Notice of Decision

of the Local Mental Health Director of Ventura County
REGARDING
the Application for Restatement of the Lanterman Petris Short (LPS)
Designation of Aurora Vista Del Mar, LLC

INTRODUCTION

What is "LPS"?

The Lanterman-Petris-Short (LPS) Act is the primary California law governing the involuntary evaluation and psychiatric treatment of patients meeting specific criteria even when the patient is opposed, sometimes violently, to receiving care. Patients cared for under the Act's involuntary treatment provisions are uniquely vulnerable. They usually have not sought out treatment and enter LPS "designated" facilities in a stage of their illness that prevents them from being effective advocates for their own rights and needs.

Californians with mental illnesses who are receiving treatment in mental health facilities, including those persons subject to involuntary commitment, are guaranteed numerous rights under California Welfare and Institutions Code (W&I Code), Section 5325, including the right to be free from abuse and neglect, the right to privacy, dignity, and humane care, and the right to basic procedural protections in the involuntary commitment process.

What is an "LPS Designation"?

Psychiatric facilities in California are not required to admit or treat involuntary patients – those that wish to admit or treat involuntary patients must apply to the Local Mental Health Director in the County where the facility is located. The County reviews the facility and determines if the facility can demonstrate knowledge of the rights of such patients as well as policies and procedures to keep them safe. If successful, and the Department of Health Care Services agrees, the facility is "designated" as one where patients can be brought by police, crisis teams etc. for evaluation and treatment and where other facilities lacking inpatient psychiatric units can transfer patients in need of such care.

Not including Aurora Vista Del Mar Hospital, Ventura County has only one LPS "designated" facility at the moment – Hillmont Psychiatric Center; some counties have none.

BACKGROUND

- LPS patients have been treated at Aurora Vista Del Mar Hospital (VDM) in Ventura since the 1990s. The current owner, Aurora Vista Del Mar, LLC, purchased the

facility in 2002. It applied to the County for and received "designation" to treat involuntary patients from the County Board of Supervisors on December 17, 2002.

- The facility is part of a chain of similar facilities managed by Signature Healthcare Services, LLC (Signature) which owns and operates nineteen facilities in California, Nevada, Texas, Massachusetts and Arizona (Signature Healthcare Services | About SHC (signaturehc.com). Vista Del Mar Hospital "Plan for Provision of Care" 3. Organizational Structure, paragraph b (2023).) Both Limited Liability Companies, VDM and Signature, are wholly owned by Doctor Soon Kim. (*Samantha B. v. Aurora Vista Del Mar, LLC* (2022) 77 Cal.App.5th 85, 91.)

- Both VDM and Signature are "sophisticated parties who should know how to operate a psychiatric hospital to assure the safety [and rights] of their patients". Id.at 105

- On October 9, 2023, I notified VDM that its LPS designation would be suspended effective October 16, 2023. I used the authority given to me as Mental Health Director to suspend the designation because at that time I had no reasonable belief that involuntary patients, their rights and their well-being, were safe at VDM.

- This suspension had no impact on the facility's license to operate – that license is under the oversight of the California Department of Public Health (CDPH). My decision simply restricted VDM from accepting or treating patients subject to the involuntary evaluation and treatment provisions of the LPS Act. VDM has lawfully remained open treating patients who voluntarily sought care there. If a voluntary patient's condition deteriorated while at VDM the facility was expected to assess if a "hold" subject to California Welfare and Institutions Code (WIC) Sections 5150 or 5585 was appropriate and, if a hold was placed, to transfer the patient to a designated facility.

Before Suspension

- Prior to suspending the facility's LPS designation, I and others working at the Ventura County Behavioral Health Department (VCBH) made numerous attempts to work with VDM concerning individual patient situations in which the patient's rights or safety appeared to have been negatively impacted by operations at VDM. We provided technical assistance about VDM's responsibilities under the LPS Act, conducted a detailed audit at the facility and asked VDM to complete corrective action plans addressing deficiencies found in that audit. VDM's responses to these efforts lacked detail and in general did not provide evidence of the facility's

willingness or ability to maintain the safety and rights of patients under LPS involuntary evaluation and treatment. For example, a response to a detailed review and findings by the County's Patient Rights Advocate in July 2022 was not received from VDM until August 2023.

- VCBH also saw an alarming rise during 2022-2023 in the number of incidents at VDM which were separately investigated and substantiated by the California Department of Public Health's Licensing and Certification Program where serious deficiencies, including patient rights violations, were found. The incidents included a completed patient suicide at the facility, discharges with negative patient outcomes immediately after discharge, and chronic and continuing failures to follow procedures required under the LPS Act.

