Joint Oversight Hearing
Assembly Committee on Health and
Assembly Committee on Aging and Long Term Care

California Department of Health:
What Progress is Being Made to Improve Nursing Home Oversight?

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Testimony submitted by
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Assembly Member Bonta and Assembly Member Brown, Committee members, thank you for the opportunity to address some of the issues with the Department of Public Health, Licensing and Certification's nursing home oversight system and to offer some recommendations for improvement. My name is Pat McGinnis, and I am the Executive Director of California Advocates for Nursing Home Reform. Our organization has been monitoring the problems with California's nursing homes and with licensing and certification for over 30 years.

The hearing asks the question: What progress is being made to improve nursing home oversight? The answer is pretty simple – absolutely none. In fact, if anything, oversight is worse today than it was ten years ago or even one year ago when I testified at another oversight hearing to the same Committees on the same failures of the Department.

The Department's enforcement of nursing home standards has a long and disgraceful history. Over the past ten years, Licensing and Certification has been the focus of several state audits, scathing reviews and sanctions by the federal Centers for Medicare and Medicaid Services (CMS), a DPH-funded consultant report in 2014, two major lawsuits, oversight hearings by the California Legislature in 2005, 2011 and 2014, and a litany of negative reports by state and federal watchdog agencies and the media. (See attached) The Department of Public Health's response to these critical reports and their recommendations has been to thumb its nose at any attempts to hold it accountable.

The Department would have you believe it is on the road to improvement and uses misleading data to make its case. The truth, however, is the Department's leaders remain indifferent to the profound suffering that occurs in California's worst nursing homes on a daily basis. I am here to tell you that far too many of these residents are forced to lie in their own waste for hours at a time, to go hungry and thirsty because no one assists them with their meals or drinks, to have their hands and joints become debilitated due to lack of therapy or exercise, to be left dangling in unsafe wheelchairs for many hours at a time beyond the point of exhaustion, and to be drugged into a zombie state by powerful antipsychotic drugs that stop them from expressing distress.

Why aren't the Department's leaders talking to you about what they are doing to protect the most vulnerable members of our society from bedsores, malnutrition, severe dehydration, deadly infections, chemical restraint, physical and sexual abuse that make their lives unbearable? They don't speak to these issues because they don't want you to understand that these conditions exist under their watch. But they do exist and we need new leaders who will take strong and direct action to address them.

In November, the Sacramento Bee published a powerful series of articles on California nursing home chains that showed some of the largest for-profit chains in California have low staffing levels and very poor track records. The Bee investigation found that DPH is not doing anything to monitor these chains and that the ownership information it discloses on its consumer website is next to useless for the public. Where are the Department's plans to deal with these issues?

If the Department has its way, the Legislature will rubber stamp its plan to add more than 250 positions and go along with its excuse that its problems are caused by lack of staff. This plan, like plans before it, is doomed to failure because it ignores the main problem. The real problem is a profound lack of leadership at all levels involving nursing home oversight. With some exceptions, DPH's state and district offices are filled with managers who have performed very poorly and do not see the Department as a consumer protection agency. If California brings large numbers of new employees into this culture, little will change.

We've been down this path before. A Bureau of State Audits review in 2006 found Licensing

and Certification had failed to meet many investigation deadlines, prioritize cases by severity, provide reliable investigation data or give timely responses to complaints. Instead of calling for reform or for heads to roll, the Legislature and Administration agreed to an $18.5 million special fund appropriation in the 2006-07 budget to create more than 140 new positions – positions which the Department noted in their request – would allow it "to complete all required state licensing and federal certification workload including complaint investigations, periodic survey inspections of health facilities and the monitoring of medication-related error reduction plans."

Obviously that did not happen.

Instead of using those funds to actually improve the oversight or complaint response system, Department leadership instead used hundreds of personnel hours and untold Department resources to gain accreditation from the Public Health Accreditation Board – a distinction that few, if any, California consumers care about at all. And what the Department did not disclose is that the activities of the Licensing and Certification program, which make up about one-third of the Department's responsibilities, were completely excluded from the accreditation process. Had these failures been included, it is doubtful that this wasteful exercise would have resulted in any type of accreditation.

The disgraceful response to complaints is in the news because of the State Auditor's finding that the Department had a backlog of 11,000 open nursing home complaints. One of the Auditor's most alarming findings is that many complaints that put nursing home residents in imminent danger of harm or death had been open for years. Although this is not news to us and is the subject of earlier audits and investigations of the Department, we hoped this time the Department's leaders would be shamed into action.

Just the opposite is the case. Even with the additional 250 positions it wants to add, the Department predicts it will take at least four years to catch up with its current investigative caseload. What kind of plan allows for the possibility that existing complaints of abuse and neglect won't be addressed for another four years?

