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COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

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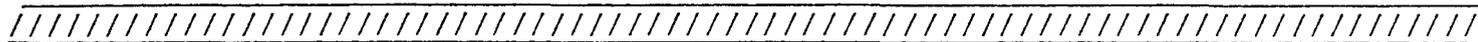
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THE LITTLE HOOVER COMMISSION'S
REPORT ON COMMUNITY RESIDENTIAL CARE
FOR THE ELDERLY



JANUARY 1989

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January 5, 1989

The Honorable George Deukmejian
Governor of California

The Honorable David Roberti
President pro Tempore of the Senate
and Members of the Senate

The Honorable Kenneth L. Maddy
Senate Minority Floor Leader

The Honorable Willie L. Brown, Jr.
Speaker of the Assembly
and the Members of the Assembly

The Honorable Ross Johnson
Assembly Minority Floor Leader

Dear Governor and Members of the Legislature:

Recently, media from all over the country converged on Sacramento when police unearthed the bodies of seven elderly people, apparently killed for their social security checks by the operator of an unlicensed residential care facility. Government officials, news commentators, and people on the streets were shocked: How could this have happened?

The Little Hoover Commission, however, was not stunned. Five years ago, this Commission investigated the care that society provides for the elderly in residential homes, and produced a grim and ugly picture of neglect, abuse and inadequate government controls. Our scathing report recommended numerous changes designed to protect vulnerable elderly Californians.

Today, our Commission is back with the results of a review begun early this year of conditions in residential care facilities. The outcome is only marginally less bleak while the findings regarding the State's role as protector of society's weakest members is every bit as blistering as it was five years ago.

Sacramento's board and care death house is, of course, a sensational case that we can all hope is unique. But our Commission's fear is that many other such tragedies await discovery because the Sacramento house reflects so many of the statewide problems with residential care facilities.

For instance, the Sacramento board and care facility was unlicensed, but continued to receive referrals from government social workers. One of the biggest threats to the protection of the elderly is unlicensed facilities where the State plays no role in monitoring the quality of care. Nationally, it is estimated that one in six residential care facilities is unlicensed.

Yet California has no aggressive strategy to eliminate these operations that prey on senior citizens. Because of the backlogged, time-consuming licensing process, many operators find it fiscally advantageous to begin their businesses with no license. The State's response, once an unlicensed facility is discovered, is to speed the application process for the operator. To date, there are no regulations to impose the \$200-a-day fines written into law at the urgings of the Little Hoover Commission in 1985.

In short, not only are there no effective punishments for unlicensed facilities, the State, through its policies and actions, actually provides incentives for these renegade operators.

Had the facility in Sacramento been licensed, would anyone have noticed substandard care or abuse, or done anything about it?

Statistically, across the State overworked ombudsmen are only able to visit 40 percent of the board and care facilities. In the small portion that they oversee, they find on an annual basis about 550 cases of confirmed abuse. When one also considers the unknown number of unreported cases, we have a frightening concept of the lives of senior citizens who are no longer at home with loved ones.

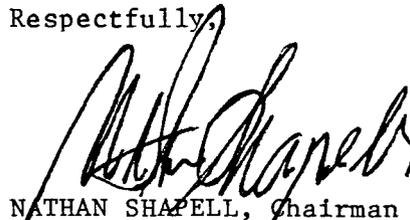
When ombudsmen report abuse and violations of regulations, they find a frustrating, uneven and lethargic response from the State. Fines that are paltry--\$25 and \$50 a day--compared to those levied on other care institutions are frequently waived or never collected. There is no clear coordination between the State's oversight function and local prosecution efforts. And the State makes no effort to let local referral agencies know the licensing and violation status of facilities in their area.

Clearly, the system is in need of a drastic overhaul. The Little Hoover Commission, in the attached report, makes specific and detailed recommendations. Some of the changes are technical in nature, such as altering fire code requirements and waiving locked-facility regulations. But others, such as the following, are clear-cut, broad institutional changes:

1. A well-coordinated campaign to find and eliminate unlicensed facilities should be a top priority. Homes like the one in Sacramento must be stamped out of existence.
2. The State should make a strong effort to enforce existing laws regarding care and to crack down on violations in a timely, uniform and convincing manner. This means higher fines and more consistent prosecution of violators.
3. Those who are actually providing the care for the elderly need to be trained and certified to ensure that they are capable of meeting the needs of senior citizens. Creating a professional career ladder, reaching from the bottom aide to the top administrator, will do much to enhance the quality of care in residential facilities.

It is past time to put a stop to the inhumane treatment of people as they near the end of their lives. We urge your most energetic cooperation in adopting the recommendations of the Little Hoover Commission to remedy this horrifying situation.

Respectfully,

A handwritten signature in dark ink, appearing to read 'Nathan Shapell', written in a cursive style.

NATHAN SHAPELL, Chairman
Haig Mardikian, Vice Chairman
Senator Alfred Alquist
Mary Anne Chalker
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Senator Milton Marks
Assemblywoman Gwen Moore
George Paras
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EXECUTIVE SUMMARY

Ours is a rapidly aging society. The United States population over 80 years old will grow from 2.9 million in 1980 to 7.9 million in 2020. In California, the aging of the population is accelerating more rapidly than in the nation at large. Over the next 20 years, Californians aged 80 and over will increase by 138 percent.

Issues affecting the aged will, therefore, be more acute sooner in California than in most other states. Thus, unless problems such as abuse and neglect in residential facilities are corrected soon, they will affect greater and greater numbers of California's elderly. Despite many improvements made over the last five years, California's system of residential care for the elderly is still not adequate, even in licensed facilities.

Nationwide, between 500,000 and 1,000,000 cases of elder abuse are reported annually. This represents as many as one in every 25 persons over the age of 60. Thus, approximately 150,000 Californians may be victims of elder abuse. During the first quarter of 1987-88, ombudsmen throughout the State received 237 reports of abuse in residential facilities for the elderly. They investigated 226 of those reports and confirmed that abuse had occurred in 137 cases. Given the likelihood that the first reports in this new reporting system would undercount actual incidents, the reports demonstrate that abuse is a very real problem.

The Commission's study revealed that performance by the Department of Social Services' (DSS) Community Care Licensing Division is often arbitrary and slow. At both hearings held over the course of this study, the Commission heard testimony regarding the Department's arbitrary, inconsistent and delayed implementation and enforcement of licensing laws and regulations. Applications for licensure are severely backlogged, and the Department's computer system does not appear adequate to overcome performance weaknesses.

The study determined that the Department of Social Services' Enforcement Program suffers from underutilization of penalties and fines and a lack of coordination with local law enforcement. Fines for licensing violations in residential care facilities range from \$25 to \$50 per day. This is significantly less than fines for similar violations in skilled nursing facilities which range from \$100 to \$10,000 per incident. In addition, of the fines that are assessed by the Department of Social Services, only half are actually collected. Moreover, the Department is not required to involve local law enforcement in cases of abuse and neglect within set time limits. Thus, coordination between DSS and local law enforcement agencies on which the Department must rely to prosecute cases, varies dramatically. Without consistently enforcing the civil sanctions and effectively utilizing all law enforcement resources, the protection mechanisms established to insure the safety of elderly residents will continue to be ineffective.

The Commission believes that the continued operation of unlicensed facilities poses a serious threat to the safety and well-being of residents. The facility owner who starts operations without a license faces no significant penalty for doing so. Indeed, in light of potential revenue losses resulting from delays in license application processing, facility

owners actually have an economic incentive not to seek licensure. The Commission believes that investigating and prosecuting unlicensed facilities is difficult. However, it is imperative since currently unprotected residents are suffering because of the lax enforcement of laws.

In our 1983 report, the Commission found that residents are rarely visited by outsiders and that case management services were available for the developmentally and mentally disabled but not for the elderly. Case management begins with an assessment of an individual's functional abilities, using a standardized assessment instrument. The assessment becomes the basis for a decision to place an older person in a particular facility. Case management also includes ongoing visitation to monitor the individual's health status and overall well-being. Five years later, except for those elderly certifiably frail enough to be at risk of placement in nursing homes, case management services comparable to those provided for other vulnerable populations still are not available to older Californians on a systematic basis.

In addition, the Commission found that residential facilities for the elderly are caught from both sides by State fire regulations. On the one hand, they face slow and fragmented enforcement of fire codes that delay licensing or make continued operation difficult. On the other hand, these facilities often are plagued by rigid interpretation of the codes that force them to make costly changes that alter the noninstitutional setting in residential facilities. Without appropriate recognition of residential facilities as a special situation, the supply of residential care homes for the elderly may be greatly limited.

Additionally, the Commission's study determined that small facilities, licensed to serve six or fewer residents, lack the special oversight they need to function in the residential care network. One of the particular problems faced by licensees operating family setting residences is isolation. There is a great unmet need for respite care for administrators of family setting residences. Furthermore, Licensing is particularly ill-suited as the sole regulatory program for family setting residences. The loss of direct interaction with social workers resulting from the Community Care Act of 1973 exacerbates the potential for adverse effects from isolation that characterizes family setting residences.

Moreover, the Commission determined that quality is a low priority in California's Residential Care Regulatory Program. Licensing alone does not constitute a system of controls that could ever prescribe and monitor quality of care in the thousands of residential care facilities throughout the State.

Factors contributing to the public sector's lack of control over the quality of care in residential facilities include the State's lack of ability to offer performance incentives, lack of training, failure to assess the care needs of the residents, regulations that discourage specialization, lack of requirements for English-speaking capability and lack of adequate consumer education. Without the prescription of controls, quality of care in residential facilities will be inconsistent and, in many cases, inadequate.

The study also determined that there is no State level policy on or protocol for emergency relocation of community care residents, but local government is generally expected to support this activity in times of crisis. Because relocation procedures are not provided by the State, orchestrating a transfer becomes the responsibility of local authorities. However, the current county level emergency response capability is no match for the incidence of elder abuse and abandonment in residential care facilities.

Furthermore, the cost of providing residential care is not adequately documented. However, the Commission found that during the first half of the current decade, real spending on programs for seniors rose six percent while the over-60 population increased by 25 percent. Although approximately one-fourth of the residents are SSI/SSP recipients, the California Association of Residential Care Homes (CARCH) believes that many small homes cannot afford to accept SSI/SSP clients. CARCH estimates that the actual monthly cost per client is nearly double the current rate of \$678. The State needs to know how much it costs to provide regulated levels of service in residential care facilities so that rates paid by the State to purchase those levels will assure that adequate service is available to those who qualify.

