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California's protection and advocacy system

January 14, 2011

(Via Electronic Mail to RNUnit@cdph.ca.gov)

Pamela Dickfoss
Acting Deputy Director
Center for Health Care Quality
RNUnit@cdph.ca.gov

Re: Comments Regarding California State Auditor's Recommendations on
Management of State and Federal Health Facilities Penalties Accounts

Dear Ms. Dickfoss,

Disability Rights California is established under federal and state law to protect the rights and interest of persons with disabilities. In addition to providing individual advocacy, class action representation, and information and training to people with disabilities and their families, Disability Rights California investigates allegations of abuse and neglect against people with disabilities, including residents of long term care facilities. Based on the issues identified in its investigations, Disability Rights California develops and implements public policy initiatives to prevent similar incidents in the future. Disability Rights California reviews all Department of Public Health (Department) citations and, in select instances, conducts independent investigations into the underlying incidents.

Disability Rights California supports the recommendations enumerated in the Bureau of State Audit's (BSA's) June 2010 report regarding problems with the Department's citation penalties accounts (Report 2010-108). While our investigations have not involved tracking the payment of citation penalties and citation appeals, case investigations and citation monitoring have provided sufficient evidence to support the report's recommendations.

Disability Rights California is submitting the following comments which further reinforce the rationale underpinning this report and its recommendations:

1. The Department Should Complete Investigations in a Timely Manner

Department citations are frequently issued months and, in some cases, years after the event. This means that egregious wrongdoing goes unpunished, corrective action to prevent future abuses is not implemented timely, and the incidents are hidden from the public and vulnerable consumers. For example:

- On January 13, 2007, a staff member at a for-profit intermediate care facility (ICF) beat a resident with a belt so severely that he required treatment at a local hospital for the resulting welts across his shoulder and back. The Department issued a Class B citation against the facility on April 2, 2010, over three years after the abuse occurred.
- On July 24, 2008, a sixty year old resident of a skilled nursing facility (SNF) died after falling and hitting her head when the fraying sling for the mechanical lift tore apart while she was being transferred into bed. The facility acknowledged a standard practice of washing lift slings in bleach, a practice known to weaken fabric over time. The Department finally issued a Class AA citation more two years after the incident.
- On September 29, 2007, a resident of a SNF choked to death after eating in the dining hall. The resident had a known a history of choking and to be supervised at mealtimes to prevent such incidents. After he was found unresponsive, staff at the facility did not attempt CPR, waiting instead for the Fire Department, which arrived several minutes after the resident was discovered. DPH did not cite the facility until November 18, 2010, over three years after this incident. This was not the first choking death at this facility. In 2006, Disability Rights California conducted an investigation concerning a strikingly similar choking death of a resident at the same facility.

Although on-site investigations must be initiated within 10 working days after the receipt of a complaint (within 24-hours if there is imminent danger of harm or death)¹, delays in concluding the investigation and issuing the resulting citation significantly

¹ Health and Safety Code §1420(a)

undermine replenishing the State Health Facilities Citation Penalties Account (Account). To mitigate the financial effects of these delays, the Department should develop a process to expedite completion of investigations likely to result in Class A and AA citations. This not only protects residents against the most egregious abuse, but also reduces the time to collect the significantly higher penalty amounts.

Furthermore, the timeliness for issuing citations has even more bearing as , the Department implements its new Skilled Nursing Facility Quality and Accountability Program. This program will reward facilities that meet certain quality indicators with increased facility payments. Facilities that have been cited with a Class A or AA citation during the relevant review period will be ineligible for the supplemental payments. Delays in issuing citations means that facilities that have had a critical event will be eligible to receive the enhanced payments between the time the event occurred and the citation was issued, a period of time that could last years. Furthermore, such facilities can hold themselves out to the public as exemplary, because they have been awarded enhanced payments, despite a recent serious incident for which they have yet to be cited by the Department, due to citation delays.

2. The Department Should Increase Citation Penalty Amounts

The citation penalties levied by the Department often represent the only fiscal consequence levied against the facility. Private civil actions and criminal prosecutions against facility owners and operators are uncommon. The current citation penalty amounts are disproportionately low for the corresponding violation. These are the equivalent of a slap on the wrist for many for-profit nursing home chains, hardly serving as a deterrent to poor management practices or a motivator for management to ensure consistent implementation of prompt corrective action.

- In April 2010, DPH issued one Class B \$1000 citation when several direct care staff, as a prank, coated seven elderly residents from head to toe with A&D ointment. Although the perpetrators of the abuse were arrested, de-certified as Nurses Assistants, and charged with elder abuse by the local District Attorney, the citation penalty levied against the SNF was \$1000, despite there being seven victims. This SNF was cited previously when three different nursing assistants ridiculed and repeatedly abused five male residents for months, pinching their genitals, and forcing them to eat feces. This incident resulted in one Class A citation of \$20,000.

- In a more recent case from an ICF, three reported cases of physical abuse against the same victim over a one month period resulted in only one \$1000 Class B violation instead of three separate citations for each incidence of abuse.

