

Residential Care in California: Unsafe, Unregulated & Unaccountable

A SPECIAL REPORT BY:

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Table of Contents

Executive Summary	3
Overview	4
A New Model of Care	4
RCFE Inspections	5
Complaint Investigations	7
Penalties	8
Private Right of Action	9
Consumer Information System	9
Staffing Requirements	10
Resident Rights	11
Recommendations	12

Executive Summary

Over the past twenty years, residential care/assisted living has become the fastest growing component of long term care. With approximately 31,000 residential care/assisted living communities now serving one million residents across the country, the demand for assisted living will continue to grow with the rapid increase in the aging population.

In California, these facilities are licensed as Residential Care Facilities for the Elderly (RCFEs). The growth in the number of RCFEs in California mimics the growth nationwide. With 7,500 RCFEs currently licensed for 174,000+ beds, RCFE residents in California are facing a crisis in care. The recent Frontline/ProPublica documentary, “Life and Death in Assisted Living,” and investigation, “Elderly, At Risk and Haphazardly Protected,” highlighted some of the critical issues faced by RCFE residents in California. A September 2013 investigative report by the San Diego Union Tribune and the CHCF Center for Health Reporting revealed that hundreds of elders suffered broken bones, deadly bedsores and sexual assaults in San Diego RCFEs, while documenting at least 28 deaths in these facilities due to injuries and neglect.

California’s current “one size fits all” approach to regulating RCFEs is clearly inadequate, given the growing acuity levels of RCFE residents. A failed inspection system; a broken complaint system; limited and ineffective penalties for violations; outdated and inadequate staffing and staff training requirements; the failure to provide consumers with any comparative information about the quality of care or enforcement actions against RCFEs; and “paper tiger” resident rights provisions that provide no enforcement power to residents - all contribute to a system that is unsafe for RCFE consumers, while leaving RCFEs essentially unregulated and unaccountable for their actions.

With this report and its recommendations, we call upon Community Care Licensing, the agency responsible for regulatory oversight and enforcement of the RCFE laws, to reclaim its role as a consumer protection agency, and we call upon California legislators and the Department of Social Services to address this crisis in care and to create a new model of care where the health and safety of residents takes priority.

Overview

In 1985, the California Legislature passed the California Residential Care Facilities for the Elderly Act, which established a separate category for Residential Care Facilities for the Elderly (RCFE) facilities licensed by the Department of Social Services (DSS). Until then, elders in need of care and supervision and wanting community-based housing resided in facilities that may or may not have been designed to meet their needs. RCFEs, also referred to as assisted living, are licensed as non-medical facilities serving individuals age 60 and older. RCFEs provide room, meals, supervision and, depending on the needs of the residents, assistance with activities of daily living and distribution of medications.

According to DSS, there are currently over 7,500 licensed RCFEs in California with a total bed capacity of 174,108, ranging in size from two-bed facilities to 200+bed facilities. A majority of RCFEs (79%) have six or fewer beds, while a majority of RCFE residents (71%) live in one of the 50+ bed RCFEs. Because these facilities are – in theory at least - non-medical, RCFEs are regulated by the Department of Social Services, Community Care Licensing (CCL). Residents pay out of pocket for services, with fees ranging from \$2,500 to as much as \$8,000 for specialized care. In California, public funding from Medi-Cal or Supplemental Security Income (SSI) is extremely limited, so access to RCFE care is limited to those who can afford to pay privately.

Although over 90% of California’s RCFEs are owned and operated by for-profit providers, most are small facilities, i.e., six or fewer beds. However, the past few years have shown a marked increase in the acquisition and development of RCFEs by corporate chains, mirroring the market growth of the nursing home industry in the 1990s. California has 867 facilities with 50 or more beds, and corporate chains dominate the large 100+ bed facilities. Emeritus Senior Living, for example, an assisted living corporation that was the focus of the recent Frontline/ProPublica story, “Life and Death in Assisted Living,” is the largest assisted living operator in the country, and owns and operates approximately 70 large RCFEs in California.

