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STATE OF CALIFORNIA

GEORGE DEUKMEJIAN, *Governor*

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

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February 21, 1985

The Honorable George Deukmejian
Governor of California
State Capitol
Sacramento, California 95814

Dear Governor Deukmejian:

Since the late 1970's, the Little Hoover Commission has been involved in the oversight of conditions in community residential care facilities for the elderly, mentally disabled, developmentally disabled, and others. This work culminated in an exhaustive study released in January 1984 entitled "Community Residential Care in California: Community Care as a Long Term Care Service."

During the course of that study, members of our Commission made unannounced visits to several community care facilities and received extensive testimony on over one hundred other facilities guilty of subjecting their residents to severe abuse, neglect, and generally unhealthy and uncaring conditions. We found that residents have been beaten, fed spoiled food, forced to live with toilets that don't work, sexually abused, subjected to a demeaning existence, and left unattended. In fact, we found that some residents have actually been killed in these facilities each year.

The most disturbing finding of our review was that most of the citizens of this State, as well as many of our elected officials, have been generally unaware of the conditions to which many of the 151,000 adults and children living in California's 22,000 community care facilities are subjected.

Since our report was issued, we believe the public's awareness of these conditions has been heightened. Almost daily, you can read in a newspaper in this State an account of abuse in a community care facility. This increased media coverage is both indicative of the severity of the problem and representative of the public's unwillingness to stay quiet about it any longer. This, however, demonstrates that State government must be more effective in its role of protecting the health and safety of these individuals that society in the past has chosen to forget or ignore.

Our Commission was very pleased by the actions taken last year by the Legislature and yourself to increase licensing staff, improve staff training, revise licensing requirements, and provide the public with better sources of information regarding community care facilities. Be that as it may, the members of the Little Hoover Commission believe that the State must not delay in enacting additional new laws and in

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implementing administrative improvements necessary to ensure that government is doing everything possible to protect these adults and children.

As part of our policy to follow-up on the recommendations we present in a report, our Commission conducted three workshops during the past twelve months and held a public hearing on January 31, 1985 to receive testimony on current conditions in these community residential care facilities. Based on our follow-up work, we believe there are certain actions the State must take immediately to eliminate many of the problems which continue to exist.

Of the areas of recommendations we presented in our report for administrative action by the Department of Social Services(DSS), we believe your Administration must give highest priority to (1) improving the licensing division's responsiveness and effectiveness in resolving complaints regarding conditions in facilities; (2) improving the division's coordination with other governmental units; (3) modifying certain aspects of resource management within the licensing division; and (4) amending certain regulations relating to licensure.

DSS Has Done An Inadequate Job of
Responding to and Resolving Complaints

During our study and the follow-up period, and at our recent public hearing, we have continued to receive testimony that the licensing division's responsiveness to complaints or reports of problems in facilities has been inadequate. Although the licensing staff may conduct their visit to a facility in a reasonable amount of time in many or most cases, the nature of their inspection and the actions taken are inadequate far too often.

For example, we learned at our January hearing of a case in which a facility was operating in excess of their licensed capacity for three years. This same facility had also received serious violations in June 1984 for operating with insufficient food, having emergency and fire exits blocked, and having installed hook latches on the outside of residents rooms. Although the State Licensing Division had inspected and cited the facility, all penalties were waived without any apparent just cause.

In November 1984, another facility was cited for having inadequate food supplies. However, rather than immediately citing the facility and levying a fine, the licensing evaluator allowed 30 days for correction of this serious violation! Two weeks after the citation, a volunteer Ombudsman responded to a complaint and also found an inadequate food supply; there were no eggs, milk or meat. When the Ombudsman demanded that adequate food be purchased, the staff went to the store and returned with hot dogs. This facility, according to our information, was never assessed any penalties.

Clearly, the State will never create a deterrent or remove the most serious violators from the State unless sufficiently strong enforcement actions are taken. These cases, along with other evidence outlined in

our report, indicate that such enforcement actions are not occurring as they must.

DSS Does Not Sufficiently Coordinate With Other Governmental Units

A major conclusion of our 1984 report was that "more sets of eyes" are needed to monitor community care facilities. With over 22,000 facilities, it is quite simply not possible for the licensing division to provide a broad oversight of the operations of these facilties, particularly in light of the division's other substantial responsibilities. Consequently, the State must be well coordinated with Ombudsman programs, appropriate State program agencies, local law enforcement agencies, placement agencies, and others which have contact with these facilities.

However, the Department of Social Services has not adequately coordinated its activities with these various governmental units. Local Ombudsmen continue to complain that the licensing division is not cooperative and will frequently fail to respond to requests for inspections or information.

Additionally, this Commission continues to believe that better coordination is needed with the key State program agencies and local law enforcement agencies to both educate them to enforcement problems and promote their indirect monitoring of facilities. Finally, the licensing division, as a standard practice, should provide updated lists of licensed facilities to placement agencies and require that placement officers place individuals into only these facilities. A violation should result in the individual losing his or her job.

Better Resource Management Needed

Since our work first began back in the 1970's, we have continued to receive testimony of cases of friendly inspectors always visiting the same facilities and, in some cases, providing a tip-off that they were coming. The State has continued to deny that this occurs and, consequently, few strong actions have been taken to discourage it. We were pleased to hear of an inspector being terminated for tipping off a facility. However, this event serves to illustrate that such actions continue.

In our 1984 report, we strongly recommended that licensing staff assignments in district offices be rotated on a scheduled basis. However, we were informed that no such formal policy exists. Rather, each district administrator is allowed to set their own policies. We continue to see no justification for this policy.

Certain Regulations Need to be Amended

Certain regulations for residential care facilities are ambiguous and, in some cases, do not address the needs of the residents. For example, current regulations appear to be ambiguous or inadequate

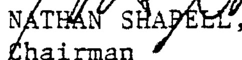
regarding requirements that staff in a facility be able to speak English. Although a representative of the licensing division testified that this is not a serious problem, we have continued to receive testimony that it is. For example, a newspaper account of a case in Modesto states that the facility operator had to have an interpreter present at proceedings to translate into the Assyrian language. Additionally, we received testimony from a Stanislaus County Patient's Rights Advocate that she frequently observes care problems that are directly related to the inability of facility staff to communicate with residents.

Perhaps the most appalling deficiency in regulations (or law) is that licensees cannot be required to know how to read. Consequently, the State cannot require the licensee to stipulate that he or she has read all the regulations and understands them. We received extensive testimony indicating that poor care provided by operators frequently is the result of their lack of familiarity with regulations.

Based upon our original study, as well as our follow-up work over the last twelve months, we are calling upon you to direct Health and Welfare Agency Secretary David Swoap and Department of Social Services' Director Linda McMahon to act upon the items we have outlined in this letter, as well as all of the remaining recommendations in our 1984 report. Additionally, the members of the Little Hoover Commission ask for your active support of a bi-partisan package of twelve legislative bills which we are sponsoring. These bills will be announced today and formally introduced in the next week.

Our State Government must not delay one more day in acting to insure that it is doing everything possible to prevent abuse and neglect in these facilities, and to provide the best services to the residents who live in them. There is no more urgent need nor proper role for government than to protect its citizens.

Respectfully submitted,



NATHAN SHAPELL,
Chairman

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cc: Commission Members
Members, California Legislature
Capitol Press Corps