Class B citation penalties must be increased. Facilities with a history or culture of tolerating abusive behaviors from staff must be fined increasingly greater amounts with each new incident. State law currently requires consideration of a facility's past history of violations in determining the citation penalty amount. Health & Safety §1424(a)(5). Yet this is not reflected in the citations issued by the Department. The failure to connect similar patterns of abusive behavior seen in cases, like the A&D ointment citation, is a missed opportunity for the Department to increase the penalty amount.

Incidents involving multiple victims, multiple perpetrators, or multiple abusive events against the same resident must be fined separately. In the A&D ointment case, only one \$1000 Class B citation was issued despite perpetrators victimizing seven elderly residents. This case should have resulted in, at the very least, seven citations for each one of the seven resident victims. A consistent application of this standard would not only be commensurate with the severity of the underlying incidents but would greatly increase monetary fines collected by the Department.

3. The Department Should Issue Citations According to the Level of Harm

Many abuse or neglect complaints issued as Class B citations should be cited as Class A citations. The Department has narrowly interpreted facts of egregious abuse resulting in serious and lasting physical harm or death and assigned lesser penalty fines than warranted, thus settling for smaller fines and lighter consequences. Addressing abusive or reckless staff behavior as Class A citations when warranted would also allow DPH to collect higher penalty amounts.

- In October 2006, a resident of an ICF, who required staff assistance with feeding and fluid intake, sustained significant weight loss over a period of weeks. The staff failed to monitor his intake of fluids and nutrition or take any action to correct his inadequate hydration and nutritional needs. Eventually the resident was taken to a hospital where he was treated for resulting serious medical conditions and subsequently died. The Department issued Class A citation, finding the failure of staff to provide adequate food and fluids were not a sufficient direct cause of the resident's death.

- On November 21, 2007, an elderly resident with frail skin was forced into a whirlpool bath. During the bath, sections of the resident's skin started bleeding and tearing off. Despite a large, bleeding skin tear from his armpit to his wrist and his pleas to be let out of the water, the staff proceeded with the bath. The resident described excruciating pain and feeling like he was "drowning". Despite the resulting in serious physical harm, pain, and lasting psychological trauma, the Department cited the facility for a Class B with a penalty of \$1000.
- A care-staff pushed two residents forcibly in their wheelchairs and then released the wheelchairs, causing the residents to sail down the corridor and slam into the wall. A prosecutor elder abuse opined that he would have prosecuted the incidents as felonies because the abusive act was likely to cause great bodily injury. The Department issued one Class B citation with a penalty of \$1000.

By failing to correctly issue citations according to the level of harm, the Department is not only minimizing the significance of the conduct and probability of harm, but failing to maximize the reasonable penalty amount. The Department should realistically assess the facts of each case for the actual or probable degree of harm sustained by the victims and assign higher penalty fines where warranted. The Department should treat all abuse cases as potential Class A citations.

The weaken of citation levels ripples further as the Department implements the new Skilled Nursing Facility Quality and Accountability Program. As described above, under this program, facilities that have been cited with a Class A or AA citation during the relevant review period will be ineligible for the supplemental payments. By issuing Class B citations for incidents meeting the statutory criteria for a higher level of citation, facilities with serious incidents of misconduct will be eligible for enhanced funding, in addition to dodging the increased penalty fines.

4. The Department Should Publish Citations on Its Website

The Department maintains a Health Facilities Consumer Information System website purportedly to provide consumers with accurate and relevant information about licensed long-term care facilities and hospitals throughout California. While the Department's website provides data about the number of complaints and enforcement actions against a facility, even cursory information about the incident itself is absent, thus providing consumers with minimal relevant or meaningful information.

- In June 2009, DPH issued an AA citation against a

- SNF for admitting a resident for whom it could not provide adequate care. Despite the resident's two separate attempts to kill himself by discharging a fire extinguisher into his mouth, the facility did not take any precautionary measures to monitor him or change his plan of care, resulting in his death by asphyxiation from inhaling the contents of a fire extinguisher on his third and ultimately fatal attempt. The website provided dates for the above-described violation and when the penalty was issued, legal citations for the regulations violated the penalty number and category but no information that the incident involved a resident suicide. None of the information provided informed the public that the facility had failed to prevent a resident with a known history of suicidal behavior from killing himself.

The information underlying a citation, including the facts of an incident and the facility's response, is available to the consumer as a public record. Currently, the public can request a copy of the notice letter and Form 2657 (statement of deficiencies) accompanying a citation by submitting a request to the DPH local district office that issued the citation. This process is cumbersome and time-consuming, however, and serves only to protect offending facilities. The public should be able to access this information through DPH's website.

Conclusion

We urge the Department to adopt all the recommendations enumerated in the BSA's report, including but not limited to: streamlining the citation appeal process, increasing the citation penalty amount, revising state law so that the Centers of Medicare and Medicaid Services (CMS) can impose a federal civil money penalty, and authorizing DPH to collect citation penalty amounts upon appeal of the citation. We urge DPH to consider these additional comments and recommendations as they examine and revise their citation penalty process,

Thank you for your consideration.

Sincerely,

Leslie Morrison
Director, Investigations Unit