

# LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER NOTIFICATION OF CLOSURE AND PATIENT TRANSFER AND RELOCATION PLAN

## **INTRODUCTION - NOTICE OF INTENT TO CLOSE & RELOCATION PLAN**

In May 2022, Laguna Honda Hospital and Rehabilitation Center (“Laguna Honda”) submitted a Notification of Closure and Patient Transfer and Relocation Plan (the “initial Closure Plan”) to the federal Centers for Medicare and Medicaid Services (“CMS”) and the California Department of Public Health (“CDPH”) following the termination of Laguna Honda’s certification in the Medicare and Medicaid Programs, effective as of April 14, 2022. Laguna Honda is now submitting a revision to the Closure Plan (the “revised Closure Plan”), as of April 18, 2023, pursuant to a settlement agreement between the City and County of San Francisco (“City”), CMS, and CDPH. Laguna Honda will notify CMS and CDPH, in writing, of further amendments to the revised Closure Plan, and obtain approval of such changes prior to implementing any such changes.

Facility Name: Laguna Honda Hospital and Rehabilitation Center Facility

License #: 220000040

Facility Address: 375 Laguna Honda Boulevard San Francisco, California 94116

Anticipated Closure Date: November 13, 2023

Patient Census (as of 4/14/23): 537

Patient Demographics:

<b>Payor Source</b>	<b>Patient Census</b>
Healthy Workers/Kids	0
Medi-Cal	97
Medi-Cal Managed Care	20
Medi-Cal Pending	0
Medicare	0
Medicare Managed Care HMO	1
Self-Pay	0
SFHP SFHN Managed Medi-Cal	415
Worker’s Comp	1
HMO/PPO	3
<b>Total</b>	<b>537</b>

<b>Patients who lack Capacity<sup>1</sup></b>	<b>Patient Census</b>
Lack Capacity w/ No Decisionmaker	0
Conserved, Public Conservator	78
Pending Public Conservator	4
With Surrogate Decisionmaker	301

## **Background**

Laguna Honda submitted the initial Closure Plan to CMS and CDPH on May 13, 2022. All facility-initiated discharges and transfers were paused as of July 28, 2022. Pursuant to the settlement agreement referenced above, Laguna Honda submitted this revised Closure Plan on April 18, 2023. Laguna Honda intends to resume facility-initiated discharges to the community or lower levels of care for residents who no longer require skilled nursing facility (“SNF”) level services and no longer meet SNF criteria.

Under the settlement agreement, Laguna Honda was scheduled to resume facility-initiated transfers of patients to other SNFs pursuant to the requirements and obligations in this revised Closure Plan on February 2, 2023. On February 1, 2023, CMS agreed that Laguna Honda may continue the pause on involuntary, facility-initiated transfers to other SNFs until at least May 19, 2023. Under the settlement agreement, CMS has agreed that if CMS determines that Laguna Honda is meeting its obligations under the settlement agreement, CMS may agree to further extend the pause on transfers of patients pursuant to this revised Closure Plan.

Nationwide, and specifically in the San Francisco Bay Area, there is a recognized shortage of Medi-Cal beds in SNFs. Even if a skilled nursing facility is certified in the Medicare and/or Medi-Cal programs, there are several reasons why those facilities will not accept Laguna Honda patients, the majority of whom are Medi-Cal beneficiaries. As detailed by the California Advocates for Nursing Home Reform, facilities often will not accept patients who are Medicare or Medi-Cal beneficiaries, patients with complex care needs, and/or patients who need long-term care.<sup>2</sup> As discussed in Part 4, below, during the initial Closure Plan, Laguna Honda staff encountered similar roadblocks when they called potential receiving facilities.

According to a 2020 report compiled by the San Francisco Department of Public Health (SFDPH), Office of Policy and Planning, on SNF bed shortages in San Francisco and the Bay Area, San Francisco has the largest number of SNF beds in the Bay Area; however, between 2013 and 2020, there was a 23.4% decrease in hospital-based and 10.6% decrease in free-standing SNF beds in San Francisco and a 2% decrease across the Bay Area.<sup>3</sup> Not counting Laguna Honda, there were only 340 Medi-Cal-certified, hospital-based SNF beds and only 368 Medi-Cal-certified, free-standing SNF beds (out of approximately 845 total free-standing SNF beds) in San Francisco.<sup>4</sup> San Francisco only had approximately 16 SNF beds per 1,000 adults

<sup>1</sup> 154 patients are their own decision maker.

<sup>2</sup> See California Advocates for Nursing Home Reform, *Medi-Cal Discrimination in Nursing Homes—Getting in is Half the Battle*, [http://canhr.org/publications/newsletters/Advocate/FrontArticle/adv\\_2019Q3.htm](http://canhr.org/publications/newsletters/Advocate/FrontArticle/adv_2019Q3.htm) (July 15, 2020).

<sup>3</sup> SFDPH, Office of Policy and Planning, Skilled Nursing Facility Data Brief, April 2020 at pp. 2–4.

<sup>4</sup> *Id.* at pp. 2.

aged 65 and older in 2020. Given the size and complexity of Laguna Honda’s patient population (many of whom have a combination of behavioral health needs, substance use disorders, and other complicated social and medical factors), the limited availability of SNF beds and beds in other appropriate placements in the San Francisco Bay Area and California, the processes required for notice and discharge, and current timeframes for resolving patient appeals—the process to transfer and discharge patients will occur over a substantial period of time.

## **Intent**

The intent of this revised Closure Plan is to ensure the safe, orderly, and clinically appropriate transfer or discharge of each patient with a minimum amount of stress for patients, families, guardians, and legal representatives (families, guardians, and legal representatives are collectively referred to as, “Representatives”). All Medicare and Medicaid (Medi-Cal) beneficiary patients will be discharged or transferred to the most appropriate setting possible in terms of quality, services, and location, as available and determined appropriate by the resident care team after taking into consideration the patient’s individual needs, choices, and interests. This objective shall be accomplished in as expeditious and safe a manner as possible under the circumstances, as set forth herein. Laguna Honda shall use reasonable best efforts to achieve the time frames set forth herein.

## **Overview of Facility Closure Transfer and Discharge Process**

For purposes of this revised Closure Plan and the attached Facility Closure Policy only, “Facility Closure Transfer” means movement of a patient<sup>5</sup> from a Laguna Honda bed to a bed at another certified skilled nursing facility or nursing facility (except for psychiatric skilled nursing facilities, as discussed below), and return to Laguna Honda is not expected.<sup>6</sup> For patients who are transferred as a Facility Closure Transfer, Laguna Honda will follow the procedures detailed in this revised Closure Plan, the attached Facility Closure Policy, and applicable state and federal law (*e.g.*, California Health & Safety Code section 1336.2). Facility Closure Transfer does not include movement of patients to an acute hospital or for therapeutic leave when the patient expects to return to Laguna Honda, *i.e.*, an acute and/or emergency care transfer. For example, a patient who is transported to an emergency room at a general acute care hospital but expects to return to Laguna Honda before the Anticipated Closure Date does not constitute a Facility Closure Transfer or new admission.

For purposes of this revised Closure Plan and the attached Facility Closure Policy only, “discharge” means movement of a patient from a Laguna Honda bed to a home or to a bed in a facility that provides lower than SNF level of care in the community, and return to Laguna Honda is not expected. Discharges also include movement of a patient from a Laguna Honda bed to any of the specialized facilities listed in Group 4 (*e.g.*, Locked Subacute Treatment, Psychiatric Skilled Nursing Facilities, and State Psychiatric Hospitals), defined in Part 2, below.

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<sup>5</sup> Laguna Honda is licensed under state law as a general acute care hospital and uses the term “patient” to describe individuals receiving care and services at the facility. Federal regulations also refer to individuals at skilled nursing facilities and nursing facilities as “residents.” For purposes of this revised Closure Plan, the term “patient” includes “residents” as the latter used in federal regulations.

<sup>6</sup> When Laguna Honda is certified in Medicare or Medicaid and the facility is allowed to admit new patients, then former Laguna Honda patients could expect to return.

For patients who are discharged, Laguna Honda will follow its standard discharge policy, LHH Policy 20-04 Discharge Planning.

As outlined in this revised Closure Plan and agreed to by CMS in its letter dated February 1, 2023, Laguna Honda may, in its discretion, discharge patients who no longer meet the requirements for SNF level of care as well as patients who present a danger to other residents and the institution, are unable to have their needs met at LHH, and require placement in a different setting outside of Laguna Honda. These types of discharges would occur even if the facility were not subject to this revised Closure Plan and Laguna Honda is accordingly following its standard discharge policy (LHH Policy 20-04 Discharge Planning).

Laguna Honda will assess all patients to prepare for the Facility Closure Transfer or discharge pursuant to the state and federal closure requirements and will continue to do so at least once every three months (or sooner if there is a significant change in condition) in an orderly, systematic manner while it also reapplies for participation in the Medicare and Medicaid programs.

During the initial Closure Plan, Laguna Honda encountered significant resistance from potential receiving facilities that were unwilling to accept Laguna Honda patients. As evidence of this fact, and despite Laguna Honda's best efforts, from May 13, 2022 to July 28, 2022, Laguna Honda was able to transfer or discharge only 57 patients out of a total patient population of 686.

During this revised Closure Plan process and in collaboration with Laguna Honda, the State will provide support by: (1) identifying skilled nursing facilities with available beds; (2) for those facilities with available beds, identifying demographics and specialized services that the facilities are able to support; (3) reminding facilities of prohibition of discrimination against Medicare or Medi-Cal members; (4) helping Laguna Honda coordinate with the receiving facility; (5) providing support in identifying community-based organizations and Medi-Cal managed care plans to assist in identifying community placement options and services; and (6) notifying Medi-Cal beneficiaries of their benefit status. State representative(s) will be on-site at Laguna Honda as part of the collaboration in assisting with Facility Closure Transfers of patients to another skilled nursing facility, when requested by Laguna Honda. Without this level of support from the State, receiving facilities will not be compelled to accept Laguna Honda patients and Facility Closure Transfers will likely proceed at a similar pace as during the initial Closure Plan.

Upon approval of this revised Closure Plan, Laguna Honda will provide preparation and orientation to all patients to provide a closure that is as safe and orderly as possible, with patient safety as our highest priority. Laguna Honda will ensure adequate staffing in all disciplines and areas to protect the health and safety of the patients residing in the facility. Patients will continue to receive appropriate skilled nursing care during the closure process.

Laguna Honda's Director of Care Coordination will serve as the Facility Closure Coordinator and will also serve as the primary contact between Laguna Honda, CMS, CDPH, DHCS, and other state agencies as appropriate. The Director of Care Coordination will provide clerical staff to assist DHCS in calling receiving facilities to identify available Medicare or Medicaid beds, provide the Utilization Management team to review patient assessments, and oversee the social

workers conducting discharge or transfer planning assessments. Each patient’s Resident Care Team (“RCT”), which is the facility’s interdisciplinary team, will conduct the assessments and screening described in this revised Closure Plan. The Director of Care Coordination will coordinate with DHCS and any applicable managed care plans for case management and care coordination.

The Medical Director and senior management are aware of the closure and participated in the development of this revised Closure Plan.

Facility Closure Administrator: Roland Pickens, MHA, FACHE  
Director, San Francisco Health Network  
Interim Chief Executive Officer, Laguna Honda Hospital  
and Rehabilitation Center

Facility Closure Coordinator: Irin Blanco, Director of Care Coordination  
Telephone Number: 415-759-2363  
Email Address: [LagunaHonda@sfdph.org](mailto:LagunaHonda@sfdph.org)

Laguna Honda paused new patient admissions beginning on April 14, 2022, and no new patients will be admitted on or after that date unless and until Laguna Honda obtains certification in either the Medicare or Medicaid programs. As the Closure Plan is implemented, Laguna Honda, in conjunction with DHCS, will provide a daily update to CMS and CDPH on the progress in transferring patients, including where they are being transferred until all patients are transferred.

