumption of Mandatory Discharges

LHH's residents may again be held hostage to mandatory forced evictions if the temporary pause on discharges isn't extended beyond the February 2 date on which discharges are scheduled to resume.

Palmer, the noted geriatrician who has monitored Health Commission meetings closely since LHH was decertified in April 2022 and has done yeoman's working organizing the community regarding LHH's recertification crisis, submitted written testimony urging the Board of Supervisors to hold a *Committee of the Whole* hearing on LHH scheduled for January 31. Palmer wrote, in part:

> "*This death, tragedy, severe stress to both present and future LHH residents, direct care staff and the massive expense that has resulted is due to poor management. This poor management and neglect by leaders of Laguna Honda (SFDPH/CCSF), CDPH (State of California),* ***should never ever be repeated.*** *There is a huge amount of work to be done over many city and higher government funded entities to make sure of this*."

By "*massive expense*," Palmer may have been referring to the known $27.3 million in consultant costs and other expenses to date involved in getting LHH re-certified, plus the known $29.7 million in lost Medi-Cal reimbursement to LHH from CMS' "*Denial of Payments for New Admissions*" and unbudgeted non-labor recertification expenses in the millions.

Palmer is absolutely right that the mismanagement of LHH since 2004 has led directly to the mess LHH now finds itself in, and should never be repeated.

"LHH's residents may again be held hostage to mandatory forced evictions if the temporary pause on discharges isn't extended beyond the February 2 date on which discharges are scheduled to resume.

On January 13, the City Attorney belatedly submitted an eight-page request letter to the U.S. DHHS to extend the pause on discharges."

Of interest, after waiting until the 11th Hour before the mandatory discharges are set to resume on February 2 LHH enlisted San Francisco City Attorney David Chiu to write to the U.S. Department of Health and Human Services requesting an extension to the temporary pause, with discharges scheduled to resume on February 2. On January 13, the City Attorney belatedly submitted an eight-page request letter to the U.S. DHHS written by Deputy Chief Attorney Tara Steeley on behalf of Chiu, noting that LHH has submitted the *Root Cause Analysis* report required by the *LHH Settlement Agreement*, which CMS approved on December 12, submitted an *Action Plan* also required by the *LHH Settlement Agreement* to correct issues identified in the *Root Cause Analysis*, and submitted a *Revised Closure Plan*.

Problem is, LHH and SFDPH have chosen to keep those documents — and many other documents — secret and has not released them to members of the public.

The City Attorney's January 13 letter included 90 pages of Exhibits of successive weekly "*dashboard*" reports showing progress toward resolving 101 deficiencies against LHH that were identified during a CMS-style recertification "*Mock*

Survey" conducted in late June. A second *Mock Survey* scheduled for August or September was never held and appears to have been abandoned, which the City Attorney didn't mention in his letter.

Unfortunately, the dashboard report at Exhibit #14 for the week of November 11 through November 18 shows that of the 101 deficiencies identified in the June "*Mock Survey*," 63 of them have been fully resolved, with 38 — 37.6% — remaining outstanding, including two deficiencies in the highest severity and scope rated as an "L" posing a widespread immediate jeopardy. Those two deficiencies not yet in compliance monitoring weren't described. It's unclear why they remain unresolved five months after the June Mock Survey.

Also unfortunately, Exhibit #14 shows only 8 of LHH's 13 patient care units ("*Neighborhoods*," a.k.a. wards) — 62% — were survey ready for an actual CMS re-certification inspection survey. It's unclear why the remaining 5 units weren't survey ready as of November 18, although infection control compliance is known to be an on-going unresolved problem.

Left unexplained is why the City Attorney had ***not*** included weekly dashboard report Exhibits for the months of December and January in his January 13 letter to illustrate how many of the remaining 38 deficiencies may have been resolved between November 18 and January 13.

"Unfortunately, the dashboard report at Exhibit #14 for the week of November 11 through November 18 shows that of the 101 deficiencies identified in the June '*Mock Survey*,' 63 of them have been fully resolved, with 38 — 37.6% — remaining outstanding.

Exhibit #14 shows only 8 of LHH's 13 patient care units — 62% — were survey ready for an actual CMS re-certification inspection survey. It's unclear why the remaining 5 units weren't survey ready as of November 18."

The City Attorney's letter noted that LHH had received an "Immediate Jeopardy" citation on December 6 involving LHH's response to a fire, which LHH says it has submitted a *Plan of Correction* over. But the City Attorney didn't include the *Fire Life Safety Plan of Correction* when he wrote to the U.S. DHHS.

Nor did the City Attorney's letter mention the citations and *Plan of Correction* LHH asserts it has submitted in response to the December 20 citations and $36,000 fines LHH received involving the patients who died following discharge last June and July.

LHH will never be a facility that doesn't make mistakes. But it needs to honestly admit its mistakes when they happen, and hold those who made them fully accountable. Starting with Pickens and his management team exported from SFGH and SFDPH to mismanage LHH. After all, LHH is losing some of its public support from Pickens' delay in gaining CMS recertification.

"LHH will never be a facility that doesn't make mistakes. But it needs to honestly admit its mistakes when they happen, and hold those who made them fully accountable."

For the sake of LHH's residents, let's hope DHHS and CMS approve the City Attorney's January 13 request to extend the pause on discharges and transfers of LHH's residents. The City Attorney requested a written response by January 27, so we'll soon know if sufficient progress towards compliance with CMS regulations has been made since May 2022. Progress towards substantial compliance required for recertification has been underway for now eight months.

We'll soon see if CMS agrees with LHH's self-assessment regarding whether enough progress has been made to warrant extending the pause on mandatory evictions.

Monette-Shaw is a columnist for San Francisco's Westside Observer *newspaper, and a member of the California First Amendment Coalition (FAC) and the ACLU. He operates stopLHHdownsize.com. Contact him at monette-shaw@westsideobserver.com.*