- **Notice of Violation**: In June 2023, the former Mental Health Director sent VDM a detailed "Notice of Violation" under WIC section 5326.9, subdivision (a) including the following summary:

  "the incidents evidence repeated VDM failures that have amounted to violations of patients' rights to be free from harm and neglect, to prompt care and treatment, and to privacy (WIC, § 5325.1(b)-(d)). Moreover, because discharge planning and care coordination have been issues in almost all incidents that VCBH itself has investigated I have determined that VDM's failure to ensure proper discharge planning and care coordination demonstrates a history and pattern of VDM neglect."

- The June 2023 Notice of Violation offered VDM thirty (30) days within which to submit:

  "[A] detailed written plan to prevent future patient rights violations, including identification and copies of the facility's related policies and procedures, methods for monitoring compliance with those policies and the individual's assigned responsibility for both compliance and monitoring each"

- **VDM's "detailed written plan",** delivered on July 24, 2023, was a 5-page chart which only addressed some of the findings of audits delivered to the facility months earlier. Some of the corrective actions were described as happening in September 2022 and February 2023. Other "plan" items were described simply as "still in progress." Although specifically requested in the Notice of Violation, the only "methods for monitoring compliance" described by VDM were closed chart reviews and a checklist that the facility mentioned using during the discharge of patients "to ensure that the correct documents / items are given to the correct

patients" in response to a HIPAA violation. No supporting documentation of actions described in the "chart" – not even the described "checklist" - was attached. Notably, given subsequent events, VDM committed in its submission that "all staff will attend …during the month of August" a long overdue training by the County's Patient Rights Advocate.

- **Patient Rights Training** - In August 2023 the Ventura County Patient Rights Advocate scheduled multiple training sessions at the facility specifically covering patient rights and requirements of the LPS process. Twenty-six staff of VDM did not attend these trainings, including the Chief Nursing Officer and Chief Executive Officer. None of the facility's attending physicians were present at the trainings.

- Meanwhile, the County's Patient Rights Advocate (PRA) and others at VCBH continued to receive reports of conditions at the facility and its treatment of patients in violation of the very types of rights covered in that August 2023 training.

Since Suspension

- On October 10, 2023, VDM requested, and I provided a document detailing requirements for reinstatement of its LPS designation and requested that the facility produce:

  "**documentary evidence** demonstrating if and how you meet each of these requirements"

  In the cover letter I emphasized to VDM that:

  "**We are particularly interested in whatever real time monitoring and reporting mechanisms VDM has or puts into place to ensure compliance with its policies and procedures.** Monthly chart reviews that occur weeks after events take place are rarely effective in changing behavior. **Copies of training materials and details of the training methods used should form part of your presentation**."

- I, and others at VCBH, answered detailed questions about the reinstatement process by video and email. In response to a VDM requests, I have met personally with the VDM Chief Executive Officer Colton Reid and listened to a PowerPoint presentation by him, his staff and individuals from Signature about improvements that they said had been made at VDM since the LPS designation was suspended.

- **VDM's Reinstatement "Application":** On November 16, 2023, VDM submitted approximately 1,000 pages of documentation labeled "LPS Reinstatement

Corrective Plan" for review and consideration in support of its request for reinstatement of its LPS designation.

- These materials, while voluminous, consisted largely of copies of policies in various stages of development. Some of these documents were undated, others were labeled as being effective in "11/23". In several instances an existing policy appeared to have been amended simply by adding, word for word, language from the Ventura County requirements document, but no accompanying change in procedure(s). Some policies had sections of text highlighted in yellow. Others not. No explanation for the yellow highlighting was included. Most policies were unsigned. These materials, labeled "LPS Reinstatement Corrective Plan" created uncertainty for me as to what policies are actually currently in effect at VDM. The materials also did not demonstrate that VDM had understood or incorporated the LPS standards into VDM's day to day operations.

- The materials submitted did not include the descriptions of "real time monitoring and reporting mechanisms to ensure compliance" I had specifically requested.

- **New Employee Orientation** The binder materials included a three-page, undated list with the heading "New Hire Orientation Topics That Must Be Completed & Signed Off On" with space after each for a Manager to initial "when completed". No material or explanation was included on what information is communicated for each topic or the method(s) of training used for each. No materials given to orientees or evidence of testing for comprehension was submitted.