The Commission study also revealed that private funding mechanisms have not been established to relieve the public sector's financial burden.

Finally, for middle-income children, the cost of maintaining an elderly parent in a residential care setting becomes increasingly burdensome. Currently, only about two percent of long-term care costs in California are paid for by private insurance. Furthermore, many policies available at present cover only skilled nursing care. Long-term care plans similar to IRAs for investment-minded consumers are currently under consideration by the federal government but are likely to be expensive due to inflation of health-related costs.

The Commission's report presents 10 recommendations to improve the quality of life for California's citizens that live in residential care facilities.

1. Certify residential care facility administrators with specific education and training requirements.
2. Authorize and fund counties, at their option, to license small residential care facilities and provide placement counseling and assistance.
3. Identify new revenue sources from which to increase funding for residential care for the elderly.
4. Improve effectiveness of monitoring and law enforcement.
5. Launch a well-coordinated campaign to detect and eliminate unlicensed facilities.
6. Strengthen current law and regulations pertaining to resident protections.

7. Develop protocols for emergency services coordination.
8. Develop a waiver application procedure for requesting permission to operate a locked facility for special conditions such as Alzheimers disease.
9. Upgrade the Department of Social Services' management information capabilities.
10. Develop fire safety regulations specific to residential care facilities.

I. INTRODUCTION

In 1983, the Commission on California State Government Organization and Economy, also known as the Little Hoover Commission, completed studies of both the nursing home and residential care industries. Since that time, significant progress has occurred in many areas of concern to the Commission. For example, the Long-Term Care Ombudsman program has been expanded to bring more volunteers into residential facilities for the elderly so that residents are now less isolated. But in certain crucial areas--such as investigation and closure of unlicensed facilities--progress is undetectable.

Ours is a rapidly aging society. Unless problems such as abuse and neglect in residential facilities are corrected soon, they will affect greater and greater numbers of California's elderly and disabled citizens. For this reason, the Commission has chosen to review the current status of the safety and well-being of individuals residing in residential facilities for the elderly.

Scope

This report includes a detailed description of California's existing system of community residential care for the elderly in particular, as well as a description of the evolution of community residential care in general. Pertinent legislation and roles of the Department of Social Services/Community Care Licensing, the Long-Term Care Ombudsman program, and other agencies are discussed. The report also profiles California's residential facilities for the elderly and describes in some detail the context in which they function, including such factors as funding, the continuum of long-term care, and demographics.

The report takes a comprehensive view of quality of care, reviewing the following specific areas:

- o Prevention of abuse and neglect;
- o Enforcement of existing laws and regulations;
- o Performance of, and appropriate role for, the Department of Social Services/Community Care Licensing;
- o Efforts to deter the operation of unlicensed facilities;
- o State fire regulations and administration;
- o Placement process;
- o Need for case management services; and
- o Adequacy of funding.

Methodology

The Commission contracted with Marquart Policy Analysis Associates to assist in the preparation of this study. The initial phase of the study consisted of a literature search (a review of existing documents and analyses), with particular emphasis on changes in the residential care system since the Commission's 1983 report. The Commission held two public hearings: one on February 26, 1988 in Santa Ana and the second on April 29, 1988 in San Francisco (the witnesses are identified in Exhibit A).

Various public officials and industry representatives were interviewed over the course of the study.

In addition, the Commission convened an Advisory Committee representing the agencies concerned with service delivery and quality of caregiving provided by residential facilities for the elderly (Exhibit B lists members of the Advisory Committee). The Advisory Committee met four times as a whole and a number of times as subcommittees and working groups, discussing issues and problems extensively and preparing papers on most of the topics covered in this report. While the Commission has given consideration to the ideas and concerns of all members of the Advisory Committee, the final report is a product of the Commission and may or may not be consistent with the viewpoint of individual members of the Advisory Committee.

II. BACKGROUND

Profile of Residential Facilities for the Elderly

A residential facility for the elderly (RFE) is a group housing arrangement chosen voluntarily by the residents who typically are over 60 years of age, although persons under 60 who have compatible needs may also be included. An RFE provides "nonmedical care and supervision" to residents. They are intended for residents who do not need the medical care or intensive supervision required in nursing homes.

RFEs are governed by Health and Safety Code Chapter 3.3, Section 1569 et. seq. (Residential Facilities for the Elderly Act). The law requires that at least the following basic services must be made available in all such facilities:

- o Assisting with activities of daily living, as defined in the Health and Safety Code, in combinations which meet the needs of residents.
- o Helping residents gain access to appropriate supportive services in the community.
- o Being aware of the residents' general whereabouts, although residents may travel independently in the community.
- o Monitoring the activities of the residents while they are under the supervision of the facility to ensure their general health, safety, and well-being.
- o Encouraging the residents to develop and maintain functional ability through participation in planned activities.

Examples of activities with which residential facilities may assist residents include housework; laundry; money management; dressing; eating; grooming; arranging for transportation; telephoning; arranging for recreation, medical, dental, and other health services in the community; supervision and storage of medications.

Under State law, residential facilities for the elderly are required to be licensed by the Community Care Licensing (CCL) Division of the Department of Social Services (DSS). As of September 1987, there were 3,675 licensed facilities operating in California, with a capacity to serve 78,817 residents. An unknown number of facilities operate without a license.

The size of the facilities ranges from homes licensed for six or fewer to much larger facilities of 500 or more residents. About 67 percent of elderly residents live in the small homes. About 30 percent depend entirely on SSI/SSP for income [CSSP:10].

Role and Responsibilities of the Department of Social Services/Community Care Licensing

The State Department of Social Services is mandated by Chapter 3 of the Health and Safety Code (SEC. 1500, et. seq.) to license all facilities providing nonmedical, out-of-home residential or day care through its Community Care Licensing Division. CCL has 15 district offices throughout the State. In 1986-87, their caseload consisted of approximately 53,000 day and residential care facilities (including foster care homes, which are licensed by county welfare departments).

The license issued to residential facility owners is a basic permit to operate a community care facility. If at any time the facility fails to meet minimum standards of health and safety, the Department may terminate the license.

Facilities are inspected at least twice a year by licensing analysts, who generally have achieved an bachelor's degree as a job prerequisite. The residential facilities for the elderly caseload, if an analyst were limited strictly to these facilities, is 55. This compares with a caseload of 83 for adult residential facilities. As of July 1, 1988, the Department had 283 analysts on staff and planned to add 60 more positions based on work volume.

The Department's basic responsibilities include:

- o Approving or denying initial and renewal applications for facility licensure;
- o Securing criminal record clearances on applicants, owners, staff, and non-client adult residents of facilities;
- o Investigating complaints against facilities;
- o Developing and enforcing regulations to protect client health, safety and human rights;
- o Visiting and evaluating all licensed facilities on a regular schedule (Exhibit C, Licensing Form 860-A, is used to evaluate compliance with laws and regulations);
- o Preventing the clustering of facilities in single neighborhoods by applying overconcentration standards to applications;
- o Providing information to the public on inspections, deficiencies, and plans of correction; and
- o Pursuing enforcement actions, including civil penalties and revocation and closure actions against facilities found in violation of law or regulations.

Role and Responsibilities of the California Department of Aging

The California Department of Aging (CDA) is the single State agency responsible for administering programs funded under the federal Older Americans Act. Through area agencies on aging, the Department oversees programs that provide services to almost 4 million older Californians. In addition, the Legislature has delegated to CDA the responsibility for developing and implementing a comprehensive range of noninstitutional long-term care services for both older and functionally impaired adults.

Services administered by the Department of Aging include social and nutrition services, senior employment programs, long-term care services, and staff training. Pursuant to Chapter 1637/Statutes of 1984 [AB 2226 (Felando)], the principal emphasis of the Department of Aging is on long-term care, reflecting the State's policy to help older Californians live as independently as possible for as long as possible by preventing unnecessary institutionalization. The 1984 legislation gave CDA primary responsibility for overall policy coordination and direction of community based long-term care. CDA now administers several community based long-term care programs, including adult day health care, the multipurpose senior services program (MSSP), and Linkages.

CDA's Long-Term Care Ombudsman program is closely involved with residential facilities. The Ombudsman program has the authority for and responsibility of receiving, investigating, and resolving complaints made by or on behalf of residents in long-term care facilities, including RFEs. Besides residential facilities for the elderly, the Ombudsman monitors skilled nursing, intermediate care, and adult day health care facilities.

The State Ombudsman office, with a staff of eight, directs and technically assists 35 local Ombudsman programs that monitor clients in long-term care facilities. The State Ombudsman office also trains and certifies volunteers. As of July 1987, there were 103 full-time equivalent paid staff and approximately 820 trained and certified volunteers in local ombudsman programs.

The goals of the Ombudsman program are as follows:

- o To assist residents to assert their civil and human rights;
- o To ensure that quality of care includes considerations of quality of life;
- o To provide appropriate referrals to agencies; and
- o To inform the appropriate agencies of substandard conditions and important issues in long-term care facilities.

The Ombudsman program functions as an advocate for individual clients, working to resolve whatever problems residents may have within a particular facility. AB 3662 required the State Long-Term Care Ombudsman to establish a 24-hour, toll-free telephone hotline to encourage reports of crises in long-term health or community care facilities. The hotline number (1-800-231-4024) is required to be posted conspicuously in a place easily accessible to residents. Chapter 769/Statutes of 1986 [AB 3988 (Papan)] established a new reporting system whereby abuse in long-term care

facilities is reported to the local Ombudsman program which, to the extent resources are available, is responsible for investigation and substantiation.

In addition to the functions mentioned above, the Ombudsman program also does the following:

- o Advises the public of any inspection reports, statements of deficiency, and plans of correction for any long-term care facility within its service area;
- o Establishes and assists in the development and maintenance of resident and family councils;
- o Sponsors other community involvement in long-term care facilities;
- o Provides community education and training to facilities and the general public about long-term care in general and residents' rights issues in particular;
- o Witnesses Durable Powers of Attorney for Health Care Agreements in long-term care facilities;
- o Witnesses certain transfers of property in long-term care facilities; and
- o Attends Citation Review Conferences.

The Ombudsman program has considerable ground to cover: nearly 9,000 facilities in all, of which approximately 3,500 are residential facilities for the elderly. During the fiscal year ending June 30, 1987, the Ombudsman program referred 1,185 complaints to Community Care Licensing. During the same period, 38 percent of licensed residential facilities had an ombudsman assigned to make regular visits.

