

Nursing Home Abuse

**and California's Broken
Enforcement System**

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A SPECIAL REPORT BY



California Advocates for Nursing Home Reform

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ABOUT CANHR

California Advocates for Nursing Home Reform (CANHR), founded in 1983, is a private, not for profit organization dedicated to improving the quality of care and the quality of life for long-term care consumers in California. CANHR seeks to educate consumers and advocates about the rights and remedies under the law and to create a united voice for long-term care reform and viable alternatives to institutionalization.

For more information about CANHR or if you would like more information about Long-Term Care Medi-Cal, call CANHR at (800) 474-1116 or visit our web site (www.canhr.org).

ABUSE CITATIONS BY COUNTY

The abuse citations studied for this report were issued during the period from January 1, 2004 through April 2006. The numbers of abuse citations are listed below for each county in which they occurred; if a county name does not appear, then none of the citations in this study occurred in that county. For detailed summaries of individual citations, contact the CANHR office (415-974-5171) or visit the CANHR website (www.canhr.org).

Alameda	7	Napa	14	Santa Barbara	4
Amador	1	Nevada	5	Santa Clara	9
Butte	12	Orange	5	Santa Cruz	3
Contra Costa	5	Placer	4	Shasta	11
El Dorado	1	Plumas	2	Siskiyou	1
Fresno	1	Riverside	4	Solano	5
Humboldt	2	Sacramento	13	Sonoma	5
Kern	20	San Benito	2	Stanislaus	3
Lake	8	San Bernardino	18	Sutter	5
Los Angeles	36	San Diego	7	Tehama	2
Marin	12	San Francisco	6	Tulare	8
Mendocino	4	San Joaquin	1	Ventura	4
Modoc	1	San Luis Obispo	3	Yolo	3
Monterey	5	San Mateo	3	Yuba	1

Abuse of California Nursing Home Residents a Continuing Tragedy

“Unlawful abuse and neglect is widespread, underreported, infrequently prosecuted and the cause of untold suffering, injury, illness and death.”

(U.S. Department of Justice, 2002)¹

This report describes horrific abuse suffered by hundreds of California nursing home residents at the hands of their caregivers from 2004 through April 2006. The elder abuse victims described here could be your spouse, parents, grandparents, friends or neighbors. All were abused at the most vulnerable time of their lives by caregivers they relied on to provide the most intimate personal and nursing care. Their abuse took many forms, ranging from physical and sexual assaults to mental and verbal cruelty.

Elder abuse is a shocking reality to hundreds of nursing home victims throughout California who suffer devastating consequences, sometimes including serious injuries or death.² Most abused residents experience mental anguish, fear, emotional distress, depression, agitation, and feelings of helplessness.

The unabated, tragic levels of abuse in California nursing homes is an indictment of nursing home practices by some operators and of California’s broken nursing home enforcement system.³ All too often, abused residents are victimized again when nursing home administrators fail to report the abuse to law enforcement and licensing officials as required. Even when abuse is reported, investigations and enforcement actions by California’s nursing home licensing agency, the California Department of Health Services, are often “too little, too late.”

The human suffering described here is presented as a call to action to root out abusive caregivers, to attack the pervasive culture of silence that exists in many nursing homes and to reform our ineffective oversight system. The report concludes with specific recommendations.

SEXUAL ABUSE

Sexual abuse includes rape, nonconsensual sexual acts, molestation, and related crimes. Perpetrators may include nursing home employees, family members, strangers, and, often, fellow residents whose sexual misbehavior may be related to their own disease or illness.