- **Power Point Slides** were included for presentations on the Environment of Care (undated); Medication Management and Safety (dated 11/16), Discharge and Aftercare Planning (dated 11/30/23), Patient's Rights, Complaints/Grievances, Incident Reporting (undated), Cultural Diversity and Linguistics (undated), Against Medical Advice (undated), Medication Consents (undated), Seclusion and Restraint (dated 11/10/2023), LPS Designation Initial Staff Training (dated 11/10), Mandated Reporting and Duty to Warn (undated)

- **Testing** - A one page mostly true / false "Cultural Diversity Test" was included, without an indication of how, when, or with whom it is used. One presentation included a slide referring to "Test Time" but nothing on what that "testing" consisted of.

- **Sign in Sheets** – Sign In Sheets were produced for a four hour "Mandatory LPS Training" covering four of the topics in the included Powerpoint Slides that was apparently presented on November 8, 9, 10 , 11, 12 and 13 were also submitted. Two of the participants listed in the Sheets were identified as physicians. The CEO also attended a session. The presenters listed were the Chief Nursing Officer (CNO), the Director of Quality Improvement, and one of the House Supervisors.

- **Resumes** for the three inhouse presenters of the "Mandatory LPS Training" segments were included in the materials produced. None of these individuals appear from these resumes to have any specialized training in educational methods or the subjects upon which they were presenting. Two were recent hires with no listed behavioral health work experience. None were from Signature Healthcare.

- **CPI Training** - Although two policies and one of the PowerPoint presentations mentioned that training by the nationally recognized "Crisis Prevention Institute" (CPI) was required before staff can "lay hands on a patient", no proof that such training actually occurs at the facility was included in the reinstatement application – not even a contract with CPI. There were no materials proving the staff competency with the tenets of this training are assessed on an ongoing basis.

- No other details of the "training protocol" required by some of the written requirements for reinstatement were included in the materials submitted by VDM.

- **Public input** - Through the Ventura County Behavioral Health Advisory Board and a public notice, I requested members of the public to provide comments or thoughts on recent experiences with VDM.

- **On site review at VDM** - After reviewing VDM's written submission, I retained a team of five clinicians from Chartis Group LLC (previously Greeley) to visit the facility and complete an independent evaluation of VDM's current practices and readiness to hold and treat patients safely according to the LPS Act. A member of VCBH Management also participated in the multi-day review.

- **Opportunity to Respond** - VDM was provided with a copy of the Chartis team's 49 page report and given time to identify any parts of the report to which they

objected and provide whatever additional information they believed should be considered by me in reviewing VDM's request for reinstatement. A written response was received from VDM on April 5, 2024. No additional documentation supporting any of the statements made by VDM in this document or contradicting the observations of the Chartis surveyors was produced by VDM.

FINDINGS

Upon review of the materials submitted by VDM, the reports from the Chartis surveyors, and interactions of VCBH staff with the VDM facility and staff since the suspension of the LPS designation, I make the following findings as Local Mental Health Director:

(A) **Since suspension of its LPS designation VDM has dedicated significant resources to improve clinical and care processes at the facility such as:**

- The coordination of patient care staffing schedules to facilitate shift hand-off communication,
- Daily huddles to discuss emerging issues,
- Improved and more frequent treatment planning meetings,
- Daily discharge planning notes, and
- Enhanced development of nursing competence.

These improvements were made at VDM during a time of limited patient census with primarily lower acuity, voluntary patients. At times only 14-15 patients are being treated at the facility - all of whom, at least initially, are voluntary patients. Given VDM's past responses to deficiencies, there is reason to doubt that these new improvements can and will be sustained if the facility once again admits involuntary patients – swelling both the number of patients and their acuity. (Prior to suspension VDM's patient census, both voluntary and involuntary patients, was in the range of 45-50 patients at a time.)

(B) **Significant deficiencies remain in VDM's operations relating to LPS compliance, patient safety and patient rights in areas such as:**

- **Attending and on-call physician documentation and apparent practice**

  Physicians, overall, and particularly the attending psychiatrists, do not seem to play a major role in the operations at VDM or the care provided to patients there.

  For example, the Chartis surveyors found and VDM did not dispute:

  - There is diffusion of responsibility for patient care with the consulting internal medicine specialist rather than the attending psychiatrists writing orders for all non-psychiatric indications. This internist – not the attending psychiatrists - is

the person "that the nurses call for virtually any question or problem that pertains to medical issues or symptoms, day or night." This practice, apparently condoned by VDM, leaves the attending physician of record – the psychiatrist – who has the ultimate responsibility for the patient's medical care out of the "loop" even in medical emergencies.