The Evolution of Community Residential Care

In 1973, the California Community Care Licensing Act was passed to establish a statewide system of community care for the elderly and other dependent clients. The Act required the Department of Social Services to develop new regulations for licensing nonmedical, out-of-home care, in part as an alternative to state hospital care for those persons who did not require institutionalization but who were unable to care for themselves entirely on their own.

Prior to the passage of this legislation, social workers in the Department of Mental Health's field offices recruited, trained, and certified family care homes. The homes were recruited on an as-needed basis and "certified" by Department of Mental Health social workers. In this system, social workers--relying on a "trained eye" and their understanding of the individual clients' needs and preferences--placed the primary emphasis on family caregivers' personal qualities. It was a subjective form of

certification, seen as a process of cultivating humanitarian motives [Thompson].

By contrast, the current system is based on the Department's monitoring role as licenser of residential facilities and tends to stress the business relationship of the licensee to the client. A license is a property right. While objective rather than subjective monitoring of minimum standards of care is appropriate, many observers point out an attendant loss of social workers' trained eyes and ears to monitor individual clients.

Issued in December 1983, the Little Hoover Commission's first report on community residential care detailed the numerous problems still existing in the long-term care continuum and evaluated the impact of the State's move to license residential facilities to meet minimum health and safety standards rather than continuing the family care home model. The report led to legislative hearings focused on the specific problems of community residential care for the elderly. A task force was organized by the California Association of Homes for the Aging (CAHA) to examine the results of the investigations and to develop recommendations for legislation.

The result of this process was Chapter 1127/Statutes of 1985 [SB 185 (Mello)], which established a separate licensing act for these facilities: the Residential Facilities for the Elderly Act. This legislation required training of both licensing and caregiver staff and mandated the development of three levels of care within residential facilities.

In 1987, SB 50 (Mello) was introduced to implement and fund the three levels of care referenced in SB 185 of 1985. The bill called for three levels of care to be established; defined the three levels of care; required that services be designated for the appropriate levels of care; prohibited facilities from accepting or retaining residents who require intermediate care or skilled nursing services; placed limits on health services to be provided to residents; provided authority to the Department of Social Services to establish criteria to approve licensed facilities' ability to provide Level II and Level III services; and provided for supplemental SSI/SSP payments for Levels II and III. Due to the State's uncertain fiscal condition, the Governor advised the Legislature that SB 50 would not be signed, however, the provisions of the three levels of care have been implemented by the Department of Social Services.

SB 50 was seen by providers and related agency representatives as a step toward bringing SSI/SSP reimbursement closer to the true costs of residential caregiving. The levels of care would have provided a means for maintaining residents for a longer time in the residential setting, thus reducing the need for placement in skilled nursing facilities.

Demographics

Health care during the twentieth century, which began with an average U.S. life expectancy of 47 years, emphasized "cure" rather than "care" [JECCUS:59]. The significance of the care is increasingly important, however, as citizens live greatly lengthened but often impaired lives.

The U.S. population over 80 years old will grow from 2.9 million in 1980 to 7.9 million in 2020 [Rich:149]--an increase of nearly 175 percent in only 40 years. In California, the aging of the population is accelerating more rapidly than in the nation at large. Compared with the national average, California has fewer people under 18 and more people between the ages of 25 and 44 ("baby boomers"). In fact, California has a higher percentage of people in this age group (33.5 percent) than all but five other states [UCSH].

Moreover, in California between 1985 and 1990, those aged 65 to 74 will increase by 16 percent while those 75 and over will increase by 19 percent [CDA, 1986, App C:2]. Between 1980 and 2000, Californians aged 80 and over will increase by 94 percent and those 85 and over will increase by 138 percent [UCSH:5].

Problems affecting the aged will therefore be more acute, sooner, in California than in most other states. Demographics become even more significant in light of the California Department of Aging's 1985 estimate that 15.4 percent of those over 65 need personal care or mobility assistance. California's policymakers also must bear in mind, according to the University of California's Academic Geriatric Resource Program, that the elderly will have more limited economic resources as the aged population becomes more ethnically diverse and predominantly female.

Fiscal Impact

As the U.S. population ages, limits to federal funding represent a growing concern. The maximum Social Security tax has increased more than 10,000 percent to date from the inception of Social Security in 1936. Moreover, in 1936 there were 46 workers for each retiree. Now, there are only three workers per retiree and, by 2020, there will be only two [Henderson, 40].

In California, for those elderly who find themselves in the position of seeking aid and assistance, myriad programs and services are mandated. In its 1988-89 Perspectives and Issues, the Legislative Analyst's Office devoted a section to State programs for older Californians, noting that 17 State agencies administer 39 separate programs which include income support, employment services, health services, social services, discounts, and nutrition. From a management and consumer standpoint, the complexity of services and of establishing eligibility for them creates something of a maze.

The cost to the State for these programs in 1987-88 was approximately \$1.8 billion, with an additional \$1.6 billion contributed by the federal government. Estimated expenditures for the 1988-89 fiscal year are about \$2 billion for the State and \$1.7 billion for the federal government (Exhibit D provides detail).

Counties have come under increasing pressure to provide a broad array of services to the elderly, particularly in program areas such as Adult Protective Services. Since the enactment of mandatory abuse reporting laws in 1982, the demand for Adult Protective Services has increased by 64 percent without a commensurate increase in funding.

The Continuum of Long-Term Care

Care and services for older Californians have been developing in piecemeal fashion over the last several years. While it is often termed a continuum, long-term care actually consists of generally unconnected programs which are provided by many agencies--17 State agencies, to be exact, administering 39 separate programs. Local government and the private sector are also involved in providing an array of services. Services offered within the long-term care continuum include adult day care, hospice care, home health care, multipurpose senior services programs, skilled nursing facilities, transportation services, preventive health care and nutrition programs (see Exhibit E for a complete list of services in the continuum).

Residential care for the elderly falls in the middle of the "continuum." Theoretically, residential care clients are too vulnerable or frail or lonely to live independently in their own homes, but they do not need the intensive medical care and attention provided by a skilled nursing facility. Residential care facilities provide an appropriate alternative which, at its best, allows older Californians to maintain a sense of independence within a home setting.

III. STUDY FINDINGS

Despite many improvements made over the last five years, California's system of residential care for the elderly is still not adequate, even in licensed facilities. This is due primarily to insufficient training for caregivers, lack of certification for administrators, mediocre performance by the Department of Social Services, continued operation of unlicensed facilities, insufficient legal protection for residents, inconsistent enforcement of existing laws, and an inadequate SSI/SSP reimbursement structure.

Additional factors include insufficient availability of placement assistance, failure to monitor clients, management information systems inadequate to support the Department's Licensing program, problems in the interpretation of State fire regulations, failure of the private sector to share the growing burden of long-term care funding, and lack of consumer awareness of the many issues relevant to quality of care in residential facilities.

FINDING #1 - Abuse and Neglect of Residents Are Ongoing Problems

The problems of abuse and neglect that were detailed in the Commission's 1983 report continue to plague elderly Californians living in residential care facilities. During February 1988, the Commission gained first-hand knowledge of the neglectful and demoralizing conditions that exist in some facilities by conducting surprise visits to several facilities in Orange County. During the visits, Commission members found residents who were not being fed regularly or receiving an adequate diet, residents suffering from severe bed sores, and residents whose doors were locked from the outside to prevent them from leaving the confines of their rooms.

One of the facilities had been cited within the prior 90 days for having a resident insufficiently clothed in a bare room, exposed, dirty, smelly, in bed, and unable to respond. The resident was unable to move or clear flies out of her open mouth.

The testimony of Orange County's Deputy Coroner points to the potential end result of such abuse and neglect:

In 1987, we had 97 board and care deaths in Orange County. Based on the kind of care that they ought to be getting at board and care homes, we shouldn't have that many deaths in board and care homes. They should die in convalescent hospitals or acute care hospitals, not board and care.

The Department of Social Services compiled a "Characteristics Survey" on dependent adult and elder abuse based on all cases reported to County Welfare Departments during a one-month period from February 15, 1987 through March 16, 1987. For the 340 cases of elder abuse reported, the study showed that, of the 93 cases among adults not living in their own homes, 30 reported incidents, or 32.3 percent, involved community care facility residents. [HWA:1988]

Nationwide, according to an estimate by a Congressional Committee on Aging, between 500,000 and 1,000,000 cases of elder abuse are reported annually. This number represents as many as one in every 25 persons over the age of 60. Thus, approximately 150,000 Californians may be victims of elder abuse [CSSA:1987]. Adding to the problem is the victim's reluctance to bring the abuse to the attention of service agencies, frequently due to the victim's absolute dependence on the abuser for basic needs. The elderly, of all age groups, are least likely to report abuse.

Table III-1 details the first quarterly reports from the newly established elder abuse reporting program administered by the State Long-Term Care Ombudsman.

Table III-1

CASES OF ABUSE IN RESIDENTIAL FACILITIES FOR THE ELDERLY
REPORTED TO LONG-TERM CARE OMBUDSMAN

Summary of Data for First Quarter of Fiscal Year 1987-88
(July - September 1987)

Age	Number of Cases Reported	Investi- gated	Abuse Confirmed	Cases Dismissed	Reports Unfounded
18-59	37	29	17	9	6
60-64	35	35	19	12	1
65+	<u>165</u>	<u>162</u>	<u>101</u>	<u>43</u>	<u>13</u>
Totals	<u>237</u>	<u>226</u>	<u>137</u>	<u>64</u>	<u>20</u>
Percentages	100%	95.4%	57.8%	27.0%	8.4%

Source: Department of Social Services, Elder Abuse Reporting Unit

As Table III-1 illustrates, of the 165 cases of elder abuse reported, 101 cases were confirmed. Annualizing the cases reported in the first three-month period means approximately 950 cases will have been reported during any twelve-month period, of which 550 will have been confirmed. While the Long-Term Care Ombudsman program is seen as the primary statewide effort to prevent abuse and neglect in residential facilities, ombudsmen are able to visit less than 40 percent of the facilities and depend primarily on a volunteer staff covering residential facilities as only one category of long-term care facilities.