EXAMPLES:

Two residents with mental disabilities were **bribed with soda and cigarettes to have sex with an employee** over a three or four-month period. One resident reported this in January 2005, but nothing was done until the second resident complained on April 28, 2005. Twin Palms Care Center, Los Angeles County – Class B, \$1000

Between 5/4/05 and 5/7/05, the Director of Nurses received several different reports of a nurse engaging in **inappropriate sexual behavior with female residents** and never reported it to the police or licensing. Pleasant Care Rehabilitation and Nursing Center, Santa Cruz – Class B, \$1000

On a Friday night in January 2005, a female resident reported to the Administrator that while she was sleeping a male **pinned down her arms and stuck his penis in her mouth**. The Administrator told the resident it was a dream or her imagination and the abuse was never well investigated or reported. The resident has trouble sleeping because she is afraid. Seacrest Convalescent Hospital, San Pedro – Class B, \$1000

On 6/13/05, a resident reported that an employee pinched his penis on at least four occasions, then looked at him, “as if to say, do you like it.” The employee also “had a field day rubbing his private area” in the shower. These **abuses occurred in front of the employee's wife, who also worked at the facility**. Country Villa Westwood Convalescent Center, Los Angeles – Class B, \$ 1000

Abuse Citations Are the ‘Tip of the Iceberg’

The abuse cases described in this report are based on citations issued by the California Department of Health Services (DHS) against licensed nursing homes.⁴ See **Table 1** for information on citation classifications and the range of fines. They were sorted into abuse categories by CANHR staff.

Abuse citations represent the tip of the iceberg. Sadly, experts estimate that for every case of elder abuse that is reported, there may be as many as five cases that go unreported.⁵ There are many reasons why nursing home abuse goes unreported, including but not limited to the following:

- Some victims are unable to report assaults due to physical or mental disabilities
- Many victims fear retaliation if they report abuse
- Victims may lack visitors to detect and report abuse
- Abuse may be difficult to detect
- Negligent operators often ignore reporting responsibilities
- Caregivers may fear retaliation by perpetrators or disapproval by superiors

In some nursing homes, the administrator and operator cultivate a culture of silence that encourages employees to ignore incidents of abuse. This culture is so pervasive that the California Court of Appeals took judicial notice of it recently while upholding the conviction of a nursing home administrator who did not report a dangerous physical assault by one of her employees. In a strongly worded ruling, the justices declared that they sought to dispel widely held misconceptions by nursing home administrators about their reporting duties.⁶

Despite mandated abuse reporting requirements that apply to nursing homes,⁷ many abuse citations are triggered by public complaints rather than by facility reports. For example, DHS investigated an anonymous complaint that a certified nursing assistant (CNA) at Hayward Hills Healthcare Center in Hayward hit a 98-year-old resident in the face, bruising her face and hurting her eye.⁸ During the February 1, 2005 investigation, the resident gave the following account of the beating:

The CNA “punched me in the head because I didn’t do what he told me to do fast enough... His fist was like a stone on my face. He hit me that hard. I screamed. Also my nose was bleeding... The next day he came to work in the afternoon. I saw him in the lobby and wanted to disappear. I was terrified he’d take care of me again. I thought he’d be really mad at me because I told on him.”

The facility administrator did not report the abuse despite the resident's injury and multiple complaints from family members that the alleged perpetrator mistreated other residents. The administrator merely moved the perpetrator to another assignment.

Most abuse citations appear to indicate endemic or habitual behavior, rather than isolated incidents.

Why Residents Are So Vulnerable

Most nursing home residents are extremely susceptible to abuse because they are largely unable to protect themselves and are dependent for their care on the kindness of strangers:

- Most are physically dependent due to multiple diseases
- Two-thirds have cognitive impairment from diseases such as Alzheimer's
- Few are married and many lack regular family visitors

One of the most common and severe forms of abuse in nursing homes is neglect. Although not always thought of as a type of abuse, neglect becomes abuse when residents develop serious infections and bedsores due to inadequate care, when they become malnourished or dehydrated due to lack of food and water, when they are unnecessarily restrained or drugged, and when their health is otherwise endangered due to lack of qualified caregivers.

For example, on November 30, 2005, at Village Square Nursing and Rehabilitation Center in San Marcos, a partially paralyzed resident developed three bedsores overnight when staff members left her sitting on a bedpan for a period of over 10 hours.⁹

Understaffing: A Recipe for Abuse

Short staffing and abuse go hand-in-hand.¹⁰ Far too many residents suffer abuse, neglect and daily indignities because operators do not hire enough staff to provide the care they need.