- Dr. Park, the facility's medical director since 2020, reported to the Chartis Physician surveyor that he has been asked to review only one "adverse event" during his time there. That one case involved a patient he personally discharged. The review consisted of talking with employees in administration but not any discussion with other clinicians. From this review, he decided to make a change in his own personal practice – but despite his role as medical director did not discuss or share this practice change with other physicians for feedback or developing consensus or policy on that issue.

  While Dr. Park told the Chartis surveyors that he has only participated in only one incident review during his time there, none of the other physicians interviewed had ever participated in any incident reviews, none had ever filed a safety report and most did not know how to file such a report. Incident reporting and reviews in healthcare are critical processes that help identify and address safety issues within hospitals. The non-engagement of physicians at VDM in this process is a sign of an underdeveloped culture of safety at the facility.

- **Physician documentation in the January 2024 patient records reviewed was "minimal"**. In two out of six records reviewed by the Chartis Physician Surveyor physician surveyor the medicines used for treatment were not even named. The documentation did not demonstrate "[a]ppropriate, thoughtful and safe clinical decision-making." A patient's level of observation was changed by the physician to 1:1 (the most intense level of observation) based on a reported suicidal gesture – but there was no physician progress note demonstrating that the physician assessed the patient on that date.

  Significantly, "none of the charts reviewed contained a clinical risk assessment by the physician prior to discharge" despite the specific findings in the Notice of Violation the facility received in June 2023 and the specific adverse events suffered by patients shortly after discharge that I summarized in the October suspension notice.

- I also note that only two physicians – neither of them Dr. Park – apparently attended the "Mandatory LPS Training" sessions held at VDM in the week before the facility submitted its application for reinstatement.

- Psychiatrists at VDM are not involved in writing LPS 5150 "holds" and except for Dr. Park have declined to participate in training related to the writing of "holds.

This creates the potential for situations in which a lower-level practitioner may write a "hold" only to be over-ruled by a physician who is unfamiliar with the law and regulations governing LPS 5150 holds. Similarly, a Psychiatrist may assess that a patient is not safe for discharge only to be overruled by a non-physician who determines that the standards for a LPS 5150 hold have not been met. In one case found by the Chartis surveyors there was no conversation between the physician and the lower-level practitioner evaluator documented, but a second 5150 evaluation was documented by another staff member - also overruling the physician's assessment of dangerousness. Ultimately, the patient left the VDM facility less than 24 hours after violently assaulting a staff member and being involuntarily medicated, still exhibiting paranoia and auditory hallucinations, and with no physician signature on the discharge order – which the psychiatrist refused to sign.

- VDM's response below to a related observation of the Chartis surveyors about lack of physician training in LPS 5150 "holds" indicates that the psychiatrist's nonparticipation in the LPS "hold" process at VDM is not accidental:

  "LPS certification is not mandated for physicians or any certain person. This does not inhibit a physician from managing the care of their patient and their ability for ongoing care and hold placement of their patients. The facility ensures adequate coverage of LPS certified individuals to meet the needs of our patients and circumstances."

  VDM has provided no evidence to support these assertions of "adequate coverage". And VDM did not respond to an observation from one of the Chartis surveyors that this lack of expertise on the part of the psychiatrists could be contributing to "discordant evaluations of safe discharge between social workers/nurses and psychiatrists" such as the one described above.

- **Lack of demonstrated competencies with respect to involuntary holds and management of acute patients.**

  VDM is not presently authorized to admit involuntary patients so there are currently limited opportunities for the staff to gain skills in managing this involuntary patient population. VDM did not present any evidence of training, drills, etc. to develop or retain such competency in their staff.

  However, three patient records in recent cases reviewed by the Chartis surveyors demonstrate serious concerns about VDM's staff's current competency to work with the acute patients that they are encountering at the facility presently:

  - The patient described above that violently assaulted a mental health worker was then subjected to a "take down" and physical hold for involuntary administration of

medication. But there was no documentation of such a restraint in the patient's chart. When the reviewer asked to look at in-house video footage a fifteen-minute hold was found in which one staff member laid across the patient and two others held the patient's upper body. As the Chartis Nurse surveyor noted (without any responding comment from VDM) the manner in which the restraint was administered was "concerning" and did not incorporate measures used to prevent patient injury. There was no documented assessment of how the patient tolerated the restraint, as required by the applicable regulations. Moreover, the lack of any documentation at all about the episode in the patient's chart raises the inference that the staff were not even aware that their actions constituted a restraint.

- A second patient who during admission removed the string from his sweatpants and tied it around his neck (which was recognized as a suicidal gesture) was allowed to keep his own clothing, including his shirt - which four hours later he tied around his neck. After this second gesture the patient underwent an LPS 5150 evaluation by the nursing supervisor, who determined that the patient did not qualify for involuntary status. This 5150 evalution was missing a description of the patient's historical course. Two hours later, after continued escalation leading to patient self-harm (punching himself in the face multiple times), despite 1:1 observation, the same LPS evaluator determined that hold criteria were now met and the patient was transferred to another facility.

- A 5150 hold was initiated for a third patient by the nursing house supervisor, but the behaviors leading to that decision were not documented by the nurse and mental health workers providing care for that patient. Physician orders for involuntary medications were received but the medications were not administered. There was no documentation of de-escalation measures attempted. Two hours later a note describes the patient as "highly agitated, yelling, banging his head on the window and walls, making threats toward staff and patients and trying to break out of the exit door." Repeated aggressive behavior the next morning resulted in other patients being sequestered in their rooms and a call to police for assistance. According to the documentation in the chart at no time was the patient restrained, secluded or involuntarily medicated. The patient was ultimately arrested and removed by police.

In response to the Chartis report, VDM stated that when questioned about this third case the Chief Nursing Officer told the Chartis surveyors that "she believed that the patient was able to be deescalated and [sic.] medication nor restraint was necessary at that time."

- **Poor documentation of patient status and day-to-day care processes,**

While VDM has certainly made some recent improvements in its nursing care practices, its overall documentation remains "poor" according to the Chartis surveyors. Some of those deficiencies are noted above. In addition, the Chartis Nurse surveyor found (and VDM did not contest) that "the medical record documentation was sometimes not adequate to justify the level of observation provided, with some reductions in observation intensity not sufficiently supported by corresponding clinical documentation."

VDM has incorporated the use of the Columbia Suicide Severity Rating Scale (C-SSRS) at the time of admission. While use of the tool is a good practice, the Chartis Nurse surveyor found that follow-up documentation at VDM contained "inappropriate" and "unclear" rationales for the frequency of observation chosen for patients at high risk for suicide. It is unclear whether this is due to poor policy guidance, inadequate training, or some other reason. VDM offered no explanation or proof to me in its response to the Chartis surveyor's findings that it has a plan to address these inadequacies.

- **Inconsistent and Missing Policies and Procedures**

Clear and accurate policies and procedures are a bare minimum expectation for operating a hospital for acutely ill psychiatric patients. As described above, the current state of VDM's policies and procedures, based on its reinstatement application, does not demonstrate VDM's ability to comply with the LPS Act requirements. Staff and clinicians cannot be expected to follow "the rules" when those rules are inconsistently expressed or simply not available for reference.

Among the materials produced by VDM in November 2023 was a policy relating to denials of patient rights. This topic was also mentioned in one of the November "Mandatory" presentation. But in neither instance was a procedure included covering who on the staff could make a determination that "good cause" existed to deny a patient their right(s), notifying the patient of such a determination, periodically reviewing the determination and documenting this in the patient's record as required by the applicable regulations. Without such a procedure it is unlikely that VDM can remain compliant in this important area of LPS Act obligations.

The Chartis surveyors made – and VDM did not contest – the following observations about policies at the facility:

- "relating to suicide precautions/observation levels … four overlapping and inconsistent policies with a fifth policy in draft."

- "There is no current documented contingency staffing plan nor is it contained in the "Staffing Patterns and Patient Accuity Policy".

- "AVDM's telehealth policy should be updated as soon as possible."

- "AVM should … strengthen its policies that support the attending physicians in owning responsibility for their patients 'medical needs. The chain of contact when medical emergencies occur, particularly during times when the physicians are not in-house, also needs to be protocolized."

- **VDM has not developed a plan for how the facility will handle the admission of involuntary patients if the LPS designation is reinstated**

During the survey visit both the VDM Chief Nursing Officer (CNO) Amber Nunes and the VDM Chief Executive Officer Colton Reid were asked what plan they had developed to "ramp up" the facility for admitting involuntary patients in the event they received a renewed LPS designation in response to this application for reinstatement. Both leaders acknowledged the need for such a plan and expressed support, in concept, for involuntary admissions initially to be limited to a small number of patients. But they each expressed different thoughts on what those involuntary patient limits should be. The CNO described – but had not reduced to writing – a plan developed and to be monitored by herself. However, the concept of limited admissions had not received even preliminary approval by Signature leadership.