The State Ombudsman estimates that 60 percent of abuse and neglect complaints are made to volunteer ombudsmen when they are visiting in a facility. It is the presence of an ombudsman that most often gives a resident the opportunity to voice a complaint. Since 60 percent of the facilities remain unvisited, it is not unreasonable to infer that the

initial reports documented in Table III-1 undercount the actual incidents of abuse.

The prepared testimony of the State Ombudsman included the following statistics in Table III-2, documenting complaints received from residents during the 12-month period ending June 30, 1987 (prior to enactment of the mandatory reporting law):

Table III-2

COMPLAINTS OF ABUSE IN RESIDENTIAL FACILITIES FOR THE ELDERLY
NUMBER AND PERCENT BY TYPE
1986-87

<u>Type</u>	<u>Number</u>	<u>Percent</u>
Physical Abuse	712	5.8
Quality of Care	1,886	15.4
Staffing	537	4.4
Resident Rights	1,815	14.9
Diet	859	7.0
Financial	1,028	8.4
Activities Program	382	3.1
Physical Plant	853	7.0
Facility Administration	667	5.5
Regulatory Agency	143	1.2
Medical Care	746	6.1
Transfers	541	4.4
Legal	425	3.5
Pharmacy	251	2.1
Placement	730	6.0
Social Services	297	2.4
Other	<u>342</u>	<u>2.8</u>
Total	<u>12,214</u>	100.0%

Source: California Department of Aging, Long-Term Care Ombudsman Program

While the number of complaints (12,214) is alarming, representatives of the California Association of Health Facilities (CAHF) testified at the Commission's San Francisco hearing in April 1988 that each local Ombudsman program has developed its own guidelines and that significant confusion surrounds the categories of "abuse" set out in Table III-2. For example, an Ombudsman may report as a case of "diet abuse," a complaint from a resident that she does not like the food or that the agency's dilatory tactics fit the description of "regulatory agency abuse."

Nonetheless, the frequency of reported and confirmed abuse and neglect of residents in California's residential facilities for the elderly is cause for serious concern. Furthermore, the evidence suggests that the problem is more widespread than is now documented. Required abuse reporting and improvements in report handling are beginning to yield better information about the actual dimensions of this problem. Having good data promotes

greater understanding of the nature and extent of abuse and neglect but cannot alone determine how to design and implement an appropriate governmental response. Until the capacity to respond is created, an unknown number of older Californians will continue to be abused and neglected by the very people who are responsible for providing their care.

FINDING #2 - Performance by the Department's Community Care Licensing Division Often Is Characterized as Arbitrary and Slow

The Commission has heard considerable testimony regarding the Department's arbitrary, inconsistent, and delayed implementation and enforcement of licensing laws and regulations. Applications for licensure are severely backlogged, and the Department's computer system does not appear adequate to allow the Licensing Division to overcome its weaknesses. According to the testimony of a representative of the Orange County Ombudsman Office:

We had an ombudsman who went in the field and found seven residents in a facility, and the facility was licensed for six; she told the owner that she was going to be reporting this.... When the ombudsman went to follow up a couple of months later, she found that [the licensee] had received an extension from Licensing...and was, for some period of time, going to be allowed to have seven residents in her facility. This [is] very difficult to explain to other owners, and it makes it very difficult for us to have any clout as well.

Local ombudsmen also report that the Department has closed facilities for little apparent cause--facilities where the deficiencies cited are not serious and where, in the opinion of ombudsmen, residents receive acceptable care. At the other extreme, the Commission has been apprised of cases involving failure to close facilities where serious deficiencies had not been corrected despite repeated notifications to licensees and where those deficiencies were considered serious enough to jeopardize the safety and well-being of residents.

Another performance problem in the Department's Licensing Division is that turnaround time for processing applications for licensure is extensive and is cited as contributing to the frequency with which potential licensees start operations before they have obtained a valid license. One factor delaying application processing is the requirement that fingerprints of all caregiving staff in the facility be checked for convictions. This process alone, undertaken by the Attorney General's Office, takes at least 30 days.

The Licensing Division's "Monthly Work Volume Report" tracks the number of applications received each month and the various dispositions of applications, but it does not indicate any time limit after which application processing is considered overdue. The figures for the first quarter of 1988 reveal that close to five times as many applications are carried over each month as are received. The figures in Tables III-3 and III-4 indicate a high volume backlog. Yet, the Department persists in claiming that its Licensing Division is adequately funded.

Table III-3

STATUS OF RFE LICENSURE APPLICATIONS
JANUARY-MARCH 1988

	<u>January</u>	<u>February</u>	<u>March</u>
Carried	524	470	470
Received	89	104	101
Adjusted	-22	-28	-5
Approved	-93	-61	-76
Denied	-4	-5	-4
Withdrawn	<u>-24</u>	<u>-10</u>	<u>-14</u>
Continuing	<u>470</u>	<u>470</u>	<u>472</u>

Source: Department of Social Services, Community Care Licensing

Table III-4

RESIDENTIAL FACILITIES FOR THE ELDERLY
AVERAGE MONTHLY NUMBER OF PENDING APPLICATIONS
1987

Under 90 Days	474
Over 90 Days, Within CCL Control	15
Over 90 Days, Outside CCL Control	<u>197</u>
Average Monthly Pending Applications	<u>686</u>

Source: Department of Social Services, Community Care Licensing

As Table III-3 illustrates, in February, the Department received 104 applications for RFE licensure alone, while only 61 were approved. For each of the three months, at least 470 were carried over. Table III-4 illustrates that the average number of applications pending per month is 686. These figures illustrate the need for the Department to address the backlog problem.

Chapter 154/Statutes of 1984 [AB 3474 (Wyman)], effective July 1, 1985, required the Department of Social Services to establish an automated information system on community care licensees and former licensees. While this has been accomplished, the Department's data processing capability does not allow it to collect or compile data flexibly to give managers the capability to focus on performance weaknesses.

This became evident to the Commission when the Department was unable to provide statistical information in summary form. The Commission requested the Department to provide the following summary information: number of

licensed beds by facility size and client population category, number of licensing enforcement actions by facility size, statistics on abuse citations and civil penalties, unlicensed facility investigation actions, and data on the timeliness of completed investigations. The Director of Social Services responded:

...[M]ost of the statistical information that you requested is either not maintained in the detail requested or is unavailable. To obtain the specific information you requested would require considerable time for each licensing office to manually compile data by review of facility files and licensing office logs.

...Information concerning turnaround time for processing applications and for conducting investigations of abuse or unlicensed operation is not available at this time. Such information is only available by reviewing facility files or district office logs.

...Information on citations of abuse can only be obtained by reviewing facility files maintained in each district office.

...Number of licensed beds for client groups is only available by manually counting from the computer list....

Clearly, if the Department is not able to produce information in response to a request from the Commission, it is unable as well to produce such information for its own internal use in evaluating its performance. It cannot identify bottlenecks so that problems can be resolved quickly, before poor performance by Licensing personnel contributes to degradation of the health and safety of residents.

The Commission's position in 1983 was that the Department should be able to target its monitoring and enforcement resources to problem facilities and vulnerable residents. More data are now available to the Department for this purpose--dependent adult abuse reports, for example--but the Department still has not adopted a strategy of preventive monitoring based on systematic data analysis, nor are its management information systems equal to such a strategy.

FINDING #3 - The Department's Enforcement Program Suffers from Underutilization of Penalties, Fines and Relationships with Local Law Enforcement Agencies

Fines for licensing violations in residential care facilities are much less than fines for similar violations in skilled nursing facilities. Of the fines that are assessed by the Department of Social Services (DSS), only half are actually collected. Moreover, the Department is not required to involve local law enforcement in cases of abuse and neglect within set time limits. Thus, coordination between DSS and local law enforcement agencies, on which the Department must rely to prosecute cases, varies dramatically. Without consistently enforcing the civil sanctions and effectively utilizing all law enforcement resources, the protection mechanisms established to insure the safety of elderly residents will continue to be ineffective.

When Licensing analysts find a deficiency, they normally schedule a plan of correction visit within 30 days to determine whether the deficiency was corrected (exceptions are made for a few kinds of deficiencies for which corrections can be demonstrated through correspondence). If the deficiency is not corrected, a civil penalty (fine) is imposed unless the problem is corrected by the time of the next visit. At the next visit, if the deficiency still is not corrected, the fine is determined to have been running from the date of the previous visit. The analyst eventually makes another follow-up visit to document the correction.

Because a license, once granted, is a property right conferring significant due process protections, licensees may seek administrative review or may go to court to dispute the Department's assessments. The Commission was told informally that, when an analyst has imposed a fine, licensees sometimes phone a district office licensing supervisor or send a letter to request reduction or elimination of a fine. Reportedly, such requests are informally granted. This practice clearly undermines enforcement.

Licensing fines--\$25 per day for less serious violations and \$50 per day for the more serious ones--are so low as to be treated simply as a cost of doing business, especially in the larger facilities. No dollar distinction is made in fines per day whether the facility is small or large--that is, whether failure to correct the violation is affecting five residents or 100 residents. Fines for licensing violations in residential care facilities are much lower than fines for licensing violations in skilled nursing facilities.

Skilled nursing facility fines, by contrast, are based on both facility size and the seriousness of the infraction. The least serious category of civil penalty is a "B" citation, which carries a penalty of from \$100 to \$1,000 per incident. "A" and "AA" citations, which carry penalties ranging from \$1,000 to \$10,000, are based on the probability that death or serious physical harm to a patient may result, or may have resulted, from the incident.

The Commission believes that penalties of \$50 per day are inadequate to deter serious violations. Moreover, methods used to collect fines once they have been assessed have resulted in a very poor collection rate. While it would seem to be an easy matter for Community Care Licensing to collect fines since it has the authority to deny the renewal of licenses when fines remain unpaid, in practice it is the Department's view that its fining structure would be perfect only if the Department collected no fines, because the Department uses the threat of fines to induce compliance.

As noted, the Department is authorized to refuse renewal of a license if the facility has an outstanding civil penalty but rarely takes this action, because the facility may continue to operate anyway until a hearing has taken place before an administrative law judge. Representing yet another enforcement challenge, the administrative hearing process routinely takes from six to nine months to complete. According to the Department, the time and expense involved can easily outweigh the collections objective.

Though licensees are required to put up bonds during the licensing process, these are surety bonds only, intended to cover any mishandling of residents' funds, but not to pay civil penalties. The provider community has observed that the Department is not serious about collecting fines and is content to keep churning out notices without trying to collect the money. Currently, civil penalties collected represent roughly half of civil penalties assessed and, for the most part, are paid voluntarily.