There is nothing wrong, per se, with corporate ownership. However, we do know that the corporate chain ownership structures of nursing homes have had a lasting negative impact on transparency, staffing levels and quality of care. Complicated ownership structures with multiple stakeholders also obscure lines of ownership and accountability. Corporate owners of RCFEs are not accountable to the residents who pay the monthly fees, but to the stockholders who demand return on their investments. Thus, any new model of residential care should discourage corporate chain ownership if the hope is to foster better care in RCFEs.

A New Model of Care is Necessary - One Size Does Not Fit All

The legislative intent of the RCFE Act of 1985 was to establish three levels of care within the RCFE regulatory structure to address the fluctuating health and care needs of older residents. Unfortunately, this section of the act is subject to Budget Act appropriations and has never been implemented. Thus, for the past 28 years, CCL has maintained a “one size fits all” approach to residential care for elders, stretching the regulations to accommodate an ever-growing acuity level among residents, and allowing non-medical RCFEs – regardless of size – to accept and

retain residents with acute medical needs. Residents needing hospice care or specialized dementia services; residents with compromised health conditions, who have bedsores, are bedridden, use oxygen, have catheters or colostomies or ileostomies, have diabetes, have healing wounds or who are incontinent of bowel and bladder – all can be accepted and retained by RCFEs under current law. The only prior approval required from CCL is if the facility accepts hospice-eligible residents.

California has not kept pace with the radical changes in health care provided by RCFEs and the type of high-risk residents they serve. Residents now are sicker, older (85+ on average), needing assistance with 3 or more activities of daily living (ADLs), taking multiple, complex medications, and dealing with many more chronic diseases. Some RCFEs serve residents who can direct their care and need only moderate assistance to meet their daily needs, while other facilities are providing a variety of health services by caring for residents with compromised health conditions. Regardless, all RCFEs are regulated under the same set of rules and requirements. This “one size fits all” regulatory approach no longer makes sense.

While RCFEs are described as an alternative to institutionalized, impersonal nursing home care and pride themselves on being non-medical models that provide a homelike environment and promote consumer choice, too many RCFEs have become health care providers serving residents with the same acute medical conditions who just years ago were being cared for in nursing homes.

It is no coincidence that, as the number of RCFEs grow, the occupancy rates in nursing homes decrease. RCFEs are growing in direct response to consumer demand. Consumers prefer to “age in place” – at home or, at the very least, in a community facility with a home-like environment, regardless of their medical condition. The goal of any new model for RCFE care should not be to displace residents into nursing homes, but to implement an RCFE system that can meet the care needs of the residents.

In 1985, the California Legislature recognized a need for a tiered level of care system that would represent the range of care needs of elderly residents including basic care and supervision, non-medical personal care, and health assistance. (Health & Safety Code §1569.70) It is now time to establish this tiered level of care system.

HUMAN TOLL: RCFE providers are pushing chemical restraints as evidenced by this fax message from a Sacramento-based RCFE to a doctor seeking an order for psychoactive drugs for a resident with common symptoms of dementia: “We are requesting a higher dosage in her sleeping medication so that she can be more rested and calmed. Also, medication for the daytime to keep her from getting aggressive.”

RCFE Inspections – Infrequent and Inadequate

California’s current RCFE inspection system fails to meet the needs of consumers, providers, policy-makers or CCL.

Once a model for other states, California’s inspection system for RCFEs is now one of the weakest in the nation. In the 1970’s and 1980’s, CCL inspected RCFEs twice per year. By the early 1990’s, inspections were cut to once per year. In 2004, inspections were slashed to once

every five years, with a small number of RCFEs subject to annual inspections. By its own admission, CCL has been unable to meet even the minimal five-year inspection mandate.

In response to years of damaging budget cuts and dwindling resources, CCL significantly changed its inspection system in 2010 and began using a “key indicator” process to increase visit frequency and save money. A key indicator inspection is an extremely abbreviated version of a comprehensive inspection based on the premise that compliance with a small number of laws can predict compliance with all laws.

CCL’s unilateral decision to eliminate tested and proven comprehensive inspections for experimental key indicator protocols is troubling. It is unclear whether key indicator inspections are adequate to protect the health and safety of RCFE residents because there are no published studies regarding these inspections in senior care settings, and CCL is not sharing any data on these abbreviated surveys with either advocates or the public.

CCL and other stakeholders all recognize the importance of frequent inspections to ensure quality of care. *“The most effective method for fulfilling our mission to protect the health and safety of clients in care is through frequent compliance monitoring.”* (CCL May 2010) The California Assisted Living Association and the Assisted Living Federation of America support annual comprehensive inspections. In its final report to the U.S. Special Committee on Aging, the Assisted Living Work Group recommended that each state have a monitoring element that includes a “system of no less than annual unannounced inspections,” and the National Association for Regulatory Administration’s best practices recommend at least two monitoring inspections per year for all facilities.

CCL’s current inspection system is completely inadequate to protect the health and safety of RCFE residents. The five-year inspection cycle not only prevents the public from obtaining timely performance information about facilities but also is a recipe for neglect and abuse. Care standards and residents’ rights become virtually meaningless when inspections are so infrequent. Issuing a license under these conditions deceives consumers who assume that the state is conducting regular inspections and offering oversight and protection to residents.

“We do not believe that a visit every five years is adequate monitoring but that is the most we can accomplish under current conditions.” (Jeffrey Hiratsuka, Former CCL Deputy Director, 2010)

“A San Diego County RCFE owner admitted paying bribes of \$2,800 in cash to one CCL licensing analyst and purchasing plane tickets for other CCL inspectors for trips to the Philippines. DSS has since terminated the inspectors who, according to testimony, accepted cash and gifts in exchange for expedited applications and positive inspections. Iris Ramirez, the RCFE owner, is still operating all four of her Ambassador Senior Retreat RCFEs in San Diego.”

“CCLD’s experience with the random sample inspection protocol and fluctuations in resources has put client health and safety at risk.” (CCL 2010-2011 Spring Finance Letter)

Complaint Investigations – A Broken System

Due to the lack of regular inspections, it is critical that CCL have a strong and effective complaint investigation system to identify and stop instances of abuse and neglect. Yet the opposite is true.

CCL's complaint investigation system is plagued by superficial investigations, poor communications with complainants, lack of transparency, weak enforcement, corruption and one-sided appeal procedures that protect operators rather than residents.

In FY 2011/12, CCL received nearly 3,000 complaints about RCFEs, an astounding number when one considers that many residents and their families may have never seen a CCL inspector, or have any reason to believe CCL will help them when they are mistreated or neglected. These complaints are merely the tip of the iceberg. The California Long Term Care Ombudsman Program reported receiving 11,673 complaints on RCFEs in FY 2012, 1,673 of which involved abuse.

Although CCL officials say that responding to complaints is their top priority, they are unable to provide any information on the nature of complaints or how they have responded to them.

An independent investigation of CCL revealed a shocking indifference to the fate of neglected or abused residents.

In September 2013, the CHCF Center for Health Reporting and San Diego Union Tribune reported that at least 27 San Diego County seniors died from neglect and injuries in RCFEs, in some cases with no investigation by CCL. The CCL Investigations Branch, an internal police force, has not made an arrest in nine years even though the investigation found that hundreds of RCFE residents have suffered sexual assaults, physical abuse, medication errors, life threatening bedsores and other abuses.

The unresponsive CCL complaint process is a large part of the problem. The law requires CCL to begin investigations within 10 days, but has no completion timeline. Nor is there a requirement to immediately investigate abuse and serious neglect cases. CCL does not send written findings to complainants except upon request, and does not give complainants any opportunity to appeal its findings. Even when complaints are substantiated, meaningful enforcement actions are very rare.

On the other hand, CCL gives RCFE operators numerous opportunities to challenge the findings. Without any legislative authority, CCL has created a formalized four-part system of appeals for RCFE operators in which residents and complainants have no input. The system is built to deter enforcement action, not to support it.