In response to its review of the Chartis report, VDM acknowledged that these discussions had occurred:

"ADVM was not directly asked to produce a "capacity" plan for review …We were under the impression VCBH would be requesting as the next step in the reinstatement process and the request would come shortly before the survey."

Although the Chartis surveyors were told that a "detailed written plan with corresponding competence validation and reinforcement was being worked on during [the] review", neither VDM or Signature has submitted such a plan.

- **Knowledge of LPS and associated Patient Rights and Responsibilities**

VDM contested the following finding by the Chartis survey team:

> "Although AVDM has many policies and procedures developed based on Title 9 and the LPS Act, few current staff members and leadership currently have a nuanced understanding of these complex statutes and regulations."

VDM did not submit any rebuttal evidence to prove its staff and leader's competence. Instead its response was an ad hominem attack against the Chartis surveyor who

included this observation in the report – "Despite the initial impression that Bud's focus during the survey would be on LPS and Title IX compliance, this was not his focus. He did not directly interview staff the day he was on-site."

Similarly, in response to a similar observation by a different Chartis surveyor, VDM responded "All other findings show interviewed staff members were conversant. Lisa did not interview staff members regarding LPS patients rights or due process. Surveyors Ann, Dr. Kroll and Amber performed the staff interviews."

VDM also asserted, in response to a similar observation in the report's executive summary:

> "concerns regarding staff competence has [sic.] been addressed and adequate staff training on LPS and Patient's Rights for all staff was completed in October and November 2023. Evidence of this was reviewed with the surveyors and submitted in the LPS requirements submission to the county."

The above findings demonstrate little, if any, progress towards any serious effort to achieve compliance with the LPS Act, related regulations and the written requirements from Ventura County. As I mentioned in my findings supporting the decision to suspend the facility's designation last October:

> "we cannot find evidence of a detailed, reliable and routinely monitored plan to protect the rights of patients receiving care at VDM. Instead, it appears that the facility is opting to take a reactive strategy, and only wait until inappropriate situations and conditions reach the notice of an agency with jurisdiction, and at that point VDM will draft a plan of correction describing policy changes and one-time educational efforts."

VDM has had ample time to not only draft but execute on whatever plans it saw as necessary to improve its operations, prepare its facility to meet the requirements of Ventura County's LPS requirements, the LPS Act and its associated regulations, and provide evidence that it had done so. As noted above, both VDM and Signature are sophisticated actors in the field of mental health care, operating similar facilities throughout California and in other states. VDM and Signature know the vulnerabilities of involuntary patients and the regulations designed to both keep those patients safe and protect their rights. It is reasonable to conclude that they know how to operate a facility that does both. Yet despite the improvements that I have tried to acknowledge above, they still do not have a "detailed, reliable and routinely monitored plan to protect the rights of patients receiving care at VDM" if the facility is again designated to do so.

I acknowledge that VDM has made significant improvements in some areas of its operations since October 2023. The County of Ventura also has a long-acknowledged need for facilities where psychiatric patients in need of acute level care – whether they seek it voluntarily or are involuntarily required to undergo it – can receive the care that they need.

Therefore, I have determined that it would be in the best interest of those patients to lift the current suspension and reinstate Vista del Mar's LPS designation - if and only so long as VDM and Signature enter into and fulfill the requirements of a Compliance and Monitoring Agreement substantially in the form attached as Exhibit "A."

Loretta L. Denering, DrPH, MS
Interim Mental Health Director

cc: Soon K. Kim, MD
1450 W Long Lake Road, Suite 340
Troy, MI 48098

Paula Wilhelm - Paula.Wilhelm@dhcs.ca.gov
Interim Deputy Director, Behavioral Health
Department of Healthcare Services

Henry Omoregie - Henry.Omoregie@dhcs.ca.gov
Chief, Mental Health Licensing Section
Licensing and Certification Division
Department of Healthcare Services

Dari Bracamonte, RN, BSN - dari.bracamonte@cdph.ca.gov
District Administrator
California Department of Public Health Licensing and Certification
Ventura District Office
1889 N. Rice Avenue
Oxnard, CA 93030

Office of Quality and Patient Safety
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181