The Department relies on small claims court as its only recourse when fines go unpaid. Many small claims courts, however, have asked the Department to stop using them on a routine basis as a collections vehicle. Licensing analysts are not trained as collection agents, nor can they afford to spend their time on collections activity at the expense of fulfilling regulatory duties.

During the course of our study, the Department centralized the collections function in Sacramento. The Department now has begun filing pages of civil penalty notices at one time in small claims court in Sacramento. The Department also has begun to collect unpaid fines through income tax returns--an approach coordinated with the Franchise Tax Board.

The Department's emphasis on rectifying unsafe and deficient conditions is laudable. On the other hand, the force of a monetary penalty can be an effective tool to ensure compliance and to deter unwanted behavior. Unless it enforces regulations uniformly, however, the Department undermines its own mission and leaves itself open to charges of capriciousness.

The Department needs clear triggering mechanisms to involve local law enforcement agencies in abuse investigations and prosecutions on a timely basis. Currently, there is no requirement in law that these transactions occur within a specified time. A pattern of delayed investigations and prosecutions fails to promote licensees' compliance with the law. A representative of the Orange County Ombudsman Office testified, for example, about a licensee:

[He was] cited for no qualified staff on premises, facility over-capacity, residents retained and admitted requiring higher levels of care, myriad careproviders without health screening and/or fingerprinting, no resident records available, inadequate and spoiled food, personnel records constantly unavailable, and illegal use of restraints. During the latter half of 1987, this licensee was also cited for having the water turned off, the exits blocked, ill residents, the home needing repair, phone disconnected, cockroaches in the food, and required medication not available.

Although we were informed over a year ago that this home was being handled by Social Services' Legal Department, this licensee continued operating until, at her discretion a few months ago, she moved from her facility one day prior to a scheduled interview initiated as a result of our request to the Orange County Register newspaper to investigate conditions in this home. We felt that was the only way we were going to get her closed down. She is currently operating unlicensed.

The cooperation of local law enforcement agencies on whom the Department must rely to prosecute cases varies dramatically. The working relationships between the district licensing office and the City and County of Los Angeles exemplify the ideal. The testimony of the Deputy District Attorney for Los Angeles County provided the Commission with the following statistics:

Accounting for the fiscal year between July 1, 1986 to June 30, 1987, my section has handled another 60 matters--22 of those matters concerned residential care facilities. Criminal charges have been filed in six of those cases. During that period of time none of the criminal cases was completed. From July 1987 to the present, we have obtained convictions in three of those six cases. The cases involved operating residential care facilities without being licensed.

In one instance, which the City Attorney has referred to, we jointly prosecuted with the City Attorney an unlicensed residential care facility and collectively in that case obtained a jail sentence. In another instance, two defendants were convicted of operating an unlicensed care facility and received a probationary term of 190 hours of community service on condition not to operate a community care facility. In that instance, also, they were ordered effectively out of the business. Three cases are still pending.

The Deputy-in-Charge, Nursing Home and Dependent Care, Office of the District Attorney, Los Angeles County, has completed a comprehensive analysis of the sections of the California Health and Safety Code which pertain to residential facilities. His observations, appended in Exhibit H, include recommended code changes which would facilitate successful prosecution.

The Department recently has become more aggressive in completing administrative actions. During calendar year 1987, the Department revoked 329 community care licenses. Seven years previously, Licensing revoked only 10 licenses in one year. Of the 329 licenses revoked in 1987, 57 were residential facility licenses [CARCH:1988].

Law enforcement personnel, Ombudsmen, Adult Protective Services workers, and Licensing staff receive differing types and amounts of training and sensitization regarding interviewing elderly or dependent adult victims of abuse. Chapter 637/Statutes of 1987 [SB 526 (Mello)] authorized the Attorney General's Bureau of Medi-Cal Fraud to train State, district, health and social services personnel, and Ombudsman staff and volunteers to evaluate and document criminal abuse. This training supports coordination and systematic information-sharing among enforcement agencies.

Given the responsibility of monitoring residential care facilities to insure that minimum standards of health and safety are met, the Department of Social Services clearly has a very difficult job to do. The degree of difficulty, in fact, demands that the Licensing Division effectively utilize enforcement resources, including penalties and fines, and establish routine working relationships with local law enforcement agencies that produce prosecutions and convictions of residential facility owners whose negligence or abuse harms the residents in their charge.

FINDING #4 - Unlicensed Facilities Are Undeterred by Current Enforcement Efforts

The continued operation of unlicensed residential facilities for the elderly poses a threat to the safety and well-being of affected residents. Facility owners who choose to start operating without a license, perhaps as an economic decision in light of the significant costs associated with delays in licensure application processing, have no economic incentive to seek licensure unless the consequences of doing so are even more costly than waiting for approval.

To date, the Department has done little to detect unlicensed facilities. That the Department does not keep centralized records of unlicensed facility investigations and case dispositions is indicative of the low priority assigned to unlicensed facilities.

Another indication of the Department's inattention to this matter is the failure to produce periodically updated lists of licensed facilities for distribution to discharge planners. The Department is not obligated statutorily to produce or distribute such reports. The Department's position is that the burden is on the individual discharge planner to call Licensing and inquire about individual facilities. In effect, discharge planners are not able to check licensing status efficiently before making placements, despite Chapter 1096/Statutes of 1985 [AB 17 (Wright)], which required placement agencies to place persons in licensed facilities only and makes placement of clients in unlicensed facilities a misdemeanor.

Assembly Concurrent Resolution 133 directed the Department of Social Services, assisted by the Department of Consumer Affairs, to develop recommendations for telephone directory listings of licensed residential care facilities in the yellow pages and to convey these recommendations to representatives of all telephone companies in California. A check on the approximately 50 residential care homes listed in the January 1988 Sacramento Yellow Pages, however, showed that only one facility advertises itself as "state licensed," although the license number for that facility does not appear in the ad (see Exhibit H).

Unlicensed facilities pose potential dangers for residents. The Los Angeles City Attorney testified that during the course of a recent investigation, a multiagency task force found:

three elderly persons literally tied to their beds. One woman was found tied to the bed with bonds across the upper portion of her body and her feet were tied to the bed. In another bedroom, a woman had her nightgown tied to the bed and her feet were bound. The last elderly female was found in a rear bedroom tied at the torso and ankles. All were in a health condition that was in dire need of skilled nursing maintenance and care. Obviously, in a case of a fire, we could have had a very terrible disaster.

In order to execute the warrant, forced entry at that location was necessary. The investigators had to kick in the door which attests to the hazard that elderly residents were living under. Additionally, there was no nursing staff present at the location. As a result of

this investigation, all three locations were closed and the elderly residents were immediately removed. My office filed criminal charges stemming from two of the locations and the Los Angeles District Attorney's Office filed charges on the third location. The operator was sentenced to 90 days in jail after she pleaded to operating an unlicensed facility and endangering an adult.

A dramatic illustration that an unlicensed facility can pose a serious threat to residents was uncovered in November of this year, when the bodies of seven elderly residents were unearthed in the yard of a facility in Sacramento. The owner/operator of the home has been charged with murder of the residents and forgery of their social security and benefit checks. According to news reports, one social worker referred 19 people to the facility because the owner accepted people who were hard to place, stating that "she [the owner of the facility] was the best the system had to offer."

A representative of the Ombudsman program also testified to abuse and neglect in unlicensed facilities:

We had an unlicensed facility that was brought to our attention by Community Care Licensing. There was a woman in the facility that they asked the Ombudsman to assist in removing. The facility knew the Ombudsman was coming. When the Ombudsman got there, the resident was in a room that had nothing in it but two beds, and a door was cracked open just enough to let a little bit of light in. The woman was filthy dirty, her clothes were dirty, her hair was matted, there were boxes filled with newspaper stacked around the room, there was rancid butter and food particles on her bedside. She was able to get the woman out of the facility and into a licensed home where her hair had to be cut off, and when they went to move the boxes, there were maggots found underneath the boxes. This home still has residents.

The Commission's 1983 report recommended that a citation system be created for unlicensed facilities. In fact, since 1985, the Department has had authority to levy a fine of \$200 per day against facilities operating without a license, but formulation of the regulations that would put this system into operation is still "in process." Given the demonstrated potential for harm to residents in facilities operating outside the law, it is difficult to understand why the system is not yet in effect.

Representatives of DSS have stated that they work with an unlicensed facility to become licensed once it has been discovered. Many of the providers on the Advisory Committee see the situation as one in which there was not only no penalty for operating as an unlicensed facility but, in fact, a benefit: an unlicensed facility can operate and make money without going to the expense of compliance with regulations. Once the unlicensed facility is discovered, DSS speeds up the licensing process during which time the facility remains open without penalty.

A representative of Bay Area Advocates for Nursing Home Reform testified at the Commission's San Francisco hearing that, after visiting what was clearly a residential facility in San Francisco and being shown a hotel license, she phoned Community Care Licensing to report the facility as

unlicensed and was told that the Department "couldn't do anything." Though Chapter 1096/Statutes of 1985 [AB 17 (Wright)] requires placement agencies to report suspected unlicensed facilities to Community Care Licensing, the system cannot function as intended unless aggressive enforcement of laws against operating a residential facility without a license is the routine follow-up to such reports.

Means to identify unlicensed facilities exist but are not being used. For example, computer tapes listing more than three SSI/SSP residents at the same address could be run against lists of licensed facilities. Also, home health care providers could be required to report unlicensed facilities.

Investigating and prosecuting unlicensed facilities is difficult. But unprotected residents are paying the penalty for lax enforcement of laws against unlicensed facilities.

FINDING #5 - Case Management Services Are Not Systematically Available to Older Californians

In its 1983 report, the Commission found that residential facilities for the elderly were rarely visited by outsiders but that case management services were available to varying extents for the developmentally and mentally disabled. Five years later, case management services comparable to those provided for other vulnerable client populations still are not available to the elderly on a systematic basis.

