DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Survey & Operations Group
San Francisco Survey & Enforcement Division
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Survey & Enforcement Division
CMS Certification Number (CCN): 555020

IMPORTANT NOTICE – PLEASE READ CAREFULLY

March 30, 2022

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

michael.phillips@sfdph.org

Subject: Notice of Survey findings, continuation of imposed remedies and termination of Medicare Provider Agreements for Laguna Honda Hospital & Rehabilitation Ctr D/P SNF 555020

Dear Administrator:

TERMINATION OF PROVIDER AGREEMENT

In CMS's February 24, 2022 imposition of remedies letter, CMS previously notified you that if you failed to reach and maintain substantial compliance with the Medicare program's nursing home participation requirements at 42 C.F.R. Part 483 by April 14, 2022—six months from the first survey documenting your noncompliance—it would be required to terminate your Medicare provider agreement. *See* 42 U.S.C. 1395i-3(h)(2)(C), 42 C.F.R. § 488.412(a).

CMS has determined that due to continued noncompliance, Laguna Honda Hospital & Rehabilitation Ctr D/P SNF does not meet requirements of participation of services in the Medicare and Medicaid program established under Titles XVIII and XIX of the Social Security Act (the Act).

By this letter, the Secretary of the Department of Health and Human Services notifies you that your Medicare provider agreement will terminate in accordance with the statutory provisions at §1819(h)(2)(C) of the Act and Federal Regulations at 42 C.F.R. §§ 488.412 and 488.456. *See also see also* 42 U.S.C. § 1395cc(b)(2); 42 C.F.R. §§ 488.456(b)(1) & 489.53(a)(1) and (3). **This termination is effective April 14, 2022 at 12:01 a.m. PST.**

Laguna Honda Hospital Ctr D/P SNF may avoid termination by providing an acceptable Plan of Correction (PoC), as requested by the California Department of Public Health (State Survey

Agency (SSA)) following the revisit survey ending on March 28, 2022, and correcting all deficient practices identified in the revisit survey and other outstanding surveys before April 14, 2022. If the SSA and the CMS determine your plan of correction for the surveys listed below are acceptable, then CMS may authorize a revisit prior to the **April 14, 2022** termination date.

When CMS terminates a provider agreement, the regulations require a safe and orderly transition of all Medicare residents to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident. (42 C.F.R. § 488.426(b); 42 C.F.R. § 483.70(l)(3)).

Should your facility determine that it will cease operations, federal regulations and guidelines govern the closure of the facility and the duties and responsibilities of the facility's owners, administrator, or their replacement(s) or temporary managers/monitors during the closure process to assure the safe and orderly transfer of residents (42 C.F.R. § 483.70(l))). At least 60 days prior to the date of closure, written notification and a written plan is required to be submitted to CMS and approved pursuant to 42 CFR783.70(1)(ii). Residents of the facility, the State Survey Agency, the Ombudsman, and the legal representatives of such residents or other responsible parties are also required to receive written notification of an impending closure at least 60 days in advance.

Given the exceedingly large number of residents at Laguna Honda (approximately 700), the unique needs of the population served by Laguna Honda, the access to care issues and the challenge of a safe an orderly transfer of residents, CMS is exercising a rare use of discretion under our authority 42 C.F.R. § 489.55(b) to provide for a transition period following the termination for the facility closure process should the facility elect to submit a notification of closure under § 483.70(l). CMS will be confirming subsequent requirements regarding the facility closure plan and timing of transition period at a later date.

Termination of your participation in the Medicare program will also result in termination of your Medicaid agreement. CMS, therefore, will forward a copy of this letter to California's Medicaid Agency. CMS is also sending a copy of this letter to your Medicare Administrative Contractor (MAC), Noridian Healthcare Solutions, LLC. Please contact your MAC to arrange a filing of a final cost report.

PUBLIC NOTICE OF TERMINATION

In accordance with 42 C.F.R. § 489.53(d), CMS will publish a legal notice prior to the termination and it will remain on the following website for six months:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Termination-Notices.html

PRIOR NOTICE

On February 24, 2022, the Centers for Medicare and Medicaid Services (CMS) informed you that we were imposing remedies due to the failure of your facility to be in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs based on surveys of your facility that were completed on

October 14, 2021, October 15, 2021, November 5, 2021, December 21, 2021, December 28, 2021, January 13, 2022, and January 21, 2022.