Six years after a January 2000 legislative deadline to provide 3.2 hours of nursing care per resident each day,¹¹ many California nursing homes routinely ignore this minimal standard. In 2004, the California Office of Attorney General reported that more than two of every three nursing homes it inspected violate this requirement.¹² In one recent example, a complaint investigation by the Department of Health Services found severe understaffing violations on 18 consecutive days in December 2005 at the Huntington Healthcare Center in Los Angeles.¹³

In 2002, a Congressionally ordered study based on eight years of research recommended 4.1 hours of care per resident day.¹⁴ It found that most nursing homes are understaffed to the point that residents may be endangered.

TABLE 1: CLASSES AND AMOUNTS OF CITATIONS

Class AA: The most serious violation, AA citations are issued when a resident death has occurred due to nursing home regulation violations, and carry fines of \$25,000 to \$100,000.

Class A: Class A citations are issued when violations present imminent danger to residents or the substantial probability of death or serious harm, and carry fines from \$2,000 to \$20,000.

Class B: Class B citations carry fines from \$100 to \$1000 and are issued for violations which have a direct or immediate relationship to health, safety, or security, but do not qualify as A or AA citations.

Citations can be appealed. The type of appeal and the outcome can be any of the following types: CRC, (Citation Review Conference) Arbitration, Court, (Municipal, Justice or Superior) or Negotiation. The fine can either be Upheld, Reduced, Increased or Dismissed. In lieu of contesting the citation, a civil penalty of a minimum or sixty-five percent of the fine, whichever is greater can be paid. Violations repeated within twelve months may be issued trebled fines (indicated as (x3))—triple the normal amount.

PHYSICAL ABUSE

Physical abuse includes slapping, kicking, beating, punching, choking, pushing, striking and other types of rough mistreatment. Isolation, unreasonable physical constraint, and deprivation of food or water are also physical abuse.

EXAMPLES:

On 7/26/05, a CNA yelled at a resident, "Go to your f---ing room." The resident said **the CNA "hit me** on my head and pulled my hair." Large clumps of her hair were found in the wastebasket and she had a bald patch. Riverside Convalescent Hospital, Chico – Class B, \$3000

On 4/22/05, a housekeeping staff person **held a burning cigarette lighter under a resident's foot** until his sock caught fire. Alameda County Medical Center – Class B, \$800

On 7/12/05, in front of residents and staff, a staff member **choked a resident**, dragged him; when the resident fought back, the staff member held him down and began punching him. Napa State Hospital – Class A, \$18,000

Two CNAs were caught on video **slapping, shoving, and roughly throwing a 78-year-old** resident onto her bed. Sierra Hills Care Center, Roseville – Class B, \$3000

On 3/21/04, a 77-year-old resident with a fractured back cried out in pain as an employee tugged her incontinence brief, **so the employee stuffed a towel in her mouth**. The resident left the facility against medical advice that afternoon because she was afraid. Valley Manor Convalescent Hospital, North Hollywood – Class B, \$800

On 9/5/04, an employee used a dry towel to clean a resident's rectum. **The 71-year-old resident screamed but the employee continued**, and laughed as she left the room. Chandler Convalescent Hospital, North Hollywood – Class B, \$1000

Small Fines, Tardy Citations Are No Deterrent to Abuse

Since 2004, DHS has issued 96 percent of abuse citations as Class "B," which carries a maximum fine of \$1,000. The tiny fines have little, if any, deterrent value because they are so disproportionate to the trauma suffered by abuse victims and have virtually no financial impact on negligent operators. Although the amount of most nursing home fines is negligible, the cost of these crimes to the human spirit is incalculable.

For example:

*A resident of Regency Oaks Care Center in Long Beach reported that an employee lured her into a laundry bathroom and sexually assaulted her on October 23, 2005. According to the DHS investigation, **for 15-20 minutes the employee placed his gloved fingers inside her vagina** and made her turn around and bend over the toilet while he placed his fingers into her rectum and fondled her breasts. The resident reported that she suffered much pain and burning. **The alleged perpetrator is a registered sex offender** who revealed on his job application that he had a conviction for assault. The facility did not conduct a background or reference check on the employee. The alleged perpetrator was arrested and charged with five counts related to sexually assaulting the resident. On January 5, 2006, DHS issued a Class "B" citation with a fine of \$1,000.¹⁵*