Two recently issued reports--one prepared by the Administration, the other by the Legislature--raise the issue of the lack of case management services available to the elderly in California. The Health and Welfare Agency's (HWA's) report to the Legislature, A Study of California's Publicly Funded Long-Term Care Programs, noted that "upwards of 50 percent of the identified needs of the elderly and disabled clients can be met with" case management and personal care services. [HWA:1988]

California's most comprehensive case management and personal care services program for the elderly is the multipurpose senior services program (MSSP), which served 7,900 clients in 1986-87. As the HWA report observed:

It is not that the service system does not exist, although there is a question of statewidness for some elements of the system--particularly in the availability of case management services--the issue is rather one of how to better link services together in a more systematic and coordinated way. [HWA:1988]

The Senate Subcommittee on Aging and Senate Office of Research jointly issued in September 1988 their report, Conservatorship of the Elderly. The report recommends State licensure of "conservatorship and case management agencies" as a means of preventing unnecessary conservatorship by making case management services for seniors more widely available.

Comprehensive case management begins with an assessment of an individual's functional abilities. Having obtained information regarding a person's degree of functional impairment and resulting needs for personal assistance and health care, the case manager then works with the client to determine

his or her preferences, availability of financial resources, and availability of friends and family members to help make decisions and to provide supportive services such as transportation, assistance with shopping, or recreation. Ideally, the assessment process would be the basis for the decision to place an older person in a particular facility.

A representative of the Ombudsman program in San Francisco testified at the Commission's April 1988 hearing regarding the critical need for case management:

The trouble with the elderly in residential care statewide is there is not yet any comprehensive case management system available to those elderly. Consequently, once they're placed, they are forgotten and visited by an occasional Ombudsman and once every six months by a Licensing evaluator.... Where there is case management of clients in residential care, a lot of the daily problems are better monitored and conflict resolutions can occur almost immediately.

This witness's sentiments are representative of those heard over and over by the Commission, both in the hearings and at the Advisory Committee meetings. Another witness, a social worker with San Francisco General Hospital, pleaded:

...an individual [case manager is needed] to follow each individual client so they can advocate for the client, so that they can relocate the client if they're in a bad circumstance, so that they can help educate the administrator, not just about the general needs of the client, but the specific needs of this client and how to help this particular client.

The need for increased case management for the elderly has long been an expressed concern, and State government has undertaken several efforts to provide it. Among the programs currently administered by the Department of Aging are:

- o The multipurpose senior services program (MSSP), which operates under a Medicaid waiver to provide social and health services case management to Medi-Cal eligible seniors who are certifiable for placement in an intermediate care facility (ICF) or skilled nursing facility (SNF).
- o The Linkages program, which provides information and referral, assessment, and networking of services. This program has a more broadly defined client population and more preventive focus than MSSP, but its continued existence is uncertain.
- o "SEED" projects are trying to develop integrated intake and assessment models for multiple interagency long-term care programs, including those providing case management services.

These programs represent piecemeal measures, rather than a statewide system of multiple levels of case management services to tie together all the existing elements of the long-term care network for seniors and disabled adults. Private pay case management is available in metropolitan areas,

but the combination of public and private services at this point still does not add up to case management's being systematically available for seniors. Increased availability of case management services would ensure more frequent resident monitoring by case workers who have been trained to evaluate the health status and general well-being of the residents and to assess the quality of care offered in each facility. Lack of case management is a missing link that has prevented RFEs from being integrated into California's continuum of long-term care.

FINDING #6 - State Fire Regulations Do Not Recognize Residential Facilities as a Special Case

Residential facilities for the elderly are caught from both sides by State fire regulations. On the one hand, they face slow and fragmented enforcement of fire codes that delay licensing or make continued operation difficult. On the other hand, these facilities often are plagued by rigid interpretation of the codes that force them to make costly changes that alter the noninstitutional setting in residential facilities.

Because State fire regulations are interpreted individually by the approximately 1,200 fire districts and departments in California, provider associations note many inconsistencies in the way regulations are applied. In fact, inconsistencies have occurred in the same jurisdiction from one inspection to the next; what causes particular hardships for providers is to receive an opinion during construction that is later reversed.

The State Fire Marshal does not have authority over local fire jurisdictions. The State Fire Marshal can advise, but local fire districts and departments are responsible for enforcing their own, sometimes higher, standards.

Current State fire regulations lack an intermediate designation for community residential care facilities. Residential care facilities of more than six beds fall into the "I" (Institution) rather than the "R" (Residence) classification, which undermines the goals of community residential care. For example, the wide doorways and halls required for the "I" classification result in the institutional look of a hospital or nursing home. The inclusion of residents who use three- or four-pronged canes ("quad canes") or walkers in the fire code definition of "nonambulatory" results in unwarranted hardship for residents who are excluded from or required to leave the facility of their choice because the structural modifications required by the fire codes to provide for nonambulatory residents on other than ground floors are prohibitively expensive, even though these residents are capable of vacating the premises in case of fire. This problem is particularly acute in a community like San Francisco, where most residences have only a garage on the ground floor so that, in effect, all residents live on the second story.

Effective January 1, 1988, responsibility for tracking fire clearances for residential care facilities shifted from the State Fire Marshal's Office to the Department of Social Services. As a result, many of these facilities no longer receive annual fire inspections, and the fire safety of their residents may be compromised. Previously, the Department of Social Services looked to the State Fire Marshal's Office to follow up on fire

clearances for all residential facilities, regardless of jurisdiction. Since the State Fire Marshal's Office sought a fire clearance for each facility in the State each year, all residents were assured of annual attention to fire safety. Many local jurisdictions, however, do not require fire clearances after the original fire clearance is obtained, except when structural changes to the facility are made. Moreover, since the Department has no authority over local fire jurisdictions or history of a working relationship, the districts have no incentive to be prompt in processing fire clearances.

FINDING #7 - Small Facilities Lack the Special Oversight They Need to Function in the Residential Care Network

Small facilities are those licensed to serve six or fewer residents. These are the facilities commonly referred to as "board and care homes." The Commission's 1983 report outlined the importance of, as well as the problems unique to, the community care "subsystem" comprised of small facilities:

Throughout the period of this study, the Commission has received comments from diverse sources on the special set of problems that is associated with small community care facilities.... The "family setting" of the small facilities represents a tradition in therapeutic environments.... It is desirable now and will remain desirable for the foreseeable future to keep community residential care decentralized and to utilize the family care setting.... The large number of facilities available, the scattered site distribution of these facilities, and the diversity in levels of care available are all characteristics of the "small facilities subsystem...." [CCSGOE:1983]

One of the particular problems faced by licensees operating family setting residences, or board and care homes, is isolation. Burnout among caregivers is common, since in many instances the same caregiver is on duty 24 hours a day, day in and day out, 365 days a year. Conventional wisdom in the long-term care field--and, indeed, common sense--has it that burnout increases the likelihood that abuse of residents will occur. There is a great unmet need for respite care for administrators of family setting residences. Current regulations do not address this need, and the State's fiscal condition does not bode well for a change.

Licensing is particularly ill-suited as the sole regulatory program for family setting residences. Prior to enactment of the Community Care Licensing Act of 1973, board and care home operators were recruited. Currently, they are "self-selected" exclusively. Prior to licensing, social workers met one-on-one with board and care home operators as often as once a week to explain the particular care needs of individuals who would soon be moving in, to counsel the operators on support services available to them, and to listen to descriptions of incidents involving the residents so as to offer advice on how to handle similar situations should they recur. The loss of these relationships exacerbates the potential for adverse effects from the isolation that characterizes family setting residences.

In large facilities run by professional administrators, quality of care is mediated not just by the Department of Social Services, but by the norms and standards inherent in professional training, by the interactions of professional staff with both the nonprofessional caregiving staff and with the residents, and by regular traffic through the facility of vendors and delivery people, visiting health professionals, church groups and service clubs, and friends and family members.

Treating family setting residences as if the same apparatus used to regulate larger facilities will assure safe, high quality care in board and care homes is unrealistic. Furthermore, it deprives the residents in small facilities of the protections and quality assurances they deserve and rely on the State to provide.

Virtually no progress has been made since the Commission's 1983 report toward the goals clearly identified at that time to identify family setting as a residential care specialty and to recognize the significant value of these residences for their ability to provide cost-effective care in all geographical locations.

FINDING #8 - Quality Is a Low Priority in California's Residential Care Regulatory Program

Other than as a response to deinstitutionalization of State hospital patients, residential care in California has developed in a policy vacuum. Licensing alone cannot prescribe and monitor quality of care in the tens of thousands of residential care facilities throughout the state.

Factors contributing to the public sector's lack of interest in providing control over the quality of care in residential facilities include the State's: (1) lack of incentives ability to offer quality of care, (2) lack of training and other qualifications requirements for either administrative or caregiving personnel in residential facilities, (3) failure to assess on a routine basis the care needs of the residents, (4) regulations that discourage specialization, (5) lack of requirements for English-speaking capability, and (6) lack of adequate consumer education.

Lack of Performance Incentives

The nursing home quality improvement program in Illinois--referred to as "QUIP"--demonstrates that upgrading quality of care is possible when facilities have positive financial incentives to strengthen caregiving performance. In addition, the placement process has been used to great advantage in Illinois to reward excellent facilities (those which go beyond minimum standards of caregiving). At present, there are virtually no such positive incentives for residential facilities in California to provide higher than minimum standards of caregiving: the State does not offer additional reimbursement for attaining higher than minimum standards of health and safety or for providing higher levels of care, nor does it make referrals of prospective residents to high performance facilities.

In Illinois, skilled nursing facilities receive visits from "nurse-managers" who monitor individualized care plans prepared for patients and determine the number of stars earned by a particular facility.

The homes are rated on hundreds of criteria used to evaluate the individualized care plans, including the degree of involvement of family members with the residents and the extent to which the facilities help residents to become meaningfully engaged in the community. The head of a provider group in Illinois has commented that the QUIP program has led facilities away from a pattern of "paper compliance" and toward real concern about quality of care.

Although some aspects of the program are not feasible for residential facilities (for example, Illinois used Medicaid savings generated by closer monitoring to reward star-earning facilities with higher cash reimbursement), the success of the program clearly points to the possibilities of enhanced morale, sense of purpose, and quality of care for residents when positive incentives for improvement are available.

Licensing may be a necessary component in any quality assurance program but, by itself, it offers no positive incentives to residential care providers either to improve quality of care or to maintain high quality standards and conditions. Licensing alone also is not sufficiently "present" (other than once or twice a year for inspection visits), much less punitive, to deter the delivery of poor care or even to deter abuse and neglect. The lack of both positive and negative incentives constitutes a major weakness in California's residential care regulatory program.