Specifically, we informed you that, as a result of the certifications/findings of noncompliance based on our determination that your facility was not in substantial compliance with the participation requirements at 42 C.F.R. Part 483 as documented during the surveys, we were imposing against your facility a civil money penalty of $2,455 per day for the ninety-nine days beginning October 14, 2021 and continuing through January 20, 2022 for a total of $243,045.00 and continuing at the reduced rate of $550.00 per day beginning January 21, 2022. We notified you that the mandatory denial of payment for new admissions started on January 14, 2022 and was continued in effect on and subsequent to January 21, 2022. The deficiencies documented during each of the listed surveys were listed on a Form CMS-2567 (copies of which you were previously provided). In addition to the remedies imposed, you were advised of your appeal rights and that the civil money penalty (CMP) may be increased or decreased based on any future determinations of non-compliance. The February 24, 2022 notice further advised that CMS would terminate your Medicare provider agreement no later than April 14, 2022—six (6) months from the last day of the October 14, 2021 survey documenting your failure to be in substantial compliance—if substantial compliance with Medicare participation requirements was not promptly achieved and maintained. *See* 42 U.S.C. § 1395i-3(h)(2)(C) and 42 C.F.R. § 488.412(d); *see also* 42 U.S.C. § 1395cc(b)(2); 42 C.F.R. §§ 488.456(b)(1) & 489.53(a)(1) and (3).

SUBSEQUENT SURVEYS

On February 3, 2022 and March 28, 2022, a complaint survey and a revisit survey were completed by the California Department of Public Health (CDPH/State Survey Agency (SSA)) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs.

The February 3, 2022 survey found that your facility was not in substantial compliance, with the most serious deficiencies at scope and severity (S/S) level G, cited as follows:

- F684 -- S/S: G -- 42 C.F.R. § 483.25– Quality of Care
- F755 -- S/S: G -- 42 C.F.R. § 483.45(a)(b)(1)-(3) – Pharmacy Services/Procedures/Pharmacists/Records

The March 28, 2022 survey found that your facility was not in substantial compliance, with the most serious deficiencies found at scope and severity (S/S) level K, cited as follows:

- F689--S/S:K—42 C.F.R. § 483.25(d)(1)(2) -- Free Of Accident Hazards/supervision/devices

The March 28, 2022 survey team found a situation of immediate jeopardy (IJ) to resident health and safety with a last day of March 27, 2022.

In addition, the following deficiency cited constitutes substandard quality of care (SQC):

- F689 -- S/S: K -- 42 C.F.R. § 483.25(d)(1)(2) -- Free of Accident Hazards/Supervision/Devices

The SSA advised you of the deficiencies that led to this determination and previously provided you with a copy of the survey reports (CMS-2567).

OPPORTUNITY TO CORRECT

Laguna Honda Hospital & Rehabilitation Ctr D/P SNF can avert termination only by correcting all deficiencies and must submit an acceptable PoC. The SSA will then verify compliance with the Medicare requirements for participation. An authorized representative should sign, date and return the Form CMS 2567 containing the PoC as soon as possible, to provide time for a revisit to be authorized. To be acceptable, your PoC must include the following:

• How corrective action 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;

• What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;

• How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and

• The date that each deficiency will be corrected.

IMPOSITION/CONTINUATION OF FEDERAL REMEDIES

In accordance with sections 1819(h)(2)(B)(ii) and 1919(h)(3)(C)(ii) of the Social Security Act and the enforcement regulations specified at 42 C.F.R. Part 488 and on the basis of the certifications/findings of noncompliance based on the findings of the surveys completed on February 3, 2022 and March 28, 2022, we have determined that the following remedies be imposed and/or continue in effect on, and subsequent to February 3, 2022 and March 28, 2022:

- Mandatory Denial of Payment for New Admissions started on January 14, 2022, and is being continued in effect on and subsequent to February 3, 2022 and March 28, 2022

- Federal Civil Money Penalty of $2,455.00 per day for the ninety-nine (99) days beginning October 14, 2021 and continuing through January 20, 2022 for a total of $243,045.00

- Federal Civil Money Penalty of $550.00 per day for the thirteen (13) days beginning January 21, 2022 and continuing through February 2, 2022 for a total of $7,150.00

- Federal Civil Money Penalty of $1,640.00 per day for the forty-seven (47) days beginning February 3, 2022 and continuing through March 21, 2022 for a total of $77,080.00

- Federal Civil Money Penalty of $10,195.00 per day for the five (5) days beginning March 22, 2022 and continuing through March 26, 2022 for a total of $50,975.00

- Federal Civil Money Penalty of $1,640.00 per day beginning March 27, 2022

- Termination of your facility's Medicare provider agreement effective April 14, 2022

Based on the February 3, 2022 and March 28, 2022 surveys, the denial of payment for new admissions will continue and remain in effect and the CMP will continue to accrue at the amount of **$1,640.00 per day** until CMS determines that your facility is in substantial compliance with the applicable requirements or the effective date of the termination of your Medicare provider agreement. **However, the amount of the CMP may be increased or decreased based on any subsequent certifications/findings of noncompliance.**

CMP Case Number

Please do not send payment now. A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. If the total amount of the CMP is not received by the due date, interest will be assessed in accordance with the regulations at 42 C.F.R. § 488.442 on the unpaid balance of the penalty beginning on the due date. The Federal rate of interest is currently **9.125%.** The CMP, and any interest accrued after the due date, will be deducted from sums owing to you **without any further notification from this office.**

Prior to the assignment of a CMP case number, you must ensure that your facility's name, CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is 555020.
- The start date for this cycle is October 14, 2021

CMP Reduced if Hearing Waved

If you waive your right to a hearing, **in writing**, within **60 calendar days** from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent 35%. *See* 42 C.F.R. § 488.436. To receive this reduction, the written waiver should be sent to the Centers for Medicare & Medicaid Services, San Francisco Survey and Enforcement Division at Yvonne.Pon@cms.hhs.gov. **Please include your facility name, CCN and the Cycle Start Date in the subject line of your email.**

The failure to request a hearing within 60 calendar days from receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.

INFORMAL DISPUTE RESOLUTION (IDR)

In its previously-provided notices, the SSA offered you an opportunity for informal dispute resolution (IDR) following each of its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

Because we are now imposing a CMP for the February 3, 2022 and March 28, 2022 surveys, which CMPs are subject to immediate collection and placement in escrow, 42 C.F.R. § 488.431 requires us to notify you that you may also have a right to an Independent Informal Dispute Resolution (IIDR). Deficiencies for which you elect IDR are not also eligible for IIDR; therefore you will need to choose which informal dispute resolution process you wish to elect to pursue. **A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the civil money penalty.**

An IIDR allows you to present written arguments and documentation that explain why you believe the deficiencies are incorrect. You may also contest scope and severity assessments for deficiencies which resulted in a finding of Substandard Quality of Care or immediate jeopardy. IIDR also requires the SSA to notify the involved resident(s) or the appropriate resident representative(s), who were involved in the deficiency; as well as to notify the State Long Term Care Ombudsman. As part of the IIDR process, these parties will be given the opportunity to comment on the relevant deficiencies.

A request for an IIDR must be postmarked within **10 calendar days** of the date of this notice. Your IIDR request must identify which deficiencies are being disputed, and provide all documentation you will use to dispute the survey findings. Please include a copy of this CMS notice with your written request for an Independent IDR. To be given such an opportunity, you are required to send your written request, i.e., why you are disputing the scope and severity assessments of deficiencies to the SSA to:

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

District Manager: Diana Marana

Phone: (415) 330-6353
Toll Free: (800) 554-0353 Fax: (415) 330-6350
Email: CDPH-LNC-DALYCITY@cdph.ca.gov

Upon receipt of your IIDR request, the SSA will provide information on the next steps in the IIDR process. If you request IIDR, the CMP may be collected on the day the IIDR is completed, or 90 days from the date of this letter, whichever is earliest.

Please note further that an incomplete Independent IDR process will not delay any deadline listed above under "Appeal Rights" for requesting a hearing, or under "Waiver Option Details Regarding the Civil Money Penalty" for requesting waiver of hearing rights.

Additional Documentation Supporting Certifications of Noncompliance

It is emphasized that even though the certifications/findings of noncompliance (and thus enforcement action noticed in this letter) are based on the findings of the surveys as set forth in the Form CMS-2567s referenced herein, CMS may have additional evidence and information (including, but not limited to State licensure information, correspondence, provider records, or verified complaints) relating to the deficiencies identified during the referenced surveys that may be presented at the time of (or before) an administrative hearing challenging CMS's certifications/findings of noncompliance. This corroborating evidence/information may be used at a hearing to resolve possible conflicts of factual information and to otherwise support CMS's adverse findings. Accordingly, nothing in this notice should be viewed as limiting or constraining CMS's right to present this additional evidence/information at an administrative hearing. (*See* State Operations Manual section 3026F.)

APPLICATION FOR READMISSION FOLLOWING INVOLUNTARY TERMINATION

Under the Medicare regulation at 42 C.F.R. § 489.57(a), when a Medicare provider agreement is terminated by CMS, a new agreement will not be accepted until it has been determined that the reason for the termination of the agreement has been removed and there is a reasonable assurance that it will not recur. **Once terminated, therefore, to obtain a new agreement, you must demonstrate through a reasonable assurance period that you can maintain substantial compliance.** Compliance with the applicable participation requirements at 42 C.F.R. Part 483 will be verified by surveys conducted at the beginning and end of this period. Additionally, before readmission to the Medicare program, you must demonstrate your ability to comply with all pertinent requirements of Title XVIII of the Social Security Act (including your financial ability to provide the services required for Medicare participation). *See, e.g.*, 42 C.F.R. § 489.12(a)(4). *See generally* 42 C.F.R. Part 489, Subpart B.

If you seek a new Medicare provider agreement, you must also establish that you have fulfilled, or have made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of your previous provider agreement (including resolution of all outstanding financial obligations due the Medicare program). 42 C.F.R. § 489.57(b). Assuming substantial compliance with participation requirements is documented at the beginning and end of the reasonable assurance period, and assuming all other federal requirements are met, Medicare certification and reimbursement will begin following the conclusion of the reasonable assurance period in accordance with the terms of 42 C.F.R. § 489.13.

NURSE AIDE TRAINING PROHIBITION (NATCEP)

Federal law, as specified in the Social Security Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities. You will receive further details about the denial of approval of nurse aide training from the State. In light of the foregoing, you may finish any nurse assistant training class you are presently conducting; you may not, however, start another such class.

APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance from the February 3, 2022 and March 28, 2022 surveys identified in this notice, 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 (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at § 498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). In this regard, please note that the each of the certifications/findings of noncompliance referenced herein, i.e. the certifications/findings of noncompliance based on the deficiencies documented during the February 3, 2022 and March 28, 2022 surveys, standing alone, establishes a separate foundation for the above referenced imposition of remedies. Your appeal must be filed **no later than 60 days from the date of receipt of this letter**. We remind you that, as indicated above, since this notice is being sent to you by e-mail, your appeal must be filed no later than sixty (60) days from the date indicated on this notice. *See* 42 C.F.R. § 498.40(a)(2).

We request that you provide an electronic copy of the request for appeal to the Office of General Counsel, Region IX Acting Deputy Chief Counsel, Femi.Johnson@HHS.GOV .

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process (see the state letter accompanying the CMS Form-2567 for additional details and deadlines), this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

Contact Information
If you have any questions, please contact Yvonne Pon of my staff at Yvonne.Pon@cms.hhs.gov or at (415) 744-3710.

Sincerely,

Jill Jones

Jill Jones
Acting Director
San Francisco and Seattle Survey and Enforcement Divisions
Centers for Medicare and Medicaid Services

CC:
State Survey Agency
State Medicaid Agency
MAC