The deterrent effect of fines is further eroded by extremely slow investigations and bureaucratic red tape. Many fines are not issued until many months or years after the abuse has taken place. For instance:

On January 4, 2005, Golden Empire Convalescent Hospital in Grass Valley reported to DHS that a certified nursing assistant was **abusing residents while training student nursing assistants**. Two students witnessed multiple incidents of abuse in 2004. DHS conducted its investigation on April 5-6, 2005, three months later, and did not issue a citation (Class "B," \$1,000) until April 6, 2006, more than 15 months after the abuse took place. Ironically, DHS cited the facility for not reporting the abuse in a timely manner.¹⁶

On November 27, 2004, a Norwalk Meadows Nursing Center resident reported that she was **raped by a male certified nursing assistant** the prior evening. That day, a Sexual Assault Response Team documented that the resident suffered vaginal trauma and supported her allegations. The nursing assistant confessed that he had sex with the resident. On March 2, 2006, 17 months later, DHS issued a Class "B" citation (\$1,000 fine) to the facility for failing to protect the resident from sexual abuse.¹⁷

Little Oversight, Weak Enforcement Enable Abuse

“A review of the system of inspections, citations and fines shows it has been undermined by massive amounts of uncollected fines, a pattern of non-responsiveness to complaints, and some systemic barriers to efficient and effective enforcement.”
 (Little Hoover Commission, 1991)¹⁸

Even more true today, this 1991 finding by California’s esteemed Little Hoover Commission helps explain why abuse of nursing home residents continues unabated in California. The DHS Licensing and Certification Division – California’s only consumer protection agency for nursing home residents with the power to enforce the law – is failing its most basic responsibility: to protect nursing home residents from abuse and neglect.

DHS: Failure By the Numbers

- According to DHS, nursing home complaints by consumers increased by 11 percent from 2003 (5,234 complaints) to 2005 (5,799 complaints)
- Despite the large increase in complaints, DHS complaint investigation hours decreased dramatically from 2003 (100,485 hours) to 2005 (71,509 hours)¹⁹
- In 2005, DHS onsite complaint investigations averaged 4.1 hours in 2005, less than half the national average of 9.29 hours per investigation;²⁰

as a result of cursory investigations, DHS substantiates only about one in four complaints²¹

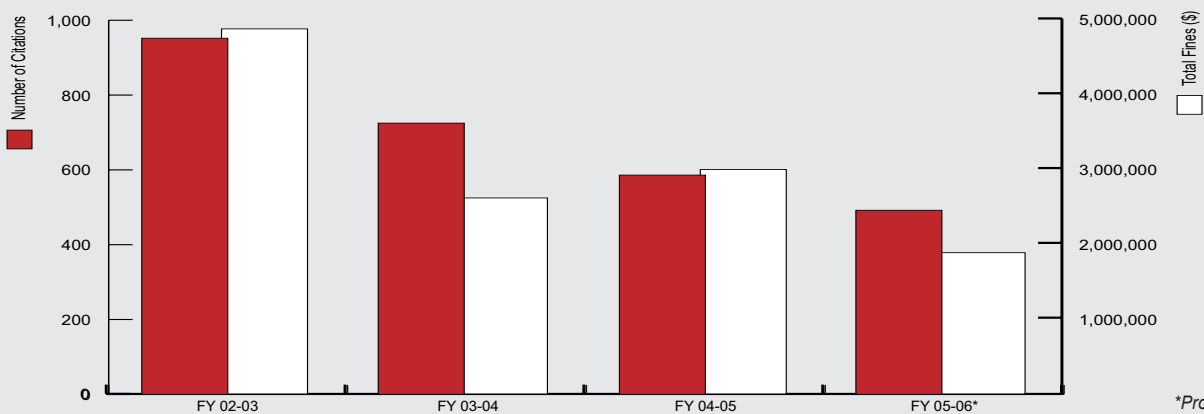
- DHS cut nursing home inspection teams by 30% since fiscal year 2001-2002²²
- The U.S. Government Accountability Office (GAO) has conducted repeated studies (1998, 2003, 2005) that found California inspectors understate harm to residents and fail to detect serious deficiencies²³
- DHS Licensing and Certification issued fewer citations, with lower total fines, in 2004 and 2005 than in the history of the citation system in California (see **Table 2**)
- The use of other state and federal enforcement remedies, including bans on admission and civil monetary penalties, has also decreased dramatically over the past few years

DHS: Failure to Obey the Law

Following these already frightening trends is a recent DHS declaration that DHS is not required to enforce state laws. As of last year, DHS now claims its primary purpose is to ensure federal standards are met.

During the last 20 years, the California legislature has enacted numerous nursing home reform laws designed to improve resident care and protect residents from abuse and neglect. For example, the Legislature established minimum staffing requirements, created abuse and neglect reporting requirements, and enhanced training requirements for certified nursing assistants.

TABLE 2: NUMBERS AND AMOUNTS OF CITATIONS DECREASING ³¹



VERBAL AND MENTAL ABUSE

Verbal and mental abuse are the intentional infliction of anguish, pain or distress through verbal or nonverbal acts such as threats, harassment, intimidation and humiliation.

EXAMPLES:

On 3/9/04, a resident asked a staff member to turn out the light, who told her, **"Let me do my job or I'll rip your f---ing arm out of its socket."** Monterey Convalescent Hospital – Class B, \$500

On 2/24/05, a CNA pointed his finger at a resident's face and told her to "get the f--- out of [his] face before [he] knock[ed] [her] ass out." He then got louder and **called the resident a "black bitch," a "whore," and a "slut."** View Heights Convalescent Hospital, Los Angeles – Class B, \$1000

On 4/21/05, a nurse approached a resident who was crying in her wheelchair, shook her finger in front of the resident's face, and shouted, **"Shut up! I am not going to put up with your crap!"** Lone Tree Convalescent Hospital, Contra Costa - \$1000

On 6/29/03, a staff member said to a resident with quadriplegia and respiratory failure, "Shut up, stop being a crybaby. **How would you like it if I shut [the ventilator] off and let your ass die?"** Community Medical Center, Fresno – Class B, \$900

On 6/16/05, a resident complained that on different occasions, a staff member **called her "an idiot," and "stupid," and withheld her pain medication.** Riverside Convalescent Hospital, Chico – Class B, \$3000

On 12/8/04, a resident wheeled herself to the kitchen and asked for another bowl of cereal. **The dietary supervisor responded by "yelling and screaming** at the top of her voice" at the resident for "bugging her." Arlington Gardens Convalescent Hospital, Riverside – Class B, \$1000

These unique California reforms, and many others, exceed federal nursing home standards. But DHS does not enforce those reforms. At this time, DHS does not evaluate compliance with any of California's requirements during annual nursing home inspections.²⁴

DHS: Failure to Protect or Respond

DHS is not investigating complaints of abuse and neglect in a timely manner, and is withholding information about nursing home performance histories.

In failing to respond to serious abuse complaints, DHS is defying California law requiring it to conduct onsite investigations within 24 hours if a resident is in imminent danger and other complaints within 10 working days.²⁵ DHS data shows that it investigates less than half of complaints subject to the 10-day time frame in a timely manner.²⁶ Many complaints are held until the next regular inspection, up to 15 months later.²⁷ By the time investigations are conducted, evidence is lost, staff is gone, and witnesses are unavailable. The Los Angeles Times reported instances where nursing home residents actually died before DHS investigated complaints submitted by their family members.²⁸

On October 17, 2005, CANHR and family members of deceased nursing home residents filed suit in San Francisco Superior Court against the Department of Health Services seeking enforcement of California's statute requiring timely complaint investigations.²⁹ Yet DHS continues to consistently disregard its duties.

At the same time—after over a decade of making raw enforcement data readily available to the public, consumer advocacy groups, and policy makers—DHS has been withholding key data since January 2004.

This denial of access to public data appears intended to hide DHS's failure to perform its regulatory enforcement duties.

DHS: Failure By Every Measure

If the Department of Health Services is not responding to complaints, not conducting effective inspections, not enforcing California laws, not providing information about nursing home performance, and not issuing citations or collecting fines, then we have, in essence, no oversight or enforcement system in California.