Lack of Training and Other Qualifications Requirements

Administrators and licensees of residential facilities are required to take 20 hours per year of continuing education. No training requirements have been set for caregivers, however, despite the complexities inherent in meeting the comprehensive needs of residents. The caregiving skill gap is further exacerbated by the complete lack of formal education and experience requirements for administrators who are mandated to train the caregiving staff. The industry is without recognized career paths, further contributing to quality of care problems.

Quality in caregiving demands a complex set of skills and a broad knowledge base. For administrators there are six areas in which training and education are necessary to collectively constitute a "uniform core of knowledge" include:

1. Laws, regulations, policies, and procedural standards that impact the operations of residential care facilities for the elderly
2. Business operations
3. Management and supervision of staff
4. Psychosocial needs of elderly residents
5. Physical needs of elderly residents
6. Community services available to seniors

Previous proposals have recommended that administrators should receive a total of 20 hours of credit each year, 10 hours of which must be from areas 1, 2, and 3, and 10 hours from areas 4, 5, and 6. Exhibit I further breaks down each of the six main categories of the uniform core of knowledge into subcategories; it is worth reviewing if only to realize the breadth of information relevant to caregiving in residential facilities.

Administrators with fewer than 16 beds are not required to possess any academic qualifications whatsoever. For administrators of larger residential facilities, the existing academic and experience requirements, as shown below, are unlikely to promote high quality of care. Moreover, there is no formal means of verifying administrator qualifications as there would be if certification of administrators were required.

Table III-5

EDUCATIONAL REQUIREMENTS FOR RFE ADMINISTRATORS

	<u>College Education</u>	<u>Years of Experience</u>
Medium Facility (16 - 49 Beds)	15 Units	1
Large Facility (50+ Beds)	2 Years	3-4

There is a glaring discrepancy between requirements for residential facility administrators and requirements for nursing home administrators. Nursing home requirements are based directly on a medical model and therefore on the needs of the most frail. But residential facility administrators have a comparable need to understand and effectively manage the "community-based health services model" that has become the norm in RFE caregiving.

Other than training provided by administrators, the hands-on caregiving line staff are unlikely to be trained at all, nor are they required to be trained or to demonstrate caregiving skills to qualify for employment. Furthermore, training and education for either administrators or caregivers are not widely available. There is, however, at least one encouraging sign of progress: through the combined efforts of the Department of Aging, California State University/Chico, and CARCH, three hours per month of satellite TV programming targeted to residential facilities is being offered at 72 sites throughout California.

Current regulations also lack specific standards for residential facility supervision. For example, other than at night and in facilities with more than 50 beds, no minimum staffing ratio of caregivers to residents has been established. There is no regulation to prevent one licensee/administrator from supervising multiple facilities where he or she avoids more stringent regulation because each facility is licensed for well under 50 beds, although the total number of beds for which this individual is responsible may exceed 50.

Failure to Assess Care Needs

Many residents in RFEs may require higher levels of care than current law and regulations allow to be provided in community care facilities. Indeed, the Department's own recent survey of the health status of elderly residents revealed a much older and more frail population than anticipated.

Federal reimbursement to hospitals is now based on diagnostically related groups (DRGs), tying reimbursement directly to a patient's diagnosis. If the cost for a particular patient exceeds the designated amount, the hospital must absorb the additional cost. This has led hospitals in some cases to release patients less fully recovered than previously--the "quicker and sicker" syndrome. Consequently, lower cost facilities--skilled nursing facilities and residential facilities--are now taking in clients with more serious health conditions than they did previously.

By definition, residential facility clients are more vulnerable than the general population, and, understandably, they don't like to move. Thus, out of concern and affection for residents whose health is deteriorating, many facilities voluntarily enter a cycle of providing more care than current law allows to accommodate the wishes of residents and their families.

Existing law and regulations envision a population of well elderly, but that vision does not correspond with what is actually occurring. A recent legislative proposal, Chapter 1127/Statutes of 1985 [SB 185 (Mello)], would have required resident assessments and care plans to assure that placement was appropriate. In effect, this approach would standardize the availability of health care services in residential facilities for the elderly.

The Department of Social Services recently completed statewide training relative to care needs assessment. This training is designed to acquaint State licensing analysts with specific medical conditions that are or are not permitted within the scope of caregiving in a residential facility and to bring consistency to care needs evaluation. The Department's process stops short, however, of prescribing care or services for which the residents now have unmet needs.

Regulations That Discourage Specialization

As long-term care matures into a true continuum of options, the suppliers of care need to diversify to respond to special needs. To some extent, current law and regulations inhibit this process from taking place in residential care.

Alzheimer's disease sufferers, for example, often become sufficiently "gravely disabled" to require protective supervision and may have conservators (legally authorized decision makers) appointed for them under provisions of either the Probate or Welfare and Institutions Code. Apart from their dementia in the early stages, some individuals are healthy and do not require skilled nursing care. Victims of Alzheimer's disease tend to wander away from home, however, then become disoriented and unable to find their way back. Their disorientation makes them fearful and sometimes suspicious of and combative with people who try to help them.

Well elderly do not enjoy sharing residence with dementia patients, whose behavior can be disruptive, loud, and violent. Of special concern is the fact that dementia patients frequently are awake and restless throughout the night, depriving others in the house or facility of sleep.

Special training is available for teaching people how to manage the difficult problems associated with dementia and such staff are needed in facilities serving Alzheimer's disease patients. Because early dementia does not require skilled nursing care, residential care facilities, who specialize in serving dementia patients exclusively would be desirable.

Patterns of behavior among victims of Alzheimer's disease and other dementias have led to including placement in a locked facility in the definition of "protective supervision" for such persons. This practice, however, is a violation of current community care facility regulations. Section 87144 of Title 22 of the California Administrative Code reads in pertinent part as follows:

- (a) Each resident shall have personal rights which include, but are not limited to, the following:
- (b) To leave or depart the Facility at any time and to not be locked into any room, building, or on Facility premises by day or night. This does not prohibit the establishment of house rules, such as the locking of doors at night, for the protection of residents; nor does it prohibit, with permission of the licensing agency, the barring of windows against intruders.

During the course of the Commission's study, we learned of a facility in San Diego licensed as a residential facility for the elderly. Licensed to accommodate 64 elderly persons, the facility was developed to serve primarily persons with Alzheimer's disease and other dementias. At the time the situation came to our attention, seven such persons resided in the facility, all of whom were conservatees under the Lanterman-Petris-Short (LPS) Act. The facility intends to restrict its admissions to LPS conservatees. The Department, however, has notified the licensee that the facility is operating in violation of Section 87144(a)(6).

The facility has applied for a waiver of this provision, pursuant to Section 87118, which provides that the use of alternative programs and procedures or the conduct of experimental projects shall not be prohibited by the Department's regulations, provided that (1) the alternatives are carried out with "provisions for safe and adequate services," and (2) the licensee requests and is granted a written waiver by the Department.

At present, there are few options for the placement of persons who are gravely mentally disabled but who are otherwise healthy and do not require skilled nursing care. The lack of options reduces the "least restrictive alternative placement" goal in the LPS Act to merely an ideal. As we have seen, existing community care licensing regulations may occasionally have the unintended consequence of inhibiting or discouraging specialization which would expand the options for meeting the special needs of particular residential care clients.

Lack of Requirements for English-speaking Capability

It is imperative that each residential facility have a staff member available at all times who can communicate effectively in English; to understand Licensing regulations and requirements; to effectively

understand and communicate with residents and family members, Ombudsmen, Adult Protective Services workers, and State Licensing personnel; to comprehend medical and medication-related instructions; and, most importantly, to communicate effectively in case of medical and other kinds of emergencies. Currently, there is no requirement pertaining to English-speaking capability.

The Commission is supportive of the greatest possible variety of multicultural settings, recognizing the benefits to ethnically diverse residents. In no way should the finding of a need for English-speaking capability in a residential care facility for the elderly be construed as being at odds with this value. The issue arises strictly as a matter of protection for residents.

Inadequate Consumer Education

As a routine matter, there is no uniform process available to the public to help potential residents and family members locate high quality facilities. Recent unsuccessful legislation would have called upon the Department to publish a comprehensive brochure to include:

...guidelines highlighting resident health and safety issues to be considered in the selection of a residential care facility for the elderly, locations of the licensing offices of the State Department of Social Services where facility records may be reviewed, types of local organizations which may have additional information on specific facilities, and a list of recommended inquiries to be made in the selection of a residential care facility for the elderly....

Consumer education is necessary to further complement the placement process. There will be rapidly accelerating needs for all of these services as the population of California becomes a more aged one.

FINDING #9 - Emergency Relocation Procedures Are Not Standardized and Are Underfunded

There is no State-level policy on or protocol for emergency relocation of community care residents, but local government is more or less expected to support this activity in times of crisis. Local ombudsmen report scenes of chaos and trauma when conditions are so threatening to the well-being of residents that the Department determines particular facilities must be closed at once and the residents must be transferred. Because relocation procedures or guidelines are not provided by the State, orchestrating such a transfer becomes the responsibility of local ombudsmen and local placement authorities, usually a county's Adult Protective Services unit. Moreover, since many counties do not have Adult Protective Services on call at night or on the weekends, the safety of residents living in community care facilities may be jeopardized.

Funding for Adult Protective Services is consolidated into "County Services Block Grant," which also funds in-home supportive services (IHSS) case assessment, social work staff development (for all children and adult programs), and information and referral. In 1987-88, funding levels for this block grant were 24.7 percent behind the consumer price index since

1983-84, with increases directed only to IHSS caseload growth, making emergency response a desperately underfunded area of service delivery.

At the Commission's San Francisco hearing, the State Ombudsman testified:

Sometimes, there is no provision for emergency care and shelter for residents when the caretaker is taken ill or leaves the home. On several occasions during the last year, the Ombudsman Program Crisis Line has been contacted and asked for assistance because there was no caretaker in a facility--usually this has been at night or on a weekend. Many counties have no Adult Protective Services workers on call and Licensing offices are closed.

The current county-level emergency response capability is no match for the incidence of elder abuse and abandonment in residential care facilities. Lack of adequate funding precludes the availability of basic public safety personnel and programs in the evenings and on weekends.

FINDING #10 - The Costs of Providing Residential Care Are Not Documented by the State

In California, the Governor and the Legislature are under pressure from the growing senior population to expand long-term care services at a much faster rate than the constitutionally governed increase in the overall appropriations limit permits. During the first half of the current decade, real spending on programs for seniors rose by 6 percent. During the same time period, the over-60 population increased by 26 percent. California's appropriations limit (the "Gann limit") exacerbates state government's inability to respond to needs for long-term care because the costs of creating and sustaining that system would require that State spending exceed the limit (this situation is illustrated graphically in Exhibit F).