This revised Closure Plan is organized into the following eight parts for transferring or discharging patients\*:

1. Notification Requirements
2. Patient Assessments
3. Initial and Follow-up Patient and Family Meetings
4. Identification of Beds and Match with Patients
5. Discharge/Transfer Appeal Hearings
6. Admissions Freeze
7. Patient Facility Closure Transfer and Discharge
8. Implementation and Coordination
9. Administrator and Facility Closure Team: Roles and Responsibilities

\* Some of these activities may be conducted simultaneously.

## **PART 1 - NOTIFICATION REQUIREMENTS**

Centers for Medicare and Medicaid Services. Laguna Honda submitted the initial Closure Plan to CMS for review and approval on May 13, 2022. A revision of the Closure Plan will be submitted to CMS for review and approval on April 18, 2023.

California Department of Public Health. Laguna Honda submitted the initial Closure Plan to

CDPH for review and approval on May 13, 2022. This revision to the Closure Plan will be submitted to CDPH for review and approval on April 18, 2023.

Employees. Laguna Honda will notify all staff of the revised closure timeframe and procedure within 14 days after CMS and CDPH approve the revised Closure Plan.

Patients. Patients received the Notice of Closure in May 2022, and because of the revisions to the Closure Plan, will receive the following notices.

1. Notice of Closure (per 42 C.F.R. § 483.70(l) and Cal. Health & Safety Code § 1336.2)

Starting on May 15, 2022 and consistent with 42 C.F.R. § 483.70(l) and California Health and Safety Code Section 1336.2, Laguna Honda notified each patient and/or designated Representative verbally and in writing of the facility's anticipated closure and provided a hard copy of the Notice of Closure and the Executive Summary of the Closure Plan in their preferred language. The notice included information about the nature of the proposed Facility Closure Transfer/discharge based on the assessments described in Part 2, below, and it also included all information required by law (for example, the information listed in California Health and Safety Code § 1336.2). A sample of that letter is attached hereto. (**See Attachment 1, Sample Letter to Patient/Family Member/Legal Representative**).

On December 8, 2022, Laguna Honda provided each patient and Representative a letter describing the settlement agreement, the new Anticipated Closure Date, and the potential that involuntary transfers and discharges could resume starting February 2, 2023. Laguna Honda will provide an additional and timely notice to patients and their Representatives after CMS and CDPH approve the revised Closure Plan and after CMS notifies Laguna Honda that Facility Closure Transfers and discharges will resume and the date on which they will resume. The revised notice will include an Executive Summary of the revised Closure Plan, consistent with 42 C.F.R. § 483.70(l) and 42 C.F.R. § 483.15(c)(8). (**See Attachment 2, Executive Summary of Revised Closure Plan**). A full copy of the approved revised Closure Plan will be made publicly available on the City's website (sf.gov). The revised notice will advise patients and their Representatives that Laguna Honda already provided to them the 60-day notice letter required by California Health and Safety Code Section 1336.2 and will attach the patient's original notice of closure letter.

Laguna Honda has hosted several community meetings for residents and their families (including, most recently, on November 30, 2022) and will continue to host family town halls, consistent with California Health and Safety Code Section 1336.

2. Individual Notice of Proposed Facility Closure Transfer

Pursuant to 42 C.F.R. § 483.15(c), an individualized and timely Notice of Proposed Facility Closure Transfer will be sent out on a patient-by-patient basis to the patient and the patient's Representative based on the particular needs of each patient after Laguna Honda completes the screening and assessments described in Part 2, below, to minimize the possibility of transfer trauma (*i.e.*, the stress that a person may experience when changing living environments), including a day of transfer assessment to determine that patients are stable for Facility Closure

Transfer or discharge. Patients will be assessed starting on all units, and if Laguna Honda finds an appropriate Facility Closure Transfer location for any patient, it will be offered to that patient. Each individual Notice of Proposed Facility Closure Transfer will be sent after the patient assessments are complete, and as soon as Laguna Honda and DHCS locate an appropriate, available placement. Laguna Honda will request the receiving facility hold the open bed for at least seven days to provide the patient with time to file an appeal. The notice will include the contents required by 42 C.F.R. § 483.15(c)(5), including the reasons for the move, the effective date of the move, the location of the move, a statement of appeal rights, and contact information for the State Long-Term Care Ombudsperson, and Disability Rights California (for developmentally disabled patients) in a language and manner the patient and patient's Representative understand. (**See Attachment 3, Notice of Proposed Facility Closure Transfer and Right to Appeal**).

### 3. Individual Notice of Discharge

Also pursuant to 42 C.F.R. § 483.15(c), an individualized and timely notice of discharge will be sent out on a patient-by-patient basis to patients and the patient's Representatives for those patients who meet the criteria for discharge. Such notice will be provided pursuant to LHH Policy 20-04 Discharge Planning. The notice will include the contents required by 42 C.F.R. § 483.15(c)(5), including the reasons for the move, the effective date of the move, the location of the move, a statement of appeal rights, and contact information for the State Long-Term Care Ombudsperson, and Disability Rights California (for developmentally disabled patients) in a language and manner the patient and patient's Representative understand.

### 4. Right to Appeal Described in the Notice

Each patient and/or Representative has the right to appeal a discharge or Facility Closure Transfer under federal and state law and to have a hearing before the DHCS Office of Administrative Hearings and Appeals, and/or, for those patients with a managed care plan, through that managed care plan. During the initial Closure Plan negotiation, CDPH instructed Laguna Honda to include in the individual notice a statement that the appeal process will not result in restoration of benefits or coverage during their stay at Laguna Honda through the closure process, and the appeal may involve an assessment of whether, after refusing an available and acceptable Facility Closure Transfer or discharge option, the patient has other means available to pay for the cost of services at Laguna Honda during the closure process through the Anticipated Closure Date. Ordinarily, appeals must be completed within 90 days of the filing of the appeal, which may further impede the pace of Facility Closure Transfers and discharges. (**See Attachment 3, Notice of Proposed Facility Closure Transfer and Right to Appeal**).

Local and State Long Term Care (LTC) Ombudsperson. Laguna Honda will notify the local and State Ombudspersons in a timely manner upon approval of this revised Closure Plan to provide transfer assistance to patients and Representatives, as required by California Health & Safety Code Section 1336.1(b) and 42 C.F.R. § 483.15(c)(8), and to assist with any patient/Representative concerns about the relocation requirements and process. CDPH and DHCS will coordinate with the State Ombudspersons so the State Ombudspersons know and understand the process and procedures for Facility Closure Transfers and discharges.

Department of Health Care Services (DHCS). Laguna Honda will provide a written notification to the DHCS Office of Administrative Hearings and Appeals in a timely manner upon approval of this revised Closure Plan in anticipation of discharges or Facility Closure Transfers and related appeals that might be filed by patients residing at Laguna Honda. In addition, Laguna Honda will send written notice of all Facility Closure Transfers to DHCS, and to a patient's health plan, if any, as required by California Health & Safety Code Section 1336.1(c), and will request DHCS to be on-site as needed to assist Laguna Honda with coordination of Facility Closure Transfers.

Physicians and Other Healthcare Providers. Patient care teams play a role in drafting the placement plan for the patient and Laguna Honda will notify them in writing of the impending closure after CMS and CDPH approves the revised Closure Plan. Once a placement is located for each patient, all involved caregivers will be notified of the anticipated Facility Closure Transfer or discharge date and proposed location of the patient.

Transport and Vendor/Contractor Services. Laguna Honda's transport service and vendor providers will also be notified and informed of their respective roles in the closure after CMS and CDPH approve the revised Closure Plan.

## **PART 2 - PATIENT ASSESSMENTS**

The patient population at Laguna Honda is large and complex. Many patients have complicated chronic medical needs along with behavioral health components (such as diagnosed mental illnesses and/or substance use disorders) and other social or behavior issues. This makes placement difficult in many situations, as some facilities do not have the capability or capacity to serve patients with complex medical and/or behavioral needs. Given the size and needs of the current patient population, it will take a significant amount of time for staff to complete adequate, comprehensive assessments of all patients as outlined in this Part 2.

State and federal standards require SNFs to complete comprehensive assessments of every patient prior to any transfer to another facility during a facility closure. These assessments are key to identifying appropriate facilities that can meet the specific needs and preferences of each patient. For those patients who no longer require SNF level of services and are ready to be discharged home, to the community, or to a lower level of care facility, Laguna Honda will create a discharge plan consistent with Discharge Planning Policy 20-04. In addition, patients who primarily require custodial care, such as assistance with activities of daily living, but have skilled nursing needs will continue to receive services at Laguna Honda, and be assessed to determine appropriate level of care.

*Phase 1 (Preliminary Screening).* Laguna Honda previously completed a patient chart review process on all patients in May 2022 to identify patients who could potentially be discharged to lower levels of care. Laguna Honda will begin a new round of preliminary screening of all current patients to confirm all patients previously identified with the potential to be discharged to lower level of care facilities, and identify additional patients whose condition has improved such



that they do not require SNF level of services and may potentially be discharged to a home, to the community, or to lower level of care facilities.

The individual assessments and RCT meeting described below under Phase 2 will be used to establish each patient's risk of transfer trauma, including the individualized interventions that Laguna Honda will implement to address the potential risk of transfer trauma during the patient's stay at Laguna Honda and intervention ideas for receiving facilities to implement in case a patient shows symptoms of transfer trauma.

*Phase 2 (Patient Assessments & Interdisciplinary Team Review).* Phase 2 involves an interdisciplinary team who assess each patient and plan interventions to prevent or ameliorate potential adverse health consequences of a Facility Closure Transfer or discharge. The team will include (at a minimum) physicians, nursing, and social services, and, when indicated, substance use, mental health, dietary, pharmacy, rehabilitation, and patients as well as Representatives when appropriate. Each discipline will assess each patient and review each patient's medical records based on their scope of practice, meet to discuss each patient as part of the Resident Care Team, and provide comprehensive documentation at each step, discussed in greater detail below. Each individual patient will continue to be monitored and, as needed, assessed, as a patient may exhibit medical and cognitive changes after the initial assessments.

Concurrent Assessments. Upon completion of Phase 1, each of the 13 units at Laguna Honda will conduct the patient assessments required by this revised Closure Plan listed below on a rolling basis, with the goal to always have multiple patients ready to place associated with each Group listed in this Part and Part 8, below, to utilize placements at every Group level as they may become available. As soon as each individual patient assessment is done, that patient will be moved to the next stage to identify a placement as quickly as possible, consistent with the patient-centered prioritization described in Part 8, below.

Phase 2 will include the individual assessments listed below for all current Laguna Honda patients who have been determined during Phase 1 to have a skilled nursing need and who will be transferred to a skilled nursing facility. For patients who are being discharged to the community or lower levels of care, Laguna Honda already assesses each patient and prepares a discharge care plan pursuant to LHH Policy 20-04 Discharge Care Planning. For clarity, those assessments conducted under LHH Policy 20-04 will include transfer trauma assessments and mitigations. Laguna Honda intends to complete approximately 78 patient assessments on average each week. Once this process begins, Laguna Honda may inform CDPH and CMS of any updates to this timeline, including the reasons for the updated timeline.

Laguna Honda will provide the assessments as part of the information packages that will be sent to the receiving skilled nursing facilities or lower level of care because, while a referring facility may make recommendations to a receiving facility about ways to mitigate a specific patient's transfer trauma risk and begin the preparation for transfer trauma mitigation.