DHS failures are putting the health and safety of over 100,000 nursing home residents at risk.

Limited Remedies for Victims of Abuse

The litany of sexual, physical and verbal abuse against California's nursing home residents is shocking and disturbing. Even more disturbing, however, are the facts that few elder and disabled victims of abuse are ever compensated for their injuries, and few facilities are ever punished for their acts of abuse other than with a minor civil penalty that is usually reduced.

While California's nursing home industry would have us believe that "thousands" of lawsuits by residents have led to a liability insurance crisis, CANHR's study of actual elder abuse lawsuits filed against California nursing homes over a three-year period showed that, not only were there no "frivolous" elder abuse lawsuits, but there were few elder abuse lawsuits in the first place.³⁰

Although the Elder Abuse and Dependent Adult Civil Protection Act (EADACPA) can be a valuable remedy for victims of abuse and neglect, only a handful of the victims of the abuse as outlined in this report will be able to seek justice and compensation under EADACPA. The high burden of proof for elder abuse victims strictly limits the number of lawsuits that are filed in any given year. While few can take advantage of the opportunity under EADACPA to challenge abusive providers in court, it does provide a measure of accountability and needs to be preserved and strengthened.

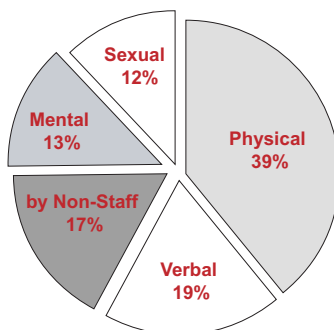
The only other legal remedy for nursing home residents is Health and Safety Code §1430(b), which was enacted in 1982. It provides a private right of action for residents whose rights have been violated. Because of the \$500 limit on civil damages, few residents' rights lawsuits have been filed, despite thousands of documented residents' rights violations.

Thus, the high legal burden of EADACPA, the limited remedies for residents' rights violations and the abandonment by Licensing and Certification of their role as a consumer protection agency leave California nursing home residents with no protection against abuse and limited legal recourse.

TABLE 3: DISTRIBUTION OF ABUSE TYPES FOR CITATIONS STUDIED

Citations studied include all state citations issued by the Department of Health Services (DHS) to nursing homes during the period from 1/1/2004 through April 2006.

During that period, 266 citations were found to center on one of these forms of abuse.



DIGNITY

Actions that violate a person's dignity are a type of mental abuse.

In September 2004, a CNA abused residents by holding a resident's stool in front of her and asking her to taste it; **using lipstick to make a resident appear "clown-like;"** torturing a resident by repeatedly opening her privacy curtain and laughing at her; **slapping stickers on residents' faces; and spiking their hair.** Eskaton Care Center Fair Oaks, Sacramento – Class B, \$1000

While washing a resident on 5/27/05, a CNA used the same washcloth to clean all parts of the resident's body without rinsing it, sprayed soap and water into her face, and **lifted her breasts by the nipples, making her cry out in pain.** Willow Glen Convalescent Hospital Rest Care Center, San Jose – Class B, \$800

On 3/16/05, a CNA grabbed a spoon of puree food from the tray of the resident she was feeding and **threw it in the face of a 93-year-old** resident seated at another table, then laughed and said it was a joke. Several staff witnesses verified the abuse. Valley View Skilled Nursing Center in Ukiah – Class B, \$1000

On 6/2/04, the Director of Nurses **told an 82-year-old resident that she was too fat**, spoke to her in a "mean and hateful" manner, and repeatedly demanded that she get out of bed, despite the fact that her legs hurt from arthritis. Ridgecrest Healthcare Center – Class B, \$500

In February 2004, **a CNA called a resident "fat, ugly, and poor" on several occasions.** The CNA harassed her by refusing to leave her room, taking her snacks, and lying on her bed. During the investigative interview, the resident cried and said that the CNA made her scared, afraid, nervous, and anxious. Valley Convalescent Hospital, Bakersfield – Class B, \$1000

Recommendations

All citizens of California have a stake in what goes on in our nursing homes. Supported primarily by our taxpayers' dollars and home to our mothers and fathers, our brothers and sisters, and our sons and daughters, California's nursing homes should be to our credit – not to our shame.