As of September 1987, about 19,700--or 25 percent--of California's residential facility residents were SSI/SSP recipients [CSSP:10]. Whether current SSI/SSP rates cover the costs of residential care is unknown. The California Association of Residential Care Homes (CARCH) believes that many small homes cannot afford to accept SSI/SSP clients. CARCH estimates the actual monthly cost per client is nearly double the current residential care rate of \$678 (this rate reflects an increase which becomes effective January 1, 1989) and lobbied last year to increase the rate to \$990 per month (\$891 for room, board, care, and supervision and \$99 for personal and incidental expenses). No increase was approved.

The Commission does not fully accept CARCH's cost estimate of approximately \$1,200 per resident per month, because that estimate includes the full mortgage payment for a six-bed, owner-operated residence. The Commission believes the mortgage payment paid by a resident operator cannot be legitimately viewed entirely as a cost of operating the facility.

A recent legislative proposal (SB 50) would have established supplements to SSI/SSP payments to support higher levels of intensive nonmedical personal care or health-related services not presently available in residential facilities for the elderly. The proposed supplemental rate for the higher level of care was \$220 per month. If implemented statewide, the

Legislative Analyst estimated the General Fund costs of this measure would have been approximately \$22 - \$25 million annually. Due to the projected fiscal impact of SB 50, the Governor advised the Legislature he would veto the bill.

At the Commission's San Francisco hearing in April 1988, an owner/administrator of an 89-bed residential facility in Stanislaus County testified as follows:

Rates for care should directly reflect the people of the State of California's desire to see their elderly cared for appropriately.... If you want excellent care, pay excellent rates. If you will accept lousy care, pay lousy rates. But please don't demand excellent care and not give providers the tool they need to provide it.

The same logic asserts itself in the 1988-89 Perspectives and Issues report from the Legislative Analyst's Office. The Analyst discussed the difficulty of developing a coherent long-term care policy due to the aging of the population and the pressures the size of this group will create to increase expenditures for long-term care services. To meet the needs, long-term care expenditures would have to increase at a much greater rate than the rate of growth in the overall State appropriations limit. Such increases would have been unlikely in any case, but the passage of Proposition 98 in November 1988 (guaranteeing State spending on public schools as a constant percentage of total State spending) makes increased spending for long-term care impossible.

The fiscal options identified by the Analyst do not hold great promise for enhanced quality of care in residential facilities. Those options are as follows:

- o Increase funding for long-term care services by (a) redirecting funding from other public programs to long-term care, and/or (b) expand the use of alternative sources of funding, such as federal funds or private health insurance.
- o Limit the level of services available to the population in need of long-term care.

The second of these two options, limiting the level of services available to the long-term care population, is clearly not viable, either in terms of the associated human cost of potential abuse, neglect, or suffering or in terms of the need to meet at least minimum standards of health and safety that the State itself has already mandated.

If the industry is correct in asserting that the SSI/SSP residential care rate is too low, it could mean that administrators are unable to hire well-trained caregivers because they cannot afford to pay more than minimum wage. Special dietary requirements may be so costly that residential facilities cannot accept SSI/SSP residents who need extraordinary foods or special preparation of meals. Amenities that would make old age more pleasant and comfortable, such as air conditioning, may not be feasible on a bare bones budget. The administrator of an owner-operated facility may not be able to afford time off. Not being able to get away on a regularly

scheduled basis from a demanding and stressful caregiving regimen contributes to the likelihood that a tired administrator will neglect, abandon, or abuse the residents.

Part of the problem is that the State has not developed the capacity to estimate or measure the cost of providing residential care. Consequently, there is no source of information from within State government that can become a basis of comparison with the claims of provider groups. The resulting annual arguments over rates tend to obscure the issue, which is that residential care is a necessary component of California's long-term care system.

It is neither feasible nor desirable to care for the same client population in more expensive and restrictive intermediate care or skilled nursing facilities. The State needs to know how much it costs to provide regulated levels of service in residential care facilities so that the rates paid by the State to buy those levels of service will assure that services are available to those individuals who qualify.

FINDING #11 - Private Funding Mechanisms Are Too New and Untried to Relieve the Public Sector's Financial Burden

The demographic picture of an increasingly aged population clearly indicates the rapid acceleration in long-term care expenditures that Californians can expect to make, whether publicly or privately. For working, middle-income children, the cost of maintaining an elderly parent in a residential care setting becomes increasingly burdensome over time because payments for long-term care represent a continuing drain on their disposable income. Price increases may be impossible for them to meet.

While many corporations offer generous benefits to their employees, eldercare is still unusual in an employee benefit plan. A May 1988 survey of personnel managers found that a 67 percent majority felt that eldercare deserves attention, but few of those surveyed indicated they have considered offering eldercare as an employee benefit. Many corporations are only now offering to help pay child day care costs.

There is little public awareness of the need for long-term care financial planning. Currently, only about two percent of long-term care costs in California are paid for from private insurance; and nationally, only a few hundred thousand people are covered by long-term care insurance. Furthermore, many policies available at the present time cover only skilled nursing care and private limited coverage. The California Legislature recently passed legislation prohibiting long-term care insurers from offering benefits for skilled nursing care only [Chapter 1328/Statutes of 1988 (SB 170/Mello)]. In addition, the National Association of Insurance Commissioners is proposing changes in its long term care policy that would eliminate many of the restrictions in coverage that make it difficult for policy holders to collect any benefits. These provisions include: (1) coverage for a minimum of 24 consecutive months; (2) no requirement of prior hospitalization; and (3) no cancellation on the basis of age or health of insured.

Long-term care plans similar to IRAs for investment-minded consumers are under consideration by the federal government, but such plans are likely to be expensive due to inflation of health-related costs.

In short, funding available from private sources is dwarfed by the numbers of people needing services and by the costs of this care. Approximately 25 percent of all elderly residents in residential facilities are SSI/SSP recipients. The other 75 percent are private pay residents who may be exhausting their life savings or depending on support from relatives whose ability and willingness to continue paying may be both time-limited and price-sensitive.

IV. CONCLUSIONS AND RECOMMENDATIONS

Despite various improvements over the last five years, California's system of residential facilities for the elderly is not structured to guarantee that acceptable care will be provided. The Commission's findings are supported by estimates made by California's Long Term Care Ombudsmen. Ombudsmen for Stanislaus and San Joaquin Counties rated 10 percent of the facilities in their counties as good, 70 percent as mediocre, and 20 percent as substandard. In Sacramento County, Ombudsmen indicated that 20 percent were good or excellent, 30 percent were mediocre, and fully 50 percent were "substandard and unlivable".

Licensing of residential facilities for the elderly stresses the business relationship of the licensee to the client. While the Department of Social Services' monitoring of compliance with minimum standards of care is necessary and desirable, current regulation neglects more client-centered elements of care necessary to ensure their well-being. Trained, concerned "eyes and ears" should be available to observe residents and conditions in residential facilities on a regular basis, to spot and address potential problems before they become unmanageable. The State must be able to offer positive incentives to licensees to upgrade the quality of care above minimum standards. Residential care, as a system, must provide informed, concerned placement counseling to prospective residents and their families.

Limited case management and service coordination have long been accepted in California as necessary for developmentally disabled and mentally ill individuals residing in community care facilities. Similar services are needed to ensure the well-being of elderly community care residents.

Significant problems in residential care require significant State action. These problems include: insufficient training for caregivers, lack of certification of administrators, ineffective performance in several crucial areas by Community Care Licensing, the continued operation of unlicensed facilities, inconsistent application of fire regulations, arbitrary enforcement of licensing laws and regulations, insufficient funds for emergency services, and an inadequate reimbursement structure for SSI/SSP recipients.

The State must face the problem of who will pay for the care of the elderly as fewer taxpayers are available to support services for a larger and larger elderly population. The cost to society, families, and older Californians themselves will be overwhelming unless realistic financial planning and incentives to invest and save are developed and applied to the cost of long-term care.

Provision of support must not and cannot be a concern solely of the government. Innovation must be forthcoming from the private sector to help the public sector address the crushing cost burden of long-term care.

RECOMMENDATIONS

The Little Hoover Commission recommends that the Governor and the Legislature take the following specific actions to address the problems identified in this study of California's residential facilities for the elderly.

1. Certify Residential Care Facility Administrators

- A. The Governor and the Legislature enact legislation to require certification of on-site administrative personnel in residential facilities for the elderly. One of the most direct paths to upgrading the quality of residential care is to specify education and training requirements for facility staff and to take steps to ensure that the necessary education and training will be available. Without education and training opportunities specific to administration of and caregiving in residential facilities, the establishment of career paths in residential care is not possible. Certification should be developed relative to the special needs of particular client populations and for specialized residential care functions.
- B. The State agency responsible for this certification should be the Board of Examiners of Nursing Home Administrators (BENHA), expanded to become the Board of Examiners of Long-Term Care Administrators (BELTCA).
- C. Certification should be a requirement of licensure for all new applicants and, following a three-year phase-in period, for all renewals.
- D. Any new State funds made available to supplement reimbursement for SSI/SSP residents should follow only those residents in facilities operated by administrators certified in a relevant specialty.
- E. Certified personnel should be required to pass qualifying examinations in competencies related to the residential care specialties for which they seek certification. The exams should be based on a core of knowledge to be established by BELTCA.
- F. The unique advantages of family setting residences (six beds or fewer) should be retained by tailoring certification for family setting administrators to require their participation in "self-help" programs that (1) provide respite care opportunities for participating administrators, and (2) establish ongoing, structured processes to achieve resolution of problems unique to small facilities. Family setting administrators should receive continuing education credits for participation in BELTCA-approved self-help programs.
- G. The Governor and the Legislature enact legislation to upgrade current continuing education requirements by:
 - o Specifying a minimum number of hours per year for each personnel classification in residential facilities (see Recommendation #6(c) regarding residential care personnel classifications);

- o Requiring all personnel classifications to complete the specified number of hours of continuing education every year; and
 - o Requiring administrators to maintain accurate and up-to-date records on continuing education credits earned by every staff person in the facility.
- H. The Governor and the Legislature enact legislation that would establish a recognizