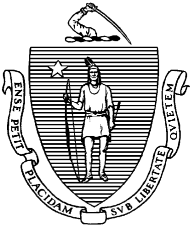


The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Care Safety and Quality
Division of Health Care Facility Licensure & Certification
67 Forest Street, Marlborough, MA 01752

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

April 21, 2021

Jason J. Ardizzone
Halcyon House
175 Berkeley Street
Methuen, MA 01844
j.ardizzone@yahoo.com

BY EMAIL ONLY

Re: **Approval of Closure Plan**
Facility: Halcyon House
Ref. #: 1144-016

Dear Mr. Ardizzone:

The Department of Public Health (the “Department”) received a draft closure plan (the “Plan”) for Halcyon House (the “Facility”) on March 16, 2021. The Plan calls for closure of the Facility on or about July 16, 2021.

After consideration and review of the Plan and any comments submitted to the Department on the proposed closure of the Facility, the Department approves the Facility’s plan for voluntary closure under 105 CMR 153.023.

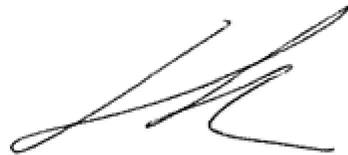
In conjunction with approval of the Plan, the Facility agrees not to admit any new residents from the date of this letter through the date of closure. This does not apply to Facility residents who are hospitalized but are expected to return to the Facility prior to the closure date. For any such residents, the Facility should continue to plan for and coordinate the relocation and transfer of the resident to a suitable facility prior to closure.

Walter Mackie, Licensure Unit Coordinator, will be the Department’s liaison for the closure. Please provide an updated Resident Roster (see attachments) each Tuesday to the Department. This should be faxed to Walter Mackie’s attention at (617) 753-8089. Immediately following the transfer of the last resident, please forward the complete alphabetical list of residents, date transferred and the name/location of the facility where they were transferred, along with a completed closure form (see attachments). As a reminder, although the licensee is no longer required to return its Facility license to the Department, once the Facility closes, the Facility license is no longer valid or in effect.

Please note that our office will be working closely with other state agencies, including the Office of the State Long-Term Care Ombudsman, to monitor the closure.

If you have any questions, please do not hesitate to contact Walter Mackie by email at Walter.Mackie@Mass.Gov. Material may be faxed to our attention at (617)753-8089.

Sincerely,



Sherman Lohnes
Director

Attachments:

1. Closure Form
2. Resident Roster Form

Cc:

E. Kelley, DPH
S. Lohnes, DPH
C. Fenn, ELD
W. Mackie, DPH
H. Hoefler, DPH
M. Callahan, DPH

FACILITY CLOSURE FORM

Massachusetts Department of Public Health
Division of Health Care Facility Licensure and Certification
67 Forest Street
Marlborough, MA 01752

Dear Facility/Agency Administrator: Please complete this form at the time of closure.

The Department will review your closure form, notify interested agencies, and update your licensure and/or certification status with us as appropriate.

A. CLOSING FACILITY/AGENCY INFORMATION:

1. ____
Closing Facility or Agency Name

2. ____
Closing Facility or Agency Address (Street, City/Town, ZIP)

3. ____
Administrator's/Closure Coordinator's Name

4. ________________________ 5. ________________________
Telephone Number Email Address

6. DPH License/Registration number __ __ __ __

7. Is this a satellite, branch, campus or other subset of a licensed/certified provider?

No __; Yes __. If "Yes", License/Registration number of parent: __ __ __ __

8. ____
Parent Agency/Facility Address (Street, City/Town, ZIP)

B. CLOSURE INFORMATION:

1. Effective Date of Closure: ____

2. Have all services been closed: No __; Yes __. Specify services closed if partial closure: ____

3. Has all signage been removed: No __; Yes __.

C. LICENSE INFORMATION (Please return your license to DPH by mail):

____ Original license will be returned, no new license needed (full closure).

____ Revised license requested (closure of services, or branch/satellites).

D. MEDICAL RECORD STORAGE INFORMATION:

1. Medical records will be stored for _______ years at:

2. ____
Medical Records Storage Site Address (Street, City/Town, State, ZIP)

3. ____
Contact Person's Name/Title

4. ____
Contact Person's Address (Street, City/Town, State, ZIP)

5. ___________________________
Contact Person's Telephone Number

E. MEDICATION DISPOSAL INFORMATION:

1. Were medications stored on-site by closing facility/agency: No __; Yes __.

2. If yes: Date of disposal: _______________

3. Method of disposal: ____

____

4. Persons Responsible: ____

F. RESIDENT/PATIENT NOTIFICATION INFORMATION:

1. Were residents/patients notified of closure: No __; Yes __.

2. Method of notification: ____

G. RESIDENT/PATIENT ROSTER AND MDS:

1. NURSING HOME, REST HOME OR HOSPICE: Attach resident roster indicating resident/patient name and transfer information.

2. NURSING HOME ONLY Were discharge MDS assessments successfully processed for all applicable nursing home residents? Yes___ No___ (If no, please contact Andrew Sinatra, DPH MDS Automation Coordinator, at 617-753-8188, to provide explanation for lack of MDS discharges.)

SIGNED UNDER THE PENALTIES OF PERJURY, this ___________ day of

______________________________ , 20_____________.

____
Administrator or Closure Coordinator's Signature

____
Administrator or Closure Coordinator's Printed Name and Title

RESIDENT ROSTER

NAME OF FACILITY: ______________________ AS OF DATE: __________ TIME: ___________

#	LAST NAME	FIRST NAME	AGE	SEX	RESIDENT CHARACTERISTICS/ COMMENTS	STATUS: DISCHARGE DATE AND LOCATION (PLANNED OR ACTUAL)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Starting Census: _____ Current Census______
Report Completed By:________________________ Phone: ______________ Page _____ of ______