To protect nursing home residents from further abuse, CANHR makes the following recommendations.

1. DHS – Require Accountability as a Condition of 2006-2007 Budget Increases

As a condition of approving the Governor's pending budget proposal to add 141 staff positions to the DHS Licensing and Certification Division, the Legislature should require DHS to:

- Immediately investigate all backlogged complaints
- Begin onsite investigations of all new complaints within statutory requirements
- Conduct thorough investigations of all complaints
- Complete complaint investigations within 45 days
- Immediately and fully notify complainants of investigation findings
- Promptly apply enforcement remedies when violations are detected
- Provide complainants with appeal opportunities as provided by law

Additionally, DHS should be required to conduct all nursing home inspections on an unpredictable schedule, using fully staffed, qualified inspection teams.

2. DHS - Enforce California Nursing Home Laws

As required by law, DHS should evaluate compliance with California's numerous nursing home reform laws, including its minimum staffing requirements, during nursing home inspections and complaint investigations and swiftly enforce the laws when violations are detected.

3. DHS - Post Regulatory Oversight Information Online

The Department of Health Services should be required to post online, each month, raw data files containing every element of regulatory oversight data its Licensing and Certification Division gathers in relation to nursing home oversight, except for confidential information specifically restricted by law. This will allow consumers to monitor care of loved ones and allow policy analysts to evaluate DHS performance.

4. Legislature - Treat Abuse as an "A" Citation

California's nursing home citation system should be amended to require that abuse be treated as a Class "A" citation.

5. Legislature - Increase the Limit on Damages for Rights Violations

The California Legislature should strengthen nursing home residents' ability to obtain fair compensation when their rights are violated by increasing the limit on damages (set at Health and Safety Code Section 1430(b)) from \$500 to \$5,000.

6. Legislature - Improve Abuse Victims' Access to Civil Justice

The California Legislature should improve elder abuse victims' access to the civil justice system by lowering the evidentiary burden to a "preponderance of the evidence" in cases brought under the Elder Abuse and Dependent Adult Civil Protection Act.