It would be very wrong to let these complaints go unaddressed for another four days, but waiting another four years would be a near criminal level of neglect by the Department. Behind each

complaint is a person who may be in misery due to poor care, abuse or mistreatment. Does anyone other than the Department really think it is acceptable to let these complaints sit for more years before responding? If the Legislature signs off on the Department's budget plan, we have its word that is exactly what it will do.

CANHR is proud to sponsor AB 348, Assembly Member Brown's bill to establish a 40 working day deadline for completing complaint investigations. In setting a clear deadline, the bill would accomplish the State Auditor's recommendation. The only thing standing in the way of the bill becoming law is the Department, which has rejected the State Auditor's recommendation and twice fought and defeated legislation on this subject. When the Department opposed this same legislation in 2014, it told the Legislature it was too busy assessing itself.

Our concerns about the Department apply doubly to its contract with the Los Angeles County Department of Public Health. The squabbling over the number of positions the County needs to carry out its positions is a distraction from the County's dreadful performance over many years. The L.A. County Health Department is the proverbial fox guarding the henhouse. It has long acted as if protecting nursing home operators is its goal. We see no signs that anything has changed since some of its corrupt practices were exposed last year.

The Department's oversight of nursing homes is failing at every level, not just investigating complaints.

- Caregivers who have abused residents continue to work in nursing homes because of long delays in conducting investigations and appeals.
- Critical federal enforcement actions are almost never taken because the Department classifies even extreme violations as minor problems.
- Even when the Department determines that a resident died due to abuse or neglect, it usually waits years before issuing a citation. This practice leaves little room for the Attorney General to prosecute.
- One example is citation 110011120 issued in November 2014 for a fall that occurred **3-1/2 years** earlier. On 5/3/11, a resident with amputations below both knees fell from a special toilet for people with limited mobility. He sustained a severe head wound and a cervical

spine fracture. The facility failed to properly account for the resident's fall risk and did not use the resident's leg prosthesis to decrease that risk. The facility was cited for failing to use preventative measures to reasonably reduce his fall risk.

- Hundreds of nursing home residents are illegally evicted or transferred every year with no intervention from the Department. Although residents are granted a hearing, even when they win the hearing and the Administrative Law Judge orders the facility to readmit the resident, the facility refuses. Why? Because the Department does nothing to enforce the law, except to issue a citation for $500 or $2,000 at most. For the nursing home, that's a bargain. They can free up a Medi-Cal bed for a private pay or Medicare patient, even while violating the law. As one evaluator wrote after to speaking to the admission nurse at a nursing home: "she stated – *We are not accepting the patient back to our facility. I have spoken to the administrator and we are aware of the penalties and fines for patient dumping and do not care."*

Enough is enough! We agree with the State Auditor's assessment that the Department of Public Health is a high risk agency, which, unfortunately, is the only agency charged with protecting nursing home consumers.

Recommendations:

- **Visionary Leadership** is urgently needed at the Department of Public Health, Licensing and Certification and at the District Offices. The same people have been making excuses and implementing the same dangerous and misguided policies and procedures for the past 10 years. Throwing more money at DPH didn't work before and is not likely to help now. Until the Department demonstrates that it has a leadership team in place that is ready, willing and able to carry out its mission to protect nursing home residents from poor care and abuse, more money won't help anything. The Legislature and the Administration should demand accountability, and we urge the Committees and legislative leaders to have honest discussions with the Administration about addressing the root causes of these problems and to give urgent attention to bringing in leaders who will fix them. Nursing home residents in California deserve no less.

- **AB 348 (Brown) would establish statutory timelines** to complete investigations of complaints within 40 working days of receipt of the complaint. In 2007, the Legislature passed AB 399 (Feuer) by a collective 117-1 vote. If not vetoed by former Governor Schwarzenegger, it would have required DPH to complete investigations of nursing home complaints within 40 working days, just as DPH policies required. It would have been an important reform then and would be today. The bill had no opposition, not even from the nursing home industry. The veto signaled that DPH did not want to be held to account even to its own standards. Now is the time to pass this legislation and hold the Department accountable.

- **AB 927 (McCarty): Ownership Suitability and Disclosure**: As the recent Sacramento Bee series revealed, the Department often has no idea who owns or operates nursing homes in California, and some of the poorest performing providers are given carte blanche to take over even more facilities. A Sacramento Bee editorial following the series summed up the situation: *People who enforce the rules fail on the most basic level – helping people understand which chains operate safe and humane facilities, and which aren't acceptable.* AB 927 would establish suitability and ownership disclosure requirements that would provide the Department and the public with the information necessary to make informed choices.
- **Protect residents from patient dumping**: The Department should be ordered to use its full range of state and federal sanctions, including referrals to the Attorney General's Office, to prevent what is becoming an epidemic in nursing homes – evicting and transferring out those residents whose private pay or Medicare funds have run out. These Medi-Cal certified facilities sign a contract, under penalty of perjury, to comply with state and federal laws and those laws should be enforced.