HUMAN TOLL: *Joan Boice, a resident of Emeritus Emerald Hills, an RCFE in Placer County, died from numerous skin pressure sores that developed over her body during her stay – directly due to neglectful care of facility staff. CCL investigated the Boice case, found the facility had retained a resident with a prohibited health condition (several stage 3 and 4 pressure ulcers) and issued no fine – not even a trifling \$150. In 2013, a jury awarded her family over \$27 million.*

Weak Penalties – No Deterrent to Neglect and Abuse

There is not much mystery why facilities often fail to meet the state’s minimum standards of care as outlined in regulations – the consequences of noncompliance are trivial. Currently, RCFEs are subjected to a *maximum* civil penalty of \$150 for regulatory noncompliance. In a large, 100-plus bed RCFE bringing in a million dollars in revenue each month, a \$150 fine is virtually meaningless. Other states have substantially greater fines with maximum amounts varying between \$1,000 and \$5,000 per incident. Nursing homes in California have fines that range from \$2,000 to \$100,000.

A life in an RCFE is just as valuable as a life in a nursing home.

In a handful of cases, CCL can issue daily penalties from \$50 - \$150 to RCFEs that remain non-compliant with laws or regulations. But daily fines are not available for continuous or daily violations that occur prior to CCL’s intervention. Therefore, RCFEs that have violated a regulation (e.g., failure to have adequate staff), face a one-time \$150 fine and have no financial incentive to increase staffing until CCL formally investigates and issues its findings.

Nursing Home Citation System		
Type of Citation	Violation	Maximum Fine
AA	Direct proximate cause of resident death	\$100,000
A	Presents imminent danger of death or serious physical harm to residents	\$10,000
B	Direct or immediate relationship to resident health, safety, or security	\$2,000

Aside from weak fines, CCL has virtually no other remedies for facility wrongdoing. An RCFE that repeatedly fails to comply with regulatory rules can have its license revoked but the process often takes years and residents suffer in the meantime.

To further compound the problem of weak penalties, CCL has taken the position that it cannot issue any penalty at all unless the licensee has some personal culpability. On November 9, 2012, residents of Gold Age Villa, an RCFE in Loomis, CA, were fed soup made from poisonous mushrooms that a staff person had picked and used to prepare the soup. Four residents out of six died. CCL found no violations, stating the licensee was not culpable for the unanticipated actions of her employee. Future residents will never know about the poison soup from checking the CCL records on the facility. If residents are dying because of a staff person’s neglect or ineptitude, the licensee has to assume liability; otherwise they will have no incentive to ensure their staff members are complying with the applicable rules and treating the residents well.

HUMAN TOLL: *Eden Manor, a former RCFE in Oakland, was in financial trouble in early 2012. By June 2012, the facility building was in foreclosure and resident care suffered. The heat didn't work, there was insufficient food for the residents, and residents may have had their money stolen by the facility's management. Despite the fact that CCL knew the facility was in major trouble, Eden Manor kept operating until it was finally taken over by new management in March 2013. CCL finally took action to have the licenses of the facility's management revoked, but the process has dragged on and will not be resolved until June 2014 at the earliest. Meanwhile, two of those managers were operating a facility in Castro Valley called Valley Springs Manor which itself was providing seriously deficient care and was ordered to close in October 2013. However, CCL did not take precautions to ensure the safety of the residents and they were left without caregivers - virtually abandoned - from October 24 - 26 until the facility cook called 911 and sought intervention.*

Private Right of Action – A Strategy for Resident Empowerment

Given the lack of CCL presence in RCFEs (e.g., inspections required only once every five years) and its weak enforcement efforts, new alternatives for protecting residents' rights and promoting quality of care must be considered. One way to increase enforcement without requiring any additional expenditure of state resources is to give residents a private right of action to remedy violations of the regulatory care standards and/or their rights as residents. Currently, residents do not have a viable way for pursuing court intervention unless they wait to suffer actual harm from a facility's failure to follow the state's rules.

California nursing home residents were granted a private right of action to counter declining regulatory enforcement in 1982 (Health & Safety Code §1430(b)). It has proven to be a powerful tool. Staffing, evictions, and privacy rights such as visitation have been successfully fought and won by thousands of nursing home residents since the adoption of the private right of action. Major class action cases have transformed the quality of care in large nursing home chains.

Enhancing resident rights by adding a private right of action would provide a much needed enforcement alternative to CCL without costing the state any money. From an enforcement perspective, residents, family and friends are best suited to monitor care and pursue remedies.

