ATTACHMENT 7

LHH Facility Closure Policy

FACILITY CLOSURE PLAN

POLICY:

The Laguna Honda Hospital and Rehabilitation Center (LHH) Chief Executive Officer (CEO), as the Administrator of LHH, shall be responsible for compliance with federal Medicare Conditions of Coverage and state statutory and regulatory requirements in the event of a closure of this facility.

PURPOSE:

To outline the roles and responsibilities of the CEO and the Facility Closure Team in the event that facility must close.

PROCEDURE:

The CEO shall:

Submit a closure/transition plan (Plan) to the San Francisco District Office of the Licensing and Certification Program of the California Department of Public Health (CDPH) for approval, in accordance with federal and state requirements.

Submit the Plan at least 30 days prior to giving any written notice of the closure for approval by CDPH.

Involve the Chief Medical Officer for LHH and management staff in the development of the Plan for the safe and orderly transfer, discharge or adequate relocation of all patients.

Have in place a team of professional staff to assist patients and families in obtaining alternate placement.

Identify available settings in terms of quality, services, and location prior to the provision of written notification of the closure.

Ensure that a medical assessment is completed by each patient's attending physician, and resident care team (RCT).

This assessment shall include the patient's medical condition, and susceptibility to adverse health consequences including psychological effects/transfer trauma prior to providing written notification of the closure.

A complete assessment shall contain recommendations for counseling, follow-up visits, and other recommended services by designated health professionals.

Ensure that an assessment of each patient's social and physical functioning of the patient based on the relevant portions of the minimum data set (MDS), as identified in the Welfare and Institutions Code §14110.15 is completed by appropriate staffs prior to written notification of the patient.

After CDPH approval of the Plan, provide written notification to the following persons/agencies no less than 60 days prior to the proposed date of closure;

LHH staff;

Patients;

Legal Representatives of patients;

Other responsible parties;

State Long-Term Care Ombudsman;

State Department of Health Care Services;

CMS Region IX, Survey and Certification;

Any health plan of an affected patient; and

Community staff providing care to patients.

Include the names of affected patients with appropriate identifying information in the written notification to the Department of Health Care Services (DHCS) and any health plan of an affected patient.

The content of the written notice shall follow federal and state requirements.

Schedule a community meeting with invitation to patients, legal representatives for patients, family and local health officials.

Not admit any new patients on or after the date the written notification is sent. Patients returning from the hospital or other care setting are not considered to be new admissions.

Inform any prospective patients of the intent to close, after the written notification is provided in section 2, above.

Interview and discuss the closure with patients, their legal representatives, conservators/guardians, family/friends or others, in order to help understand the closure and their rights, as appropriate in consideration of:

Each patient's needs;

Each patient's choices;

Each patient's best interests;

Recommendation of the type of setting most appropriate for each patient;

Proximity to family, friends, and/or legal representatives; and

The most appropriate and available type of future care and services.

Assisting patients or their representatives with obtaining information required to make an informed decision about facility relocation.

Ensure that all pertinent medical and other information is provided to the receiving facility to assure safe and effective continuity of care. In addition, the following shall be provided to the receiving facility:

Contact information for the patient's representative and person(s) to be notified;

Advance Directive information;

All instructions for special instructions or precautions, as appropriate;

Comprehensive care plan goals; and

Copy of each patient's discharge summary.

Ensure that the transfer/discharge will be noted in each patient's medical record prior to transfer. The documentation includes the basis for the transfer/discharge.

Ensure that each patient's personal possessions are accounted for prior and during the transfer.

Offer to review each patient's care routines, needs and preferences with the staff who will be caring for the patient in the receiving facility;

Notify any practitioner or health care setting which has been providing care and services to patients, of the facility closure and the contact information for the receiving facility. This includes dialysis facilities and other similar settings.

As feasible and as appropriate, will ensure trauma-informed, transparent, and timely communication regarding above processes to stakeholders to ensure effective and safe operationalization of plans.

Facility Closure Team: Roles and Responsibilities

Facility Administration Team – Will serve as the lead and staff member responsible for operation, implementation, and monitoring of designated tasks and completion timelines and deadlines; including Medical Services, Nursing Services, Quality Management, and Support Services Operation. Will provide guidance and coaching to Facility Closure Team around communication strategies with patients and families.

Facility Closure Team – Every staff member that is a part of each patient's Resident Care Team, will have a role in the transfer and relocation process to assure a safe and orderly transfer for all patients.

Disciplines	Credentials	Responsible For
Medical Services Leads: Chief Medical Officer Chief of Staff Chief of Medicine	DO or MD	Conduct medical assessments
Nursing Services Lead: Chief Nursing Officer Support Team: Nursing Directors Nurse Managers Charge Nurses	RN and LVN	Implement the general scope of nursing practice, including promotion of health, prevention of illness, and care of physically ill. Supervises other health care auxiliaries. Ensures that each patient's care plan is in place and continues throughout the closure process.
Social Services Lead: Director of Social Services	LCSW and MSW	Conduct and provide social and psychosocial assessments and support to all patients. Coordinate and conduct patient and/or representative meetings regarding the Closure Plan. Identify discharge options and services needed. Refer and coordinate referrals of patients to other facilities. Coordinate transition of patients, such as transportation, to other facilities. Collect date related to discharge options, services and discharge data.
Utilization Management Patient Flow	RN and LVN	Conducts record reviews for level of care, regulatory requirements and support Social Services in the identification of potential

Lead: Nurse Manager		facilities for bed availabilities. Coordinate regulatory requirements for discharge hearings. Ensure that there are no new admissions beginning 4/14/22. Assist in collecting data related to discharge progress.
Behavioral Health Services Lead: Chief of Psychiatry	CADC II, MSW, LCSW, PsyD, PhD, MD	As appropriate, provide trauma support to patients and/or provide emotional support resource information to families/representatives regarding the transition plan.
Activity Therapy Lead: Assistant Hospital Administrator		Assist in scheduling meetings with families and/or representatives. Assist in identifying patient preferences. Provide transportation to patients to their discharge or transfer destination as appropriate. Schedule and facilitate community meetings of patients discussing the closure plan.
Admissions and Eligibility Lead: Patient Access Admission and Eligibility Manager		Assist in referring patient's entitlement to governing bodies, such as SSA. Provide financial or entitlement education to patients and/or representatives.
Environmental Services Lead: Director of Environmental and Fleet Services		Assist in coordinating or provide transportation for patients being discharged or transferred to a new facility. Ensure that patient belongings are transported from one facility to another.

ATTACHMENT:
None.

REFERENCE:
42 CFR § 483.15(c)(1) Admission, Transfer, and Discharge Rights – Facility Requirements

42 CFR § 483.15(c)(2) Admission, Transfer, and Discharge Rights – Documentation

42 CFR § 483.15(c)(8) Admission, Transfer, and Discharge Rights – Notice in Advance of Facility Closure

42 CFR § 483.70(l) Administration – Facility Closure-Administrator

42 CFR § 483.70(m) Administration – Facility Closure

Health and Safety Code §§ 1336-1336.2 Long-Term Care Facility Advance Notification Requirements