Physician Assessment. Each patient will be assessed by the patient's attending physician to determine the patient's medical needs. The assessment will include a description of

any medical needs, associated behaviors, or challenges that may complicate placement. Where appropriate, the medical assessment will include consultations with specialized care providers, such as substance use treatment, mental health, and rehabilitation. In addition, the medical assessment will include a transfer trauma assessment for patients who will be transferred to a skilled nursing facility. A physician will update the transfer trauma assessment as necessary based on clinical assessments. The assessment will provide recommendations for counseling, follow-up visits, and other recommended services, by designated health professionals, and for preventing or ameliorating potential adverse health consequences in the event of transfer (such recommendations may be added following the RCT meeting). Additional referrals will be made to Laguna Honda's mental health team throughout the Facility Closure Transfer or discharge process when appropriate. (**See Attachment 4: Physician Pre-Discharge/Transfer Patient Assessment**).

Social Assessment. Each patient will also be assessed by social workers to identify specific social needs such as family and social services supports or other program requirements, including preferred activities inside and out of the facility, interests, and other preferences, which will play a role in finding an appropriate placement. In addition, the social worker will assess physical functioning with potential risk factors. The social assessment will include recommendations for preventing or ameliorating potential adverse health consequences in the event of transfer and a recommendation for the type of facility that would best meet the patient's needs (such recommendations may be added following the RCT meeting). (**See Attachment 5: Social Work Pre-Discharge/Transfer Patient Assessment**).

Resident Care Team Meeting. After the physician and social assessments, the RCT will meet to determine the risk level of transfer trauma during the RCT patient assessment meeting using the transfer trauma screening (described in the following paragraph) and each of the patient assessments. The RCT note also includes a nursing and MDS assessment to document the patient's functional capabilities and nursing care needs. This nursing/MDS assessment captures the patient's comorbidities, physical, psychological, and psychosocial function in addition to any treatments (*e.g.*, end of life care, oxygen therapy, dialysis) or therapies (*e.g.*, physical, occupational, speech, restorative nursing) needed. During this meeting, the RCT will provide recommendations for preventing or ameliorating potential adverse health consequences of a Facility Closure Transfer or discharge, consistent with California Health & Safety Code Section 1336.2(a)(1), (2) and will document those interventions in the patient's care plan. The RCT will also determine the patient's initial classification for potential risk of transfer trauma and corresponding prioritization. (**See Attachment 6: Resident Care Team Note: Pre-Discharge/Transfer Patient Assessment**).

Transfer Trauma Screening Tool. During the RCT meeting, the social worker will access the Transfer Trauma Screening Tool, which will be cooperatively completed by the physician, nurse, and social worker on the RCT and will identify each patient's classification for potential risk of transfer trauma (defined as "the traumatic consequence experienced as the result of the transfer of a patient from one living situation to another").

Laguna Honda previously requested CDPH and CMS for validated, evidence-based transfer trauma screening or assessment tools, but CDPH and CMS informed Laguna Honda that did not have any screening or tools, nor were they aware of any such screening or tools. This screening will include a review of at least the following factors: (1) risk due to longevity of stay at Laguna Honda; (2) current cognitive and/or medical condition; (3) physical frailty; (4) evidence of changes or new behaviors, mood, and/or physical symptoms; and (5) other or known potential triggers. Patients will be categorized, based on the best efforts of Laguna Honda, as having average (Green Tier), above-average (Yellow Tier), or high (Red Tier) risk of transfer trauma. (*See Attachment 7: Transfer Trauma Screening Tool*).

Monitoring. Following the initial transfer trauma assessment, Laguna Honda staff will observe and monitor all patients identified as having signs of, or the potential for, high risk of transfer trauma. Nursing staff will provide monitoring notes on a weekly basis at a minimum, and more often as necessary, for all patients identified as having signs of or the potential for high risk of transfer trauma. Nursing staff will document activity levels, nutrition intake, changes to baseline medical and behavioral conditions, or verbal or other communications (including patients who have communication ability deficits) shared or expressed (verbally or non-verbally) by the patient related to the patient's Facility Closure Transfer or discharge or Laguna Honda's closure. If nursing staff notes a change in the potential for risk of transfer trauma, the RCT will meet to adjust the prioritization tier and/or propose alternative or additional mitigation strategies based on the clinical judgment of the RCT. (*See Attachment 8: Nursing Weekly Summary Monitoring Note*).

Day of Facility Closure Transfer or Discharge Patient Assessment. Each patient will be assessed by the assigned physician and nursing staff to ensure the patient is stable for transfer on the day of the scheduled Facility Closure Transfer or discharge. For patients who do not meet the minimum criteria for a transfer, and show signs of transfer trauma, on the day of the scheduled transfer, Laguna Honda may reschedule the Facility Closure Transfer or discharge until the conditions that gave rise to the rescheduling of the Facility Closure Transfer or discharge are stabilized or resolved. For patients who meet the minimum criteria for transfer and show signs of transfer trauma, Laguna Honda may, depending on the clinical determination of the physician or RCT, proceed with the Facility Closure Transfer or discharge with additional or alternative mitigation strategies. Laguna Honda recognizes that facility closure means all residents will need to be relocated and that rescheduling should be an exception. (*See Attachment 9: Day of Facility Closure Transfer or Discharge Patient Assessments*).

Laguna Honda will consider the assessments listed above during the process of creating the Facility Closure Transfer recommendations for each patient as outlined below. If the patient or patient's Representative choose to initiate a Facility Closure Transfer or discharge prior to completion of the assessments, Laguna Honda shall inform the patient or patient's Representative, in writing, of the importance of obtaining the assessments and follow-up consultation. If a patient is not stable for transport, Laguna Honda shall postpone and reschedule a patient-initiated Facility Closure Transfer or discharge.

Because of likely placement delays, these assessments, except for the Day of Facility Closure Transfer or Discharge Patient Assessment, will be conducted every 3 months (quarterly) from the initial assessment date (each a re-assessment) or sooner if Laguna Honda identifies a significant change in the patient's condition. These re-assessments will take into consideration any changes in condition or clinical/nursing care needs that may affect a patient's level of care. The 3-month cadence of re-assessments will continue until the patient is transferred or discharged from Laguna Honda.

*Phase 3 (Discharge/Transfer Categorization).* Based on the assessment process, patients will be assigned to one of the following appropriate discharge or Facility Closure Transfer groups (each a "Group"), and all Groups will be considered for placement concurrently, consistent with the Patient-Centered Prioritization for patients in Group 3, discussed below in Part 8, as an additional safeguard to minimize the possibility of transfer trauma. The assigned Group may change as the facility completes the comprehensive assessments and re-assessments.

**Group 1 – Appropriate for Discharge to Home or Independent Housing:** Patient does not require skilled nursing level of care, and custodial needs can be met at home, in a residential setting, or with significant community and in-home supports, including outpatient and in-home supports for individuals with severe mental illness (SMI) and/or substance use disorders (SUD).

**Group 2 – Appropriate for Discharge to Community-based Residential Settings:** Patient does not require skilled nursing level of care but is appropriate for a community-based residential setting for custodial and supervisory care. This could include, but is not limited to, a Residential Care Facility for the Elderly (RCFE), Adult Residential Facility, ICF/DD, ICF/DD-H, ICF/DD-N, or Social Rehabilitation Programs.

**Group 3 – Appropriate for Facility Closure Transfer to Skilled Nursing Facility:** Patient requires continued skilled nursing level of care or custodial care permitted in a skilled nursing facility under Medi-Cal requirements. This may include placement in a skilled nursing facility providing a Special Treatment Program (STP) or Mental Health Rehabilitation Center (MHRC).

**Group 4 – Appropriate for Discharge to facility licensed and certified to provide specialty care:** Patient has a primary diagnosis of an SMI or SUD and requires a more specialized level of care than provided at Laguna Honda. These could include Acute Psychiatric Hospitals (APH), Psychiatric Health Facilities (PHF), Chemical Dependency Recovery Hospital (CDRH), or general acute care hospitals licensed for specialty behavioral health services or partial hospitalization services.

As applicable, Laguna Honda will note a modifier indicating whether the facility expects placement to be challenging based on specific factors, which may vary by patient, such as the presence of complex medical needs (*e.g.*, a tracheostomy tube or percutaneous endoscopic gastrostomy feeding tube (PEG tube) or mental health, substance use, or other social/behavioral needs). Laguna Honda will work to start the processes early for patients who may have

placement challenges in order to maximize placement options.

### **PART 3 – INITIAL AND FOLLOW-UP PATIENT AND FAMILY MEETINGS**

Laguna Honda will conduct an initial meeting with each patient and, where applicable, the patient's Representative, with the option for the Ombudsperson to be present at the request of the patient or Representative. These meetings will begin upon completion of the individual patient's comprehensive assessments described above or will happen concurrently to the assessment process in cases where doing so is appropriate or would be most beneficial for the patient, after this revised Closure Plan is approved and the patient or the patient's Representative receives notification of this Closure Plan. The initial meetings will continue until Laguna Honda meets with every patient (and Representative, as appropriate) at Laguna Honda. Where appropriate, follow-up meetings will be scheduled every three months to ensure that each patient and the patient's Representative understand the closure and Facility Closure Transfer or discharge process, including the option for the Ombudsperson to be present at the request of the patient or Representative. Placements may be prioritized based on the outcome of these meetings. Given the complex needs of the facility's patient population and level of preparation and coordination required with each patient, the patient's Representative, and the patient's care team, Laguna Honda anticipates conducting about sixty meetings each week. Laguna Honda intends to have these meetings occur as part of the assessment process or shortly thereafter (*e.g.*, within 2 weeks).

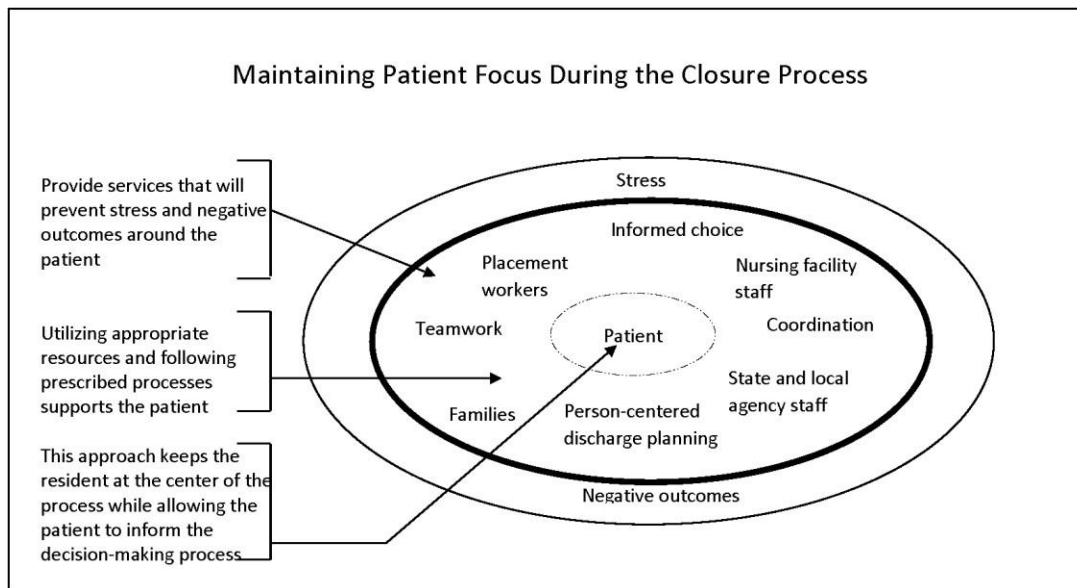
Because Laguna Honda staff conducted initial meetings during the initial Closure Plan, the purpose of this renewed meeting is to refresh the memory of the patient, provide an updated status of the Facility Closure Transfer or discharge process, provide the Representative, as applicable, with information about the closure process and to gather input related to each patient in relation to the Facility Closure Transfer or discharge decision, including whether the patient's initial preferences have since changed. Each patient and/or Representative will be notified verbally and in writing on an individual basis of the meeting. Additionally, a telephone or video meeting will be made available for those interested in participating remotely. During the meeting or otherwise, the patient and/or the patient's Representative, where applicable, will be interviewed to determine each patient's goals, preferences, and needs in planning for the services, location, and setting to which they will be moved.

The facility will: discuss Facility Closure Transfer or discharge options, including setting or type of facility and geographic location; provide information or access to publicly available information related to quality of the providers and/or services at the location the patient is considering; discuss psychological or counseling services available to each patient; and make reasonable effort to obtain each patient's goals, preferences and needs regarding receipt of services, location and setting. Subsequent phone conferences or virtual meetings will be scheduled at times to accommodate the availability of Representatives. The involvement of Representatives is essential to assuring successful placements for patients and to assure patients' rights are protected in accordance with 42 C.F.R. Section 483.10.

To achieve the overall goal of helping patients move to a new location, the facility will maintain a patient-focused discharge process. The facility will provide services such as social services and

psychiatric support to mitigate stress to patient and/or Representative. The goal for these support services is to remain focused on the best and positive outcomes for patients throughout the process. Laguna Honda staff, including the social worker and physician, as necessary, will meet with patients and the Representative, both initially and routinely, to address concerns and/or clarify information regarding the closure process. Laguna Honda will not intimidate, pressure, or bully patients into accepting a Facility Closure Transfer or discharge.

Laguna Honda will utilize the model shown in Figure 1 below in relation to the entire process of meeting with patients and Representatives, including during information gathering and through the issuance of a placement decision as described in Part 5, below. In addition, Laguna Honda will utilize the assessment process outlined in Part 2, above, to mitigate the potential for transfer trauma to each patient. Those patients identified at higher risk of such trauma will be provided, where applicable, with additional mental health support to mitigate the risk and any scheduled Facility Closure Transfers or discharge may be postponed based on the assessment and consistent with the medical opinion of the attending physician.



**Fig. 1. Laguna Honda Patient-Focused Closure Process.**

**PART 4 - IDENTIFICATION OF BEDS AND MATCH WITH PATIENTS**

Based on Laguna Honda’s review of patient charts and experience during the initial Closure Plan, about 8% of current patients (who are in Groups 1 and 2) meet SNF custodial level of care criteria (custodial level of care includes non-medical care that can be reasonably and safely provided by licensed or non-licensed caregivers), but could be discharged to home, to a lower level of care, or to other placement with adequate community support services, which may include some nursing level supports.

Laguna Honda will actively work with DHCS, CDPH, and the Medical and Health Operational Area Coordinator to identify available Medi-Cal certified beds across the state because Medi-Cal is the payor source for over 99% (532) of Laguna Honda patients. DHCS and Laguna Honda

will also contact each SNF on an individual basis to identify the beds that are currently available. During the initial Closure Plan from May 13, 2022 until transfers and discharges were paused on July 28, 2022, Laguna Honda staff contacted approximately 1,706 distinct SNFs. (See Figure 2 below)

During the initial Closure Plan process, Laguna Honda staff encountered several obstacles in obtaining available bed data, including: (1) putative receiving facility staff did not readily share the number of beds available or the breakdown of the types of beds by payor source; (2) putative receiving facility staff did not respond to or return Laguna Honda's calls and messages; and (3) the number of Medi-Cal certified beds is few or unknown. Laguna Honda reported these obstacles to CDPH and DHCS and requested assistance from other facilities. On July 1, 2022, CDPH and DHCS notified other skilled nursing facility administrators that Laguna Honda was seeking appropriate alternative placement of patients as part of the initial Closure Plan. In addition, the CDPH/DHCS letter indicated that Laguna Honda and DHCS were reaching out to facilities to locate available beds with appropriate levels of care for each patient, and if a facility has available bed capacity, the facility should contact Laguna Honda.

But, the July 1, 2022 letter did not materially increase the number of facilities willing to accept Laguna Honda patients. For example, from July 1 to July 28 (when involuntary transfers and discharges were paused), Laguna Honda identified 689 vacant Medicare beds and 48 vacant Medi-Cal beds—a *decrease* from the preceding weeks. Without direct support from CDPH and DHCS to assist with placements, Laguna Honda anticipates similar (if not greater) obstacles should Facility Closure Transfers or discharges resume.

### **San Francisco SNFs**

Laguna Honda staff identified and contacted a total of 16 SNFs in San Francisco with a total of 1,228 beds. Of these 16 SNFs, zero beds were available for Laguna Honda patients as of July 28, 2022, which was consistent with prior weeks during which Laguna Honda contacted these facilities. Laguna Honda transferred 2 patients to San Francisco SNFs through July 28, 2022.

### **Bay Area SNFs**

During the initial Closure Plan from May 14, 2022 to July 27, 2022, Laguna Honda staff contacted 1,690 unique SNFs in the surrounding Bay Area counties to identify facilities able to accept patients from Laguna Honda. Laguna Honda staff identified a total of 112 available Medi-Cal certified beds and 396 available Medicare certified beds. 92% of Laguna Honda patients in Group 3 (as of 8/14/22) met the criteria for placement and qualify for skilled nursing care. But, because the receiving facilities did not accept referrals to available beds, Laguna Honda transferred only 39 patients to Bay Area SNFs through July 28, 2022.

### **California and Out-of-State SNFs**

For patients who have Representatives outside of the San Francisco Bay Area, Laguna Honda staff will search for acceptable facilities in that area. Laguna Honda will expand the identification of appropriate placements as the facility meets with patients and learn about their preferences.

Given the large number of patients at Laguna Honda, many of whom have complex needs, and based on Laguna Honda’s experience during the initial Closure Plan, Laguna Honda continues to anticipate that placements will be necessary outside of the San Francisco Bay Area, including Northern California, the Central Valley, Southern California, and possibly to other states. Facility Closure Transfers to other states will require additional time because each patient’s Medicare and Medicaid benefits will have to be transferred to the receiving state.

There are currently about 4,000 long-term care facilities, including SNFs, in California. Laguna Honda will work with DHCS to call facilities on a daily basis to obtain a baseline on the number of total and current available Medi-Cal certified beds for each level of care.

<b>Bed-Type</b>	<b>Available in San Francisco**</b>
SNF	Total Beds: 1,228 Available Beds: 1
RCFE	Total Beds: in process Available Beds: 15
Residential Supportive Housing	Total Beds: 126 Available Beds: 30
Residential Substance Use Treatment	Total Beds: 249 Available Beds: 9
SNF with mental health services	Total Beds: 23 Available Beds: 0
Community: Respite, Shelter, Board & Care (RCF)	Total Beds: 119 Available Beds: 28 RCF: 25 Behavioral health respite: 3 Medical respite: 0 Shelter: 0

**Fig. 2. Breakdown of available beds by type of facility as of December 21, 2022.**

\*\* This data was obtained through internal SFDPH databases and calls to different programs and is provided for reference purposes only as bed availability is subject to daily change.

**Discharges to Facilities Providing Lower Levels of Care**

In addition to Facility Closure Transfers to other SNFs, Laguna Honda staff has identified non-skilled nursing facilities for patients that could transition to lower levels of care with adequate community or nursing level supports. Within San Francisco, Laguna Honda has identified about 83 available beds (*see* Fig. 2, above); however, due to the complexity of nursing care needs and dual diagnoses of patients at Laguna Honda, the facility anticipates that the majority of Laguna



Honda patients do not meet the criteria for these beds. For example, during the initial implementation of the Closure Plan and prior to the discharges and transfer being placed on “hold” on July 28, 2022, LHH was able to discharge 16 patients to a lower level of care; seven from Group 1 and nine from Group 2. Currently, there are nine residents that had been identified to be lower level of care and can be discharged to the community with significant levels of community and nursing support services. The needs of these patients cannot be maintained with the services available at places like board and care, or residential hotels. These patients will require extensive assistance from care-giver professionals for 8 hours a day or more.

Based on the information collected in Parts 2 and 3 above, the facility will review and assess each patient’s current level of care, needs, and preferences to identify potential discharge option(s). For community discharges, Laguna Honda will partner with community services and programs provided by the City and community partners to better support the patient’s transition and care needs. Laguna Honda will also refer patients meeting specific criteria to treatment programs settings and services (*e.g.*, residential substance use treatment facilities). To the extent that a patient has a special need to be met, there are other family considerations, or there are no beds within a 15-mile radius, Laguna Honda staff will search in other counties for discharge locations.

For patients who qualify for hospice care and wish to be transferred to a facility that provides hospice care services, Laguna Honda will assist those patients in identifying and then transferring to such facilities. Because such transfers are resident-initiated, Laguna Honda will follow LHH Policy 20-04 in assisting qualified hospice care patients or through an agreement with one or more Medicare-certified hospices.

### **Laguna Honda Actions Upon Identification of Available Beds**

Once an available bed has been identified, Laguna Honda staff and DHCS will match the available bed with a patient based on the best accommodation in terms of patient choice, location, services, and psychosocial needs. Patients or the patient’s Representatives will be given an opportunity to participate in this process and, if possible, to visit a suggested facility to determine whether it is acceptable. Given the large number of patients at Laguna Honda and the wide range of locations, it will not be possible in every situation to facilitate an in-person visit to the proposed location. Laguna Honda will attempt to arrange virtual tours when the proposed location is amenable to this option.

Additionally, once an available bed has been identified, Laguna Honda staff will provide the receiving facility with a referral packet, which includes the receiving facility’s application, the patient assessments, and any patient records requested by the receiving facility. Laguna Honda offers in-person screening and assessments for the staff of receiving facilities.

Laguna Honda will identify and contact appropriate transportation services that the facility will use to transfer patients and will establish whether the services have the capacity to handle the projected volume and timetable for transfer/discharge. Laguna Honda will provide appropriate transportation arrangements for each patient.

Once a placement is identified, the patient and Representative will be notified in writing by

Laguna Honda of the proposed Facility Closure Transfer or discharge and of the patient's right to appeal such proposed transfer/discharge. (**See Attachment 3, Notice of Proposed Facility Closure Transfer and Right to Appeal**). DHCS will provide a notice of action letter to patients also notifying them of the proposed Facility Closure Transfer or discharge.

### **PART 5 – DISCHARGE/TRANSFER APPEAL HEARINGS**

Each patient has the right to appeal the Facility Closure Transfer or discharge placement determination and Laguna Honda will comply with the Discharge/Transfer Appeal Hearing process and requirements for each appeal. Because residents cannot appeal the fact of the Facility Closure Transfer or discharge, patient notices will convey that an appeal will not result in restoration of benefits or coverage for their stay at Laguna Honda.

When a patient chooses to appeal the Facility Closure Transfer or discharge from Laguna Honda, Laguna Honda may not transfer or discharge the patient while the appeal is pending, unless the failure to transfer or discharge would endanger the health or safety of the patient or other individuals. Upon request, Laguna Honda will provide medical records relevant to the appeal to DHCS and patient and/or Representative.

The State of California issues a Decision and Order after the hearing and Laguna Honda will comply with the issued directions contained in the order. Ordinarily, appeals must be completed within 90 days of the filing of the appeal. Based on the fact that Laguna Honda will have to find placements outside of the San Francisco Bay Area, the facility anticipates that some patients will appeal their Facility Closure Transfer placement.

### **PART 6 - ADMISSIONS FREEZE**

Laguna Honda suspended all new admissions on April 14, 2022, and this suspension remains in effect for the duration of the revised Closure Plan unless and until Laguna Honda obtains certification in Medicare or Medi-Cal. This admission freeze will not apply to Laguna Honda patients who are or become hospitalized at an acute care facility, wish to return to Laguna Honda, and are expected to be able to safely return to Laguna Honda prior to the Anticipated Closure Date. If a patient is hospitalized and able to be returned to Laguna Honda, Laguna Honda will continue to plan for and coordinate the Facility Closure Transfer or discharge of the patient to an appropriate location.

Laguna Honda has attached the current patient census as of April 14, 2023 as part of this revised Closure Plan. (**See Attachment 10, Patient Census**). The census includes a breakdown of patients hospitalized but expected to return to Laguna Honda prior to the Anticipated Closure Date.

Due to HIPAA and other State medical privacy laws and regulations, a patient roster will be shared separately, directly with CMS and CDPH.

## **PART 7 - PATIENT FACILITY CLOSURE TRANSFER AND DISCHARGE**

Laguna Honda plans to transfer or discharge all patients by the Anticipated Closure Date (unless CMS agrees to pause Facility Closure Transfers and involuntary discharges initiated pursuant to the revised Closure Plan or Laguna Honda is recertified in either the Medicare or Medicaid program). Laguna Honda will provide daily updates to CDPH of the total number of discharges, Facility Closure Transfers, and the remaining patient census. Each patient or Representative will be provided a notice with the patient's anticipated Facility Closure Transfer or discharge date. Patients and/or Representatives who appeal the Facility Closure Transfer or discharge will require an approval from DHCS Office of Administrative Hearing and Appeals before they can be transferred or discharged.

Patients will be transferred to receiving facilities or discharged back to the community in an orderly fashion. In addition, Laguna Honda will transfer patients based on a Patient-Centered Prioritization, described in Part 8, below, which will prioritize patients by physical fragility and potential risk of transfer trauma. For discharges to home or to a lower level of care in the community, Laguna Honda will provide the patient and/or Representative discharge education and/or training (*e.g.*, use of equipment and medication treatment, arrange follow up primary care provider and services appointments, and provide discharge medications and necessary equipment and supplies good for 30 days).

Laguna Honda will provide appropriate psychological preparation and counseling for each patient to minimize the impact and trauma of the closure on patients and facilitate the patients' adjustment to their new environment.

For Facility Closure Transfers to another skilled nursing facility or nursing facility, the following steps will be taken for each patient:

Medical Records. At a minimum, Laguna Honda will complete a patient discharge summary. Laguna Honda's Medical Information Systems Department will create an electronic file of medical records to provide to the new facility. Additional legal documents such as guardianship, Power of Attorney (if applicable), and advanced directives (if executed) will be included. The last three months of each patient's medical records will be transferred to the new facility initially, with a more complete record to follow within 30 days, provided that, in extenuating circumstances or at the receiving facility's request, medical records will be transferred within a reasonable amount of time. In addition, Laguna Honda will complete and successfully transmit MDS documents for all patients including final discharge assessments prior to the transfer. MDS records, including archived files, will be transferred with each patient to their new placements.

Medications. When a patient is discharged to a community setting (*i.e.*, home or board and care), the patient will be discharged with up to 30 days' supply of medications, if clinically appropriate. For Facility Closure Transfers, Laguna Honda will provide up to 14 days' supply of medication to the new facility. Any medications not transferred with the patients will be destroyed in accordance with all applicable laws and regulations and appropriate records maintained of such destruction. Such records will be reviewed by CMS and/or CDPH on its closure visit to Laguna Honda. If a closure visit is not conducted, Laguna Honda will provide a written account to CMS and/or CDPH of medications transferred and destroyed and shall account for all medications

previously maintained by the Laguna Honda.

Patient Belongings. Laguna Honda will itemize all patient personal belongings prior to the transfer to a new facility and will reconcile the patient's inventory of personal belongings before Facility Closure Transfer or discharge. The patient's personal belongings (*i.e.*, clothing, furnishings, etc.) will be packed and transferred with the patient by Laguna Honda. The patient's personal belongings may be transferred by family members if the patient and the family so desire.

Patient Funds. Laguna Honda will arrange the patient's funds to be transferred to the new facility or ensure continuity and an accounting of a patient's funds, consistent with title 22 California Code of Regulations section 72529.

Social Security Information. Laguna Honda will complete and mail, on behalf of each patient transferred, a Social Security change of address based on the federal Social Security Administration requirements.

Transportation. Laguna Honda will work with patients and Representatives to determine the most appropriate transportation method for each patient to safely reach their transfer destination. These modes will include, but not be limited to, the following: ambulance; transport vans; commercial services; other contracted transportation services; and family or other Representative transportation.

Day of Facility Closure Transfer or Discharge. Laguna Honda will assess patients to ensure they are stable for transfer or discharge on the day of the scheduled Facility Closure Transfer or discharge. For patients who do not meet the minimum criteria for a transfer and show signs of transfer trauma on the day of the scheduled transfer, Laguna Honda may reschedule the Facility Closure Transfer or discharge until the conditions that gave rise to the rescheduling of the Facility Closure Transfer or discharge are stabilized or resolved. For patients who meet the minimum criteria for transfer, Laguna Honda may, depending on the clinical determination of the physician or RCT, proceed with the Facility Closure Transfer or discharge with additional or alternative mitigation strategies. Laguna Honda recognizes that facility closure means all patients will need to be relocated and that rescheduling should be an exception. Laguna Honda staff will contact the receiving facility and offer to update that facility's staff of the patient's condition, either on the day of Facility Closure Transfer and, if the receiving facility is not available, after the day of Facility Closure Transfer. If the patient records transmitted by Laguna Honda to the receiving facility are not current through the Day Facility Closure Transfer or discharge, Laguna Honda will transmit any updated medical records or information as soon as possible after the Facility Closure Transfer, or discharge, if applicable (*e.g.*, discharge to a board and care facility).

## **PART 8 - IMPLEMENTATION & COORDINATION:**

Patient Level of Care Review. Laguna Honda conducted a preliminary review of all current patients to estimate their current level of care needs on April 27, 2022. Based on the current census, approximately 8% of patients meet custodial care criteria but could be discharged to lower level of care facilities if a placement is identified that can meet the patient's other needs (such as wheelchair access or other access requirements) that can accommodate appropriate community or nursing level services.

Facility Closure Transfer and Discharge Process. Laguna Honda will plan to transfer or discharge all patients by the Anticipated Closure Date of November 13, 2023, working with DHCS for Medi-Cal patients requiring covered healthcare, local agencies for step down facilities, and the Ombudsperson and any other available resources. Laguna Honda will provide daily updates to CDPH and CMS via email or other similar electronic means of the total number of Facility Closure Transfers, discharges, and the remaining patient census.

Matching Patients with Available Beds. As noted above, the steps listed in this revised Closure Plan will occur concurrently, and so patients will be matched with placements as soon as their individual assessments are completed and consistent with the Patient-Centered Prioritization, discussed below. Once Laguna Honda and DHCS identify discharge or Facility Closure Transfer locations with available beds or placement, Laguna Honda will assess and match the patients concurrently for all Groups listed in the Patient Assessment section above in order to take advantage of beds as they become available, provided that, patients in Group 3 will be transferred consistent with the Patient-Centered Prioritization, below.

Discharge/Facility Closure Transfer locations for the Groups identified during the assessment include:

- Group 1 Discharge Locations:
  - 1a: Independent Living/Residential/Cooperative Living
  - 1b: Respite (Medical or Behavioral Health)
  - 1c: Hotel without significant support services
  - 1d: Other placements with appropriate services
- Group 2 Discharge Locations:
  - 2a: Hotel or Housing with support services
  - 2b: Board and Care (Residential Care Facility for Elderly and Adult Residential Facility)
  - 2c: Board and Care with delayed egress
  - 2d: Residential Treatment facilities (with behavioral health and substance use disorder treatment programs)
- Group 3 Facility Closure Transfer Locations:
  - 3a: Skilled Nursing Facility
  - 3b: Hospice Facility
- Group 4 Discharge Locations:
  - 4a: Locked Subacute Treatment (LSAT)
  - 4b: Psychiatric Skilled Nursing Facilities
  - 4c: State Psychiatric Hospital

Patient-Centered Prioritization. To ensure that the Facility Closure Transfer or discharge process is patient-centered and minimizes the impact of transfer trauma, Laguna Honda will apply the following criteria for discharge before transferring or discharging a patient. For Group 3, patients will be placed in one of the tiers described below. As patient assessments are on-going, each patient's priority tier may change due to a significant change in patient condition. The priority for Facility Closure Transfers and discharges will be Green Tier first, then Yellow Tier,

and the Red Tier.

- ***Groups 1 and 2: Discharges to Lower Level of Care or to Community***
  - Laguna Honda will discharge patients at a lower level of care placement based on LHH Discharge Planning Policy 20-04.
- ***Group 3: Criteria Prioritization for Facility Closure Transfers to other SNFs***
  - Patients will be placed under specific priority tiers using the transfer-based criteria listed below. As patient assessments are on-going, each patient's priority tier may change due to a change in resident condition.
  - "Green" Tier (average risk for transfer trauma):
    - Patients do not meet any of the criteria of the Yellow or Red Tiers.
  - "Yellow" Tier (above average risk for Transfer Trauma—If a patient meets any of the Yellow Tier criteria, that patient will be in Yellow Tier, unless the patient also meets any criteria in Red Tier, in which case the patient will be placed in Red Tier):
    - Mild cognitive loss or dementia.
    - Cognitive or physical condition change during the last 3 months.
    - Chronic, stable psychiatric conditions.
    - Patients expressing anxiety or upset over potential transfer.
    - Patients with longevity stay at LHH of greater than or equal to 10 years.
  - "Red" Tier (highest risk for transfer trauma):
    - Moderate to severe cognitive loss or dementia.
    - Greater than or equal to 85 years of age.
    - Palliative or comfort care status.
    - New psychiatric diagnosis or acute worsening of a chronic psychiatric condition.
    - Prior emotional or behavioral disturbance in the context of a change in environment.
- ***Group 4: Discharges to Specialized Facilities***
  - Patients in Group 4 necessarily need a more appropriate or higher level of care than that is provided at Laguna Honda and successful mitigation would involve transferring to a more specialized facility. Accordingly, Laguna Honda will discharge patients in Group 4 according to LHH Policy 20-04.

Records Storage. With respect to records not transferred with patients or closed/archived records, Laguna Honda has provided for the storage of such records for a period of 10 years from the date of closure as follows:

Records Storage Site: Electronic Health Records system (EHR), EPIC.  
Paper records are stored on-site at Laguna Honda or archived at multiple external, HIPAA-

compliant facilities approved by the Department of Health Services, Licensing and Certification Division.

Street Address: 375 Laguna Honda Blvd  
San Francisco, CA 94116

Records may be accessed by contacting the person below:

Person to Contact: Diane Premeau, Director of Health Information Services  
Address: 1001 Potrero Avenue  
San Francisco, CA 94110  
Telephone Number: (628) 206-6274

Facility Reports to the CMS and CDPH. Laguna Honda will keep CMS and CDPH informed of the progress of the closure on a daily basis. As a part of keeping both regulatory bodies informed, Laguna Honda will submit daily reports, beginning immediately after the approval of this revised Closure Plan by CMS, detailing the status of each patient's Facility Closure Transfer or discharge. Laguna Honda will also provide a weekly report that will include information about staffing levels (including patient care, dietary, and janitorial staff) and about the availability of supplies and resources. (**See Attachment 10, Patient Census**).

Monitoring and Closure Visits. Laguna Honda acknowledges that CMS and CDPH will conduct monitoring surveys pursuant to the settlement agreement and a final closure visit at the discretion of the CMS and/or CDPH and agrees to cooperate fully.

Final Closure Visit. Laguna Honda will submit a final closure report and final patient roster detailing where all patients were transferred at the time the last patient is transferred or discharged. In order to prepare for the final closure visit, Laguna Honda will make available: (1) a list of all the patients transferred, the facilities to which they were transferred, and the medication which accompanied them, if applicable; (2) medication disposal records, if applicable; (3) patient funds accounting records, if applicable; (4) verification of the successful transmission of the MDS documents; (5) the location where records will be stored with the name, address and telephone number of the individual responsible for the safekeeping of such records.

## **PART 9 - ADMINISTRATOR AND FACILITY CLOSURE TEAM: ROLES AND RESPONSIBILITIES**

### Administrator: Roles and Responsibilities.

Facility Closure Administrator – Responsible for the operation of the facility, and the governing body remains responsible for the oversight of the facility operation.

According to state and federal regulations, the administrator is responsible for submitting written notification of the closure and transition plan to CDPH, State LTC Ombudsperson, patients of the facility, and the Representatives. In addition, the administrator will ensure that the facility does not admit any new patients on or after April 14, 2022 and all patients will be discharged or transferred to settings based on quality, services, and location, taking in consideration the needs, choice and best interests of each patient. (**See Attachment 11, LHH Facility Closure Policy**).

Facility Closure Coordinator – Provides oversight of the eight areas of activities in the Closure

Plan. In addition, the coordinator will ensure that the steps and actions indicated are implemented and operationalized. The coordinator will report to the Facility Closure Administrator regarding the status and progress of the Closure Plan.

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 – Each patient’s RCT will conduct the assessments and screening described in this revised Closure Plan in addition to providing routine patient care. In addition to the RCT, the Director of Care Coordination will provide clerical staff to assist DHCS in calling receiving facilities to identify available Medicare or Medicaid beds, provide the Utilization Management team to review patient assessments, and oversee the social workers conducting assessments.

Disciplines	Credentials	Responsible For:
Medical Services  Leads: Neda Ratanawongsa, MD, MPH Interim Chief Medical Officer Lisa Hoo, MD, Chief of Staff Monica Banchemo, MD, Chief of Medicine	DO or MD	Conduct medical assessments
Nursing Services  Lead: Terry Dentoni, MSN, RN, Acting 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.



Disciplines	Credentials	Responsible For:
<p>Social Services</p> <p>Lead: Janet Gillen, Director of Social Services</p>	<p>LCSW and MSW</p>	<p>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 data related to discharge/transfer options, services and discharge/transfer data.</p>
<p>Utilization Management Patient Flow Minimum Data Set (MDS)</p> <p>Lead: Maria Chavez-Lagasca, Nurse Manager</p>	<p>RN and LVN</p>	<p>Conducts record reviews for level of care, regulatory requirements and support Social Services in the identification of potential 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/transfer progress.</p>
<p>Behavioral Health Services</p> <p>Lead: Yifang Qian, MD, PhD, Chief of Psychiatry</p>	<p>CADC II, MSW, LCSW, PsyD, PhD, MD</p>	<p>As appropriate, provide trauma support to patients and/or provide emotional support resource information to families/Representatives regarding the transition plan.</p>

Disciplines	Credentials	Responsible For:
Activity Therapy  Lead: Jennifer Carton-Wade, 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 Facility Closure Transfer destination as appropriate. Schedule and facilitate community meetings of
		patients discussing the closure plan.
Admissions and Eligibility  Lead: George Villavicencio, 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: Prasanthi Patel, Interim Administrative Director of Operations		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.

**Fig. 3. Laguna Honda Facility Closure Team.**

Date Revised Closure Plan Submitted: April 18, 2023




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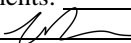
Roland Pickens, MHA, FACHE  
 Director, San Francisco Health Network  
 Interim Chief Executive Officer, Laguna Honda Hospital and Rehabilitation Center

Attachments:

- 1–Sample Letter to Patient/Representative
- 2–Executive Summary of Revised Closure Plan
- 3–Notice of Proposed Facility Closure Transfer and Right to Appeal
- 4–Physician Pre-Discharge/Transfer Patient Assessment
- 5–Social Work Pre-Discharge/Transfer Patient Assessment
- 6–Resident Care Team Note: Pre-Discharge/Transfer Patient Assessment
- 7–Transfer Trauma Screening Tool
- 8–Nursing Weekly Summary Monitoring Note
- 9–Day of Facility Closure Transfer or Discharge Patient Assessments
- 10–Patient Census
- 11–LHH Facility Closure Policy

CDPH AND CMS REVIEW AND APPROVAL/DENIAL

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Evaluated By: Cassie Dunham Date Plan Received by CDPH: 4/18/23  
Approved: X Denied:     . Comments:      Date: 04/18/23  
Reviewed By: Cassie Dunham  Date: 04/18/23  
Approved: X Denied:     . Comments:     

Evaluated By: NOT REQUIRED Date Plan Received by CMS:       
Approved:      Denied:     . Comments:      Date:     /    /      
Reviewed By:      Date:     /    /      
Approved:      Denied:     . Comments:

## ATTACHMENT 1

### Sample Letter –Notice of Closure to Patient/Representative

San Francisco Department of Public Health  
Grant Colfax, MD, Director of Health



Laguna Honda Hospital and Rehabilitation Center  
Michael T. Phillips, MHA, FACHE  
Chief Executive Officer

San Francisco Health Network  
Roland Pickens, MHA, FACHE, Director

City and County of San Francisco  
London N. Breed  
Mayor

May 16, 2022

Dear Laguna Honda Patients and Families,

Our goal at Laguna Honda Hospital remains patient safety and providing excellent care in a welcoming, healing and safe environment. It is an honor to serve Laguna Honda patients and the larger San Francisco community.

As you know, despite significant improvements to comply with regulators and support patient safety, the Centers for Medicare and Medicaid Services (CMS) recently terminated Laguna Honda's participation in the Medicare and Medicaid programs, which funds the majority of Laguna Honda patient care. Laguna Honda is required by CMS to provide this notice and the Patient Transfer and Relocation Plan (the Plan) to Medicare and Medicaid beneficiaries. The Plan addresses steps that Laguna Honda must take to continue to meet your medical needs, including to begin the process of conducting patient assessments, conducting meetings with patients/representatives, and safely transferring patients to other facilities.

As required by the Plan, Laguna Honda staff will begin assessing each patient's care needs to help with a safe and orderly transfer to an appropriate placement at another facility. We will take into account your preferences with respect to available facilities and location whenever possible and your specific specialized healthcare and mental health or treatment needs. We will also get input from patient family members.

Our staff will work together to create as little stress as possible to accomplish this process in a manner which will minimize, if not altogether prevent, the incidence of "transfer trauma." Transfer trauma is the traumatic consequence experienced as the result of the abrupt and involuntary transfer of a patient from one residential facility to another. We believe that transfer trauma can be reduced for each patient if we, the patient, and his or her family and/or responsible representative work together to provide a transfer that is organized and adheres to the regulations provided for facility closure. No amount of preparation will completely remove all the trauma of relocation either to you, or the family. We will work with you and keep you informed every step of the way to minimize these effects.

Laguna Honda Hospital and Rehabilitation Center  
375 Laguna Honda Blvd. • San Francisco, CA 94116 • (415) 759-2300 • [www.lagunahonda.org](http://www.lagunahonda.org)

## ATTACHMENT 2

### Executive Summary of Revised Closure Plan

## **LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER EXECUTIVE SUMMARY OF REVISED CLOSURE AND PATIENT TRANSFER AND RELOCATION PLAN**

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In May 2022, Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) submitted a Notification of Closure and Patient Transfer and Relocation Plan (Closure Plan) to the federal Centers for Medicare and Medicaid Services (CMS) and the California Department of Public Health (CDPH) following the termination of Laguna Honda's certification in the Medicare and Medicaid Programs, effective as of April 14, 2022. Laguna Honda is now submitting a revision to the Closure Plan, as of April 18, 2023, pursuant to a settlement agreement between the City and County of San Francisco (City), CMS, and CDPH. Laguna Honda will notify CMS and CDPH, in writing, of further amendments to the revised Closure Plan, and obtain approval of such changes prior to implementing any such changes.

The revised Closure Plan is intended to ensure the safe, orderly, and clinically appropriate transfer or discharge of each Medicare and Medicaid beneficiary patient. All patients will be discharged or transferred to the most appropriate setting possible in terms of quality, services, and location, as determined appropriate by the resident care team and taking into consideration the patient's individual needs and choices. All time frames contained within the Closure Plan are reasonable approximations. We will do our very best to relocate these patients within the CMS timeline as prescribed in this plan. If it appears that alternate placements are not available and a good faith effort to relocate has occurred, there is a shared commitment by all parties, including San Francisco Department of Public Health, CMS, and CDPH to work together to identify resources and solutions on how to best serve remaining patients.

Laguna Honda assures that it will ensure adequate staffing in all disciplines and areas to protect the health and safety of the patients residing the facility, and remains committed to its patients, families, and employees in providing excellent care during the closure process.

### **Facility Closure Transfer Notice**

Laguna Honda will provide each patient a Notice of Proposed Facility Closure Transfer or Notice of Discharge in advance of any transfer to a skilled nursing facility or discharge to a lower level of care or to a more specialized level of care. The notice will state the recommended transfer or discharge and the reasons for the move in a language and manner the patient and patient's representative understand. These notices will be sent out patient-by-patient based on the individualized needs of each patient after Laguna Honda completes the patient assessments described below to minimize the risk of possible transfer trauma. Each individual patient transfer notice will be sent as soon as the patient assessment is done and a placement is located and available.

### **Patient Assessments**

Laguna Honda will complete the following assessments for each patient before any transfer to

another facility or discharge to the community. Patients will be assessed concurrently on all units.

These assessments are critical to identify an appropriate facility to meet the needs and preferences of the patient.

Physician Assessment. Each patient will be assessed by the patient's attending physician to determine the patient's medical needs. The assessment will include a description of any medical needs, associated behaviors, or challenges that may complicate placement. Where appropriate, the medical assessment will include consultations with specialized care providers, such as substance use treatment, mental health, and rehabilitation. In addition, the medical assessment will include a transfer trauma assessment for patients who will be transferred to a skilled nursing facility. A physician will update the transfer trauma assessment as necessary based on clinical assessments. The assessment will provide recommendations for counseling, follow-up visits, and other recommended services, by designated health professionals, and for preventing or ameliorating potential adverse health consequences in the event of transfer (such recommendations may be added following the Resident Care Team (RCT) meeting). Additional referrals will be made to Laguna Honda's mental health team throughout the transfer or discharge process when appropriate.

Social Assessment. Each patient will also be assessed by social workers to identify specific social needs such as family and social services supports or other program requirements, including preferred activities inside and out of the facility, interests, and other preferences, which will play a role in finding an appropriate placement. In addition, the social worker will assess physical functioning with potential risk factors. The social assessment will include recommendations for preventing or ameliorating potential adverse health consequences in the event of transfer and a recommendation for the type of facility that would best meet the patient's needs (such recommendations may be added following the RCT meeting).

Resident Care Team Meeting. After the physician and social assessments, the RCT will determine the risk level of transfer trauma during the RCT patient assessment meeting using a transfer trauma screening tool and the patient assessments. The RCT note also includes a nursing and MDS assessment to document the patient's functional capabilities and nursing care needs. This assessment captures the patient's comorbidities, physical, psychological, and psychosocial functioning in addition to any treatments (*e.g.*, end of life care, oxygen therapy, dialysis) or therapies (*e.g.*, physical, occupational, speech, restorative nursing) needed. During this meeting, the RCT will provide recommendations for preventing or ameliorating potential adverse health consequences of a transfer or discharge, consistent with California Health & Safety Code Section 1336.2(a)(1), (2) and will document those interventions in the patient's care plan.

Laguna Honda will consider each of the assessments listed above during the process of creating the discharge or transfer recommendations for each patient as outlined below.

### **Patient and Family Meetings**

Laguna Honda will meet with each patient and, where applicable, the patient's representative. The purpose of the meeting is to give the patient and representative information about the closure process and to gather input for the transfer or discharge decision. Each patient and representative will be notified verbally and in writing of the meeting.

These meetings will begin immediately following each individual patient's assessment on a rolling basis and concurrently with the remainder of the patient assessments. Where appropriate, follow-up meetings will be scheduled to ensure that each patient and the patient's representative understand the termination and transfer or discharge process.

### **Identification of Beds and Match with Patients**

Laguna Honda will review and assess each patient's current level of care, needs, and preferences to identify potential discharge and transfer option(s). Laguna Honda will work closely with DHCS, CDPH, and the Medical and Health Operational Area Coordinator to help identify beds for Medi-Cal patients requiring covered healthcare, local agencies for step down facilities, and the Ombudsperson and any other available resources. Laguna Honda will provide daily updates to CMS and CDPH of the total number of discharges and the remaining patient census. Laguna Honda will also refer patients meeting specific criteria to treatment programs settings and services (*e.g.*, residential substance use treatment facilities).

As needed or when preferred by patients and their representatives, Laguna Honda staff will also search in other geographic areas for beds. Given the large number of patients at Laguna Honda many of whom have complex needs, Laguna Honda anticipates that placements will be necessary outside of the San Francisco Bay Area, including Northern California, the Central Valley, Southern California, and possibly to nearby states.

Laguna Honda staff will match available beds with patients to arrange for the best accommodation in terms of location, services, and psychosocial needs. Patients and their legal representatives will be an integral part of this process.

### **Discharge/Transfer Appeal Hearing**

Each patient has the right to appeal the transfer or discharge and Laguna Honda will abide by the transfer/discharge hearing process and requirements for each appeal.

When a patient chooses to appeal the transfer/discharge from Laguna Honda, Laguna Honda will not transfer/discharge the patient while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the patients or other individuals.. Note that an appeal will not result in restoration of financial benefits or coverage for a patient's stay at Laguna Honda through the closure process, but a patient would remain entitled to benefits and/or coverage at the receiving location.

### **Patient Transfer and Discharge**

Laguna Honda plans to transfer or discharge all patients by the new anticipated closure date of November 13, 2023 (unless CMS agrees to pause transfers and involuntary discharges initiated pursuant to the revised Closure Plan or Laguna Honda is recertified in either the Medicare or



Medicaid programs).

Once Laguna Honda and DHCS identify discharge or transfer locations with available beds or placement, Laguna Honda will assess and match the patients concurrently in order to take advantage of beds as they become available, provided that, Laguna Honda will apply a patient-centered prioritization for those patients who will be transferred to other skilled nursing facilities.

Patients will be transferred to receiving facilities or discharged back to the community in an orderly fashion. For discharges, Laguna Honda will provide the patient and/or family or legal representative discharge education and training (*e.g.*, use of equipment and medication treatment, arrange follow up primary care provider and services appointments, and provide discharge medications and necessary equipment and supplies for 30 days, if clinically appropriate).

In relation to patient transfers to another facility, the following steps will be taken for each patient:

Medical Records. Laguna Honda will prepare an electronic medical record, which will include any applicable legal documents such as guardianship, Power of Attorney, and advanced directives. The last three months of each patient's medical records and MDS documents will be transferred to the new facility initially, with a more complete record to follow.

Medications. When a patient is discharged to a community setting, the patient will be discharged with up to 30 days' supply of medications, if clinically appropriate. For discharges or transfers to SNFs or other facility placements, Laguna Honda will provide up to 14 days' supply of medication to the new facility.

Patient Belongings. Laguna Honda will itemize all patient personal belongings prior to the transfer to a new facility. Laguna Honda will pack and transfer each patient's personal belongings with the patient, but the patient's representatives may transfer the belongs.

Patient Funds. Laguna Honda will arrange the patient's funds to be transferred to the new facility or ensure continuity and an accounting of a patient's funds, consistent with title 22 California Code of Regulations section 72529.

Social Security Information. Laguna Honda will complete and mail, on behalf of each patient transferred, a Social Security change of address based on the federal Social Security Administration requirements

Records Storage. With respect to records not transferred with patients or closed/archived records, Laguna Honda has provided for the storage of such records for a period of 10 years.

Transportation. Laguna Honda will work with patients and Representatives to determine the most appropriate transportation method for each patient to safely reach their transfer destination. These modes will include, but not be limited to, the following: ambulance; transport vans; commercial services; other contracted transportation services; and family or other Representative transportation.

Day of Facility Closure Transfer or Discharge. Laguna Honda will assess patients to ensure they are stable for transfer or discharge on the day of the scheduled Facility Closure Transfer or discharge. Patients who do not meet the minimum criteria for a transfer and who show signs of transfer trauma, on the day of the scheduled transfer, Laguna Honda may be reschedule the Facility Closure Transfer or discharge until the conditions that gave rise to the rescheduling of the Facility Closure Transfer or discharge are stabilized or resolved. For patients who meet the minimum criteria for transfer and show signs of transfer trauma, Laguna Honda may, depending on the clinical determination of the physician or RCT, proceed with the transfer or discharge with additional or alternative mitigation strategies. Laguna Honda recognizes that facility closure means all residents will need to be relocated and that rescheduling should be an exception. Laguna Honda staff will contact the receiving facility and offer to update that facility's staff of the patient's condition.

**ATTACHMENT 3**

**Notice of Facility Closure Transfer and Right to Appeal**  
**[Forthcoming]**

**ATTACHMENT 4**

**Physician Pre-Discharge/Transfer Patient Assessment**

**LHH Pre-Discharge or Pre-Transfer Physician Progress Note**

Provider:

Patient Name:

MRN:

Date of Birth:

PCP: @PCP@

Date of Admission:

Date of Discharge: \*\*\*

**Discharge Diagnosis**

**Hospital Course by Problem**

**Physical Exam**

Last Recorded Vitals:

**Allergies**

**Current Medications:**

**Advance Directives:**

Code Status:

Surrogate Decision-Maker:

Additional Comments:

**Current Functional Status**

**Current Level of Care:**

**Factors that may contribute to Transfer Trauma, including psychosocial effects:**

**Recommendation for Transfer Trauma mitigation:**

**Recent Lab Results**

**Issues Requiring Follow-Up**

**ATTACHMENT 5**

**Social Work Pre-Discharge/Transfer Patient Assessment**

**LHH Medical Social Services Discharge or Transfer Patient Assessment**

Patient \_\_\_\_\_

MRN: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Unit: LHH NORTH 6

**Discharge/Transfer Status:**

- Discharge (to lower level of care or community) Ready
- Discharge Pending
- Discharge Barrier(s)
- Transfer (to SNF) Ready
- Transfer Pending
- Transfer Barrier(s)

**Identified Barriers to Discharge or Transfer:**

<input type="checkbox"/> <i>Totally dependent with ADLs and mobility</i>	<input type="checkbox"/> <i>Cognitively impaired and/or displays at risk behaviors, such as AWOL risk, wandering</i>	<input type="checkbox"/> <i>Uncooperative with Discharge planning or contesting discharge</i>
<input type="checkbox"/> <i>History of recurrent falls</i>	<input type="checkbox"/> <i>Undocumented</i>	<input type="checkbox"/> <i>Criminal History</i>
<input type="checkbox"/> <i>Delay in initiating self training (medication/treatment)</i>	<input type="checkbox"/> <i>Neuropsych evaluation finds resident lacks capacity and has no SDM</i>	<input type="checkbox"/> <i>History of eviction(s)</i>
<input type="checkbox"/> <i>Delay in applications and/or referrals (e.g., SSI, ID Eligibility, etc.)</i>	<input type="checkbox"/> <i>Incontinent</i>	<input type="checkbox"/> <i>Lack of participation/resistance by family</i>
<input type="checkbox"/> <i>Delay in treatment plan/waiting for surgery</i>	<input type="checkbox"/> <i>Pending processing SSI/Entitlements, etc.</i>	<input type="checkbox"/> <i>Substance use issues/Refused to participate in SATS</i>
<input type="checkbox"/> <i>Slow progress with training</i>	<input type="checkbox"/> <i>Pending conservatorship – Public Guardian</i>	<input type="checkbox"/> <i>Complex medication management (includes methadone/narcotics/insulin)</i>
<input type="checkbox"/> <i>Waiting for procedure/treatment</i>	<input type="checkbox"/> <i>Referral made. Accepted. No Bed.</i>	<input type="checkbox"/> <i>Complex discharge coordination</i>
<input type="checkbox"/> <i>Waiting to complete dental treatment</i>	<input type="checkbox"/> <i>Referral made. Denied by facility/agency</i>	<input type="checkbox"/> <i>Outside Team disagreement (e.g., DCIP, Placement, etc.)</i>
<input type="checkbox"/> <i>Waiting for home installation of</i>	<input type="checkbox"/> <i>Referral made. Pending interview/decision/response</i>	<input type="checkbox"/> <i>RCT disagreement</i>

<i>equipment/environmental modification or DME</i>	<i>by facility/agency (including Placement)</i>	
<input type="checkbox"/> <i>Chronic persistent mental illness</i>	<input type="checkbox"/> <i>Homeless upon admission</i>	<input type="checkbox"/> <i>Socially disruptive behaviors</i>
<input type="checkbox"/> <i>Harm to self/others</i>		

**Services Needed for Discharge or Transfer:**

- IHSS       Follow up medical appointment       Home Care (i.e. Health at Home)  
 Substance Use Treatment Follow Up       Meals on Wheels       Mental Health appointment  
 SF Paratransit       Community Case Management       Adult Day Health Center  
 Medical Supplies       Money management       Income benefits  
 Other

**Not Discharge Ready to the Community (i.e. Home) or lower level of care**  
**If 'Not Discharge Ready', choose one below:**

<input type="checkbox"/> <i>Behavior</i>	<input type="checkbox"/> <i>Chronic Progressive Disease</i>	<input type="checkbox"/> <i>Cognitive Impairment</i>
<input type="checkbox"/> <i>Palliative Care</i>	<input type="checkbox"/> <i>Persistent Vegetative State</i>	<input type="checkbox"/> <i>Medically Unstable</i>
<i>Physical Accommodation:</i> <input type="checkbox"/> <i>Bariatric</i> <input type="checkbox"/> <input type="checkbox"/> <i>Quadriplegic</i> <input type="checkbox"/> <i>Paraplegic</i> <input type="checkbox"/> <i>Other</i>	<input type="checkbox"/> <i>Other</i>	

If 'Not Discharge Ready,' is patient suitable for transfer to SNF:

**Social and Physical Functioning**  
**Risk Factors (triggers and sources):**

**Evaluating Relocation Needs:**

**Recommendations for Mitigating Transfer Trauma:**

**Involved Parties:**

- Case Management       GGRC       Involved Family  
 RCT acting as decision maker       Resident is own decision maker       Representative Payee  
 Conservator - LPS       Conservator - Probate       Other  
 Affidavit A (Medical Consent)       Affidavit B (Psychotropic Med Consent)

**Recommendation(s) for type of facility that would best meet patient's care needs:**

- Board and Care Home     Locked (L) Facility     SRO/Hotel  
 Shelter bed     Scattered site housing     Placement Team Referral  
 SNF LTC     Home with family     Prior residence     Other

**ATTACHMENT 6**

**Resident Care Team Note: Pre-Discharge/Transfer Patient Assessment**

**Resident Care Team Meeting Note**

**Date: Time:**

**Patient Name:** \_\_\_\_\_

**Medical Record Number:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Sex:**

**Room/Bed:** \_\_\_\_\_

**Payor Info:**

Patient/Family/SDM/Conservator participated:

Resident's preferred language:

Interpreter Use:

Meeting Summary:

Estimated Length of Stay:

Estimated Discharge or Transfer Date:

Resident/Representative consents to Resident Discharge or Transfer (another skilled nursing facility) Location:

Patient/Family/SDM agrees to discharge in less than 60 days:

If this conference is a Pre-Discharge or Transfer Patient Assessment RCC:

RCT completed LHH Risk Assessment for Transfer Trauma screening tool:

Date of completion:

RCT discussion summary of risk of Transfer Trauma:

RCT FINAL determination of risk of Transfer Trauma:

- Green Tier (average risk)
- Yellow Tier (above average risk)
- Red Tier (high risk)
- Not applicable

Recommendations to mitigate risk of Transfer Trauma:

Care plan initiated, reviewed and or updated with potential triggers and sources for transfer



trauma and interventions to mitigate risk of transfer trauma:

Insert Psychosocial-Transfer Trauma Care Plan

If SNF resident, PASRR Review and/or Discussion (if applies)

Resident/Family/SDM/Conservator agrees with the plan of care discussed during the meeting:

\_\_\_\_\_, RN

## ATTACHMENT 7

### Transfer Trauma Screening Tool

#### LHH Risk Assessment for Transfer Trauma

**Resident Name:**

**DOB:**

**Resident Patient Assessment Conference Date:**

**Definition:** Transfer trauma, aka Relocation Stress Syndrome, can be defined as a “combination of medical and psychological reactions to abrupt physical transfer that may increase the risk of grave illness or death.” The transfer trauma literature suggests that much of the cause of transfer trauma comes from a loss of control and a loss of familiar surroundings and relationships; and that certain factors increase an individual’s risk of transfer trauma, such as diminished cognitive status, age, and comorbid medical and psychiatric conditions.

***Disclaimer:** After review of the literature and consultation with geriatrics experts, state health departments, and CMS, we have been unable to identify a validated transfer trauma assessment tool, or even a widely used non-validated tool. The transfer trauma assessment tool proposed in this document represents the best available knowledge about the problem of transfer trauma. It should be noted that, while transfer trauma can be a contributing factor to morbidity and mortality, death after transfer is not necessarily linked to transfer trauma. Other contributing or causative factors include co-morbid medical/psychiatric/SUD conditions, needs of resident, natural course of illnesses. Laguna Honda will make recommendations as appropriate to receiving facilities about ways to mitigate a particular patient’s transfer trauma.*

**Red Tier (highest risk for Transfer Trauma) any of the following characteristics:**

- o Moderate to severe cognitive loss/dementia
- o Greater than or equal to 85 years of age
- o Palliative or comfort care status
- o New psychiatric diagnosis or acute worsening of a chronic psychiatric condition\*
- o Prior emotional or behavioral disturbance in the context of a change in environment

**Yellow Tier (above average risk for Transfer Trauma) any of the following characteristics:**

- o Mild cognitive loss/dementia
- o Cognitive or physical condition change during the last 3 months
- o Chronic, stable psychiatric conditions (ie depression, anxiety, PTSD)\*
- o Expressing anxiety or upset over potential transfer
- o Patients with longevity stay at Laguna Honda of great than or equal to 10 years

**Green Tier (average risk for Transfer Trauma)**

- o Patients with none of the criteria for Yellow or Red Tier

**Anticipatory guidance for LHH staff and receiving facility staff to mitigate transfer trauma**

- o Encourage / enable active participation in transfer decisions and process
- o Allow resident opportunity to explore emotions and reaction to potential transfer
- o Encourage / enable involvement of resident’s support system

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\*PCPs encouraged to use PHQ9 and GAD 7 when possible to assess current state of psychiatric conditions

**References:**

- PHQ9: <https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf>

- GAD7: [https://adaa.org/sites/default/files/GAD-7\\_Anxiety-updated\\_0.pdf](https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf)

Name of Physician:

Name of Nurse (NM, CN or designee):

**ATTACHMENT 8**

**Nursing Weekly Summary Monitoring Note**  
**LHH NSG WEEKLY SUMMARY**

CLINICAL NURSING SUMMARY

Weekly review for \_\_\_ who

PSYCHOSOCIAL

\_\_\_ psychosocial well-being is met by

VITAL SIGNS

Temp:

Heart Rate:

Resp:

BP:

SpO2:

Verbal Descriptor Scale:

Pain Score:

Weight:

MEDICATION

Changes to medications

Resident is on blood pressure medications:

Systolic Min/Max blood pressure in the past 7 days:

Resident is on glucose lowering medications:

Does the patient have routine blood glucose checks?

Manual blood glucose range for the past 7 days:

Resident is on anticoagulant:

Response to medications:

DAILY CARES, ADLs & I/Os

ADLs:

Eating: \*\*\*

Feeding: Able to feed self  
Dressing:  
Toileting:  
Bladder:  
Bowel:  
Personal Hygiene:  
Level of Assistance: Limited assistance  
Bathing:  
Bed Mobility:  
Transfer:  
Walk in Room:  
Walk in Hall:  
Locomotion on Unit:  
Locomotion off Unit:

Resident is on restorative nursing plan:

% of meal intake:

Resident is monitored for I/Os:

Have there been any significant changes in the level of assistance or level of support?

#### BEHAVIOR AND MOOD

Resident currently expresses and or was observed for any emotional or behavioral changes?

Transfer Trauma Weekly Monitoring:

Does the resident exhibit stress-related symptoms and/or adverse reactions due to the facility closure or transfer to another skilled nurse facility?

RCC scheduled to re-assess risk for transfer trauma:

Signs of environmental factors, i.e. packing of belongings, reaction to new staff, etc:

Describe new sources or triggers for potential transfer trauma:

Summarize the outcome(s) of transfer trauma care plan interventions. Update care plan for individualization, if appropriate:

Is \_\_ sleeping well?

Is \_\_ on psychoactive medications and/or has order for monitoring of target behaviors?

Active Orders

There are no active orders of the following types: Restraints.

SKIN STATUS, LDAs & WOUNDS:

Lines, Drains, and Airways

Wound            Duration

Peripheral intravenous line    Duration

Incision        Duration

PROVIDER NOTIFIED OF ANY CHANGES FROM BASELINE:

CARE PLAN has been reviewed:

CARE PLAN interventions have been updated as appropriate:

## **ATTACHMENT 9**

### **Day of Facility Closure Transfer or Discharge Assessments**

#### **Day of Facility Closure Transfer or Discharge– Physician Note**

Resident Name

MRN

Resident is being: (Discharge to community/Lower level of care/Transfer to another SNF)

Date of Discharge or Transfer:

Reason(s) for Discharge or Transfer:

Discharge or Transfer Location:

Verbal hand-off to the receiving facility:

Narrative of the verbal hand-off (including plan of care review, ie transfer trauma, services needed, etc):

Condition on Day of Transfer or Discharge:

Describe any signs of Transfer Trauma exhibited today, if appropriate (applies to residents transferring to another facility):

Stable for Transfer or Discharge:

Transfer or Discharge postponed:

Resident or Representative Agrees to the Discharge or Transfer:

Other information:

#### **Day of Facility Closure Discharge or Transfer – Nursing Note**

Resident Name

MRN

Resident is being: (Discharge to community/Lower level of care/Transfer to another SNF)

Date of Discharge or Transfer:

Reason(s) for Discharge or Transfer:

Discharge or Transfer Location:

Verbal hand-off to the receiving facility:

Narrative of the verbal hand-off (including plan of care review, ie transfer trauma, services needed, etc):

Condition on Day of Discharge or Transfer:

ADLs

Eating:

Dressing:

Toileting:

Bladder:

Bowel:

Personal Hygiene:

Bathing:

Mobility:

Transfer:

Mood:

Behavior:

Describe signs of Transfer Trauma exhibited today, if appropriate (applies to residents transferring to another facility):

Other information:



**ATTACHMENT 10**

**Patient Census**

As of 4/14/23

<b>SNF Level of Care</b>	<b>CRITERIA</b>	<b>CENSUS</b>
<b>Locked/Secured Memory Care</b>	Patients with the primary diagnosis of dementia with elopement/wandering risk. Patients with serious cognitive impairment with the inability to make medical decisions for themselves; Patients who require a conservator or SDM to agree with placement of the Patient in a secured setting.	34
<b>Integrated Support</b>	Patients with behavioral impairments due to mental health disorders, behaviors seen in association with brain disease (e.g., stroke, multiple sclerosis, dementia, and neuro-oncological conditions), transient as well as permanent brain impairments (e.g., metabolic and toxic encephalopathies), and/or injury (e.g., trauma, hypoxia, and/or ischemia).	46
<b>Memory Care</b>	Patients with moderate to advanced cognitive impairment meeting the minimum requirement for skilled nursing needs.	142
<b>Language Focused</b>	Patients who meet the minimum requirement for skilled nursing needs who are predominantly monolingual; neighborhoods are committed to providing culturally sensitive and language appropriate care to all patients.	85
<b>SNF Rehab</b>	<p>Presence of one or more major physical impairments which interfere with the ability to function. Must require the supervision of nursing 24 hours daily in one or more of the following:</p> <ul style="list-style-type: none"> <li>• Training in B/B management</li> <li>• Training in self care</li> <li>• Training or instruction in safety precautions</li> <li>• Cognitive functioning training</li> <li>• Behavioral modification and management</li> </ul> <p>Must be capable of fully participating with rehabilitation program and must demonstrate the ability to progress towards measurable functional goals.</p>	34
<b>Acute Rehab</b>	<p>Patients must have significant functional deficits, as well as documented medical and nursing needs, regardless of diagnosis, that require:</p> <ul style="list-style-type: none"> <li>• 24-hour availability of nurses skilled in rehabilitation</li> <li>• Active and ongoing intensive rehabilitation therapy program by multiple other licensed rehabilitation professionals in a time-intensive and medically-coordinated program</li> </ul> <p>Patients must be capable of fully participating in an intensive level of rehabilitation (generally defined as 3 hours of therapy per day, 5 days per week). And must demonstrate the ability to progress towards objective and measurable functional goals.</p>	0
<b>Medical Acute</b>	Only acutely ill patients for whom appropriate medical care is available are admitted. Patients requiring surgical procedures, critical care, telemetry or hemodynamic monitoring cannot be accommodated on the Acute Medical Unit.	4

<b>Positive Care</b>	Patients who have HIV/AIDS and require SNF level of care. The unit meets the needs of patients with HIV related dementia and provides 24-hour support for a diverse community of people living with HIV/AIDS.	44
<b>Palliative Care</b>	Patients who meet the minimum requirement of SNF level of care who have a terminal disease or chronic and progressive illnesses who would benefit from palliative care services.	43
<b>Complex Care with Total Support</b>	Patients with medical conditions requiring a high level of support, including but not limited to tracheostomy care, enteral tube nutrition, respiratory support, and increased nursing care.	105
	<b>TOTAL</b>	<b>537</b>

## ATTACHMENT 11

### 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.

This policy applies when LHH is subject to a facility closure plan. The procedures included in this LHH Facility Closure Policy apply to residents who are being relocated to another skilled nursing facility as a Facility Closure Transfer because of the facility closure. Residents who are being discharged to an acute care facility or to the community or transferred to an emergency department will be discharged or transferred according to the procedures listed in LHH Policy #20-04, Discharge and Transfer Planning.

##### **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 discharge or adequate Facility Closure Transfer of all patients. For the purposes of this Facility Closure Policy, a "Facility Closure Transfer" means movement of a patient from a Laguna Honda bed to a bed at another certified skilled nursing facility or nursing facility (except for psychiatric skilled nursing facilities), and return to Laguna Honda is not expected. For patients who are transferred as a Facility Closure Transfer, Laguna Honda will follow the procedures detailed in the revised Closure Plan, this Facility Closure Policy, and applicable state and federal law (e.g., California Health & Safety Code section 1336.2). Facility Closure Transfer does not include movement of patients to an acute hospital or for therapeutic leave when the patient expects to return to Laguna Honda, *i.e.*, an acute and/or emergency care transfer. For example, a patient who is transported to an emergency room at a general acute care hospital but expects to return to Laguna Honda before the Anticipated

Closure Date does not constitute a Facility Closure Transfer or new admission.

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.

For patients who continue to need skilled nursing facility services and will be subject to a Facility Closure Transfer, 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.
- A complete assessment shall contain recommendations for counseling, follow-up visits, and other recommended services by designated health professionals.

For residents who continue to need skilled nursing facility services and will be subject to a Facility Closure Transfer, ensure that an assessment of each resident'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 staff.

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 of 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 for the purposes of this policy.

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.

<b>Disciplines</b>	<b>Credentials</b>	<b>Responsible For</b>
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 data 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