What Consumers Need – A Consumer Information System

Although there are nearly 7,500 licensed RCFEs in California, CCL makes absolutely no information about the quality of care and enforcement actions against facilities available to consumers. Consumers seeking information on RCFEs in California are simply out of luck if they hope to compare facilities regarding ownership, complaints or enforcement actions, since none of that information is available to the public. New recommendations by the U.S. Agency for Healthcare Research and Quality (AHRQ), which has promoted efforts related to assisted living/residential care and public reporting, noted that consumers want to be able to compare providers to guide their decision making.

Despite years of excuses, extraordinary advances in technology, and the rapid growth in the number of licensed RCFEs, CCL remains adamant in refusing to post any comparative or informative information on its RCFE website, other than the number of beds, the address of the facility and a “contact” person.

Under the current system, if consumers wish to find out more than the sparse information available on the CCL website, they are required to drive miles to one of the CCL District Offices to look at a facility file. A consumer in Los Angeles, for example, would have to drive to Monterey Park or Woodland Hills to take a look at the file of one of Los Angeles’s 1,340 RCFEs. Consumers in Humboldt, Del Norte, Lassen, Shasta and most of the Northern or Sierra rural counties are required to go to Rohnert Park or Fresno to look at a file. The burden this places on elder consumers searching for an RCFE for a loved one cannot be overstated. Even when consumers are actually able to go to a CCL District Office, their task is made difficult by CCL rules.

Although the statutory mandate in Health & Safety Code §1569.355 requires that the State Department of Social Services shall make these files “*available immediately upon the request of any consumer,*” consumers attempting to obtain information on any particular RCFE are told to make an appointment in advance and are supervised by a CCL staff person while reviewing files. Most times, consumers cannot even access more than one file. Senate Bill 1630 (Rosenthal), which mandated the availability of RCFE files, was sponsored by CANHR in 1998. Fifteen years later, consumers are still discouraged by DSS at every level in their attempts to get access to RCFE information.

CCL needs to reclaim its role as a consumer protection agency, move into the 21st Century and provide California consumers with the information they need to make informed choices about RCFEs.

Staffing Requirements - Too Little to Ensure Resident Safety

RCFE residents have serious health problems and increasing levels of dementia that six to eight years ago would have been cared for in nursing homes. Although health care needs are greater, the qualifications and training required of administrators and direct care workers is totally inadequate to meet residents’ increased needs for care and supervision. The lack of adequate staffing standards puts residents’ health and safety at risk.

RCFEs are required to have staff “in sufficient numbers” to meet residents’ care needs. Other than this, the current minimal staffing requirements for RCFEs is limited to the night shift and depends on the number of licensed beds. Facilities with 15 beds or less are required to have one staff on call at night; facilities with 16 to 100 beds are required to have one staff person awake and one on call; facilities with 101-200 beds are required to have one staff awake and two on call; another “awake” staff person is required for each additional 100 beds. Needless to say, the current RCFE staffing requirements do little to ensure minimum health and safety protections for residents.

RCFE administrators are not required to have a college degree or professional license (e.g., R.N., L.V.N.) regardless of whether the RCFE is licensed for 6 beds or 100+ beds, and regardless of the health conditions of the residents. For facilities with 15 beds or less, administrators only need to have a high school diploma or GED, take a 40-hour course, pass a state test, and get a criminal clearance.

The employment requirements for direct care staff are also minimal. They must be 18 years of age and pass a criminal clearance. They receive a meager 10 hours of training during the first four weeks of employment. A manicurist in California must have 400 hours of training and pass a state exam.

Three of the top five complaints by residents and family members deal with staffing: (1) lack of staff, (2) poorly trained staff who are unqualified to meet resident needs, and (3) medication errors.

Finally, there is no requirement for a licensed health care worker, (e.g. R.N. or L.V.N.) to regularly monitor the overall health condition of RCFE residents or to access a resident's capability to self-administer medications, supervise medication set up, regularly check medications or provide technical assistance or advice on medications.