Notes

- 1 Marie-Therese Connolly, Coordinator, Elder Justice and Nursing Home Initiative, U.S. Department of Justice, *Federal Law Enforcement in Long Term Care*, Journal of Health Care Law and Policy, 2002.
- 2 United States Government Accountability Office, *Nursing Homes, More Can Be Done to Protect Residents from Abuse*, GAO-02-312, March 2002.
- 3 See, for example, *Abuse of Residents is a Major Problem in U.S. Nursing Homes*, Minority Staff, Special Investigations Division, Committee on Government Reform, U.S. House of Representatives, July 30, 2001.
- 4 DHS, through its Licensing and Certification Division, is mandated to monitor compliance with California and federal laws governing nursing homes. California law authorizes it to issue three classes of citations (“AA,” “A,” and “B”) when it finds that a nursing home resident has suffered harm or died due to nursing home neglect or abuse.
- 5 California Attorney General’s Office, Department of Justice, *Your Legal Duty, Reporting Elder and Dependent Adult Abuse*, 2002.
- 6 *People v Davis*, 2005 WL 388510, 2005 Cal. App. Lexis 258 (Cal. Ct. App. 2005).
- 7 Section 15630 of the California Welfare and Institutions Code defines a mandated reporter as any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency.
- 8 Citation Number 02-1204-0002828-S, issued March 1, 2005 to Hayward Hills Healthcare Center, 1768 B Street, Hayward, CA 94541.
- 9 Citation Number 08-1568-0002877-F, issued January 12, 2006 by California Department of Health Services to Village Square Nursing and Rehabilitation Center, 1586 W. San Marcos Blvd., San Marcos, CA 92069.
- 10 Hawes, Catherine, Ph.D., *Elder Abuse in Residential Long Term Care Facilities: What is Known About Prevalence, Causes and Prevention*, Testimony Before U.S. Senate Committee on Finance, June 18, 2002.
- 11 California Health and Safety Code Section 1276.5.
- 12 Bureau of Medi-Cal Fraud & Elder Abuse, California Department of Justice, 2004, *Operation Guardians 2001-02 and 2002-03 Results*.
- 13 Citation Number 97-1771-0001460-S, issued February 6, 2006 to Huntington Healthcare Center, 4515 Huntington Drive South, Los Angeles, CA 90032.
- 14 U.S. Centers for Medicare and Medicaid Services, Prepared by Abt Associates Inc., 2002, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final*. Volumes I-III. Baltimore, MD: CMS.
- 15 Citation Number 94-1645-0001516-F, issued January 5, 2006 to Regency Oaks Care Center, 3850 E. Esther Street, Long Beach, CA 90804.
- 16 Citation Number 23-1535-0002998-S, issued April 6, 2004 to Golden Empire Convalescent Hospital, 121 Dorsey Drive, Grass Valley, CA 95945.
- 17 Citation Number 94-2027-0002886-F, issued March 2, 2006 to Norwalk Meadows Nursing Center, 10625 Leffingwell, Norwalk, CA 90650.
- 18 Little Hoover Commission, *Skilled Nursing Homes: Care Without Dignity*, April 1991.
- 19 Centers for Medicare and Medicaid Services, *CASPER Report 0319S, Complaint Investigation Survey Hours*, San Francisco Regional Office, March 21, 2006.
- 20 Centers for Medicare and Medicaid Services, *CASPER Report 0319S, Complaint Investigation Survey Hours*, San Francisco Regional Office, March 21, 2006.
- 21 Harrington, C., O’Meara, J., 2004, *Report on California’s Nursing Homes, Home Health Agencies, and Hospice Programs*. Prepared for the California HealthCare Foundation.
- 22 Senate Office of Research, California Legislature, *Memorandum to Senator Elaine Alquist, Data on Oversight of Skilled Nursing Facilities*, July 14, 2005.
- 23 United States Government Accountability Office, *Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, GAO-06-117, December 2005; United States Government Accountability Office, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, GAO-03-561, July 17, 2003; United States Government Accountability Office, *California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes with Serious Care Problems*, GAO/T-HEHS-98-219, July 28, 1998; and United States Government Accountability Office, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, GAO/HEHS-98-202, July 27, 1998.
- 24 Legislative Analyst’s Office, *Analysis of the 2006-07 Budget Bill, Licensing and Certification Reform Proposals*, C-35 to C-47, February 23, 2006.
- 25 California Health and Safety Code Section 1420.
- 26 Legislative Analyst’s Office, *Analysis of the 2006-07 Budget Bill, Licensing and Certification Reform Proposals*, C-35 to C-47, February 23, 2006.
- 27 Ventura County Star, *Complaints About Nursing Homes Can Sit for Months*, April 11, 2004. See also, Joint Informational Hearing, Senate Health Committee and Subcommittee on Aging and Long Term Care, *Department of Health Services’ Testimony*, July 20, 2005.
- 28 Los Angeles Times, *Nursing Home Scrutiny Lagging*, July 31, 2005.
- 29 California Advocates for Nursing Home Reform v. California Department of Health Services, San Francisco Superior Court, Case No. 05-505749, October 17, 2005.
- 30 California Advocates for Nursing Home Reform, *Much Ado About Nothing: Debunking the Myth of Frequent and Frivolous Elder Abuse Lawsuits Against Nursing Homes*, November 2003.
- 31 Department of Health Services, *Citation Summary Report, Fiscal Years 02-03, 03-04, 04-05, 05-06 – 2nd Quarter 05-06*.



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(415) 974-5171 • www.canhr.org

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YUBA

Abuse Type: PHYSICAL ABUSE

Marysville Care & Rehabilitation Center, 1617 Ramirez Street, Marysville

Date: 08/11/2005 -- Class (current): **B** -- Fine (current): **500**

On 2/24/05, a 95-year-old resident was interviewed and stated that a licensed nurse had pinched a very painful egg shaped lump on her back two days in a row. There were no physician orders to pinch or drain the sore. The facility was cited for failing to protect the resident from physical abuse by a licensed nurse. (Issued as Class B at \$500. Case Status: Closed.) Citation #23156001146.



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