Residents Rights – Abuse Victims Lack Protections

The rights of RCFE residents have not kept pace with their greatly intensified needs. California regulations on the rights of RCFE residents are outdated and woefully inadequate. These shortcomings are most evident in California's total failure to protect RCFE residents from being given drugs to chemically restrain them. California has literally done nothing to protect RCFE residents from epidemic levels of chemical restraint that endanger residents and often destroy their quality of life.

Nationally, hundreds of thousands of elders who have dementia are subjected to antipsychotic drugs each day despite FDA black box warnings and alerts that these drugs are exceptionally dangerous. The indiscriminate chemical restraint of dementia victims is a national scandal that is rooted in ignorance and providers' choices to substitute drugs for care. DHHS Inspector General Daniel Levinson hit the nail on the head in 2011 when he said the public "should be outraged" that Medicare is often subsidizing "potentially lethal" antipsychotic drugs that are wrongly inflicted on elderly persons with dementia.

In California, where about two of every three RCFE residents have dementia, the chemical restraint of RCFE residents knows no bounds. Unlicensed and barely trained aides give out antipsychotic drugs to residents like candy, while often little or nothing is done to respond to underlying causes of pain, illness, despair and distress. In poor quality facilities, residents are "secured" or trapped in locked units that they cannot escape, and psychoactive drugs are used to sedate and subdue them. Although RCFEs are not supposed to be medical facilities, it is all too common for operators to push doctors to order antipsychotics and other psychoactive medications that are used to drug residents who have dementia.

In nursing homes, residents have the right to be free from chemical restraints, and there is a robust national campaign to enforce this right. Not so in California RCFEs where the law is silent on chemical restraints and CCL has taken no steps to even assess the level of drugging abuse, much less to stop it.

Recommendations

CANHR calls upon the State Legislature and the Department of Social Services to take immediate action to protect the elder and dependent adults living in RCFEs by adopting the following recommendations.

Levels of Care

1. Develop and implement a tiered level of care system.
2. Establish the Department of Public Health, Licensing and Certification, as the regulatory agency for the health assistance tier while maintaining the DSS, CCL as the regulator for the other care tiers. (Note: Thirty- seven other states regulate residential care/assisted living through the department of health or its equivalent.)

RCFE Inspections

1. CCL should conduct inspections of all RCFEs at least once every year, or as often as necessary to ensure the health and safety of residents.
2. Inspectors should evaluate RCFEs for compliance with all applicable rules, regulations, and laws, and not merely “key indicators”.

Complaint Investigations

1. Require investigations to begin within 24 hours for complaints of abuse or neglect and to be completed within 30 days for serious complaints and 90 days for all others.
2. Strengthen training on investigations for all complaint investigators and require investigators to interview the complainant, resident and witnesses.
3. Establish an appeal process for persons making complaints and require written notice to complainants on specific findings, enforcement actions and appeal rights.

Penalties for Violations

1. Fines for citations should be increased substantially to mirror those in nursing homes, and should be applicable on a per violation basis as well as a per day basis for violations that are continuous.
2. Adopt a statute clarifying that licensees are strictly liable for the actions of their staff.
3. Give CCL the authority to ban facilities from admitting new residents if they have repeated or dangerous regulatory violations.
4. Require RCFEs to carry liability insurance in an amount that is based on both the number and the severity of the health condition of the residents served.

Private Right of Action

Establish a private right of action that includes: the ability to seek a court order to stop illegal RCFE activities, compensation to the resident for each violation of his or her rights, and a “private attorney general” component allowing any member of the public to enforce RCFE standards that protect resident health or safety.

Consumer Information System

Mandate that CCL establish an RCFE Consumer Information on-line system to include updated and accurate survey, complaint and enforcement information on every licensed RCFE in California.

Staffing and Staff Qualifications

1. Tie minimum staffing requirements, administrator and staff qualifications and training requirements to the facility’s tiered level of care designation and the number of residents the facility is licensed to serve.
2. Require at least one certified nursing staff (i.e., LVN or RN) be on call for each shift for hospice, bedridden residents, residents with bedsores, dementia residents with histories of wandering, and for facilities where 20% or more of the residents have restricted health conditions.

Resident Rights

1. Establish a comprehensive statutory residents’ bill of rights that addresses the needs and interests of today’s RCFE residents.
2. Issue regulations within six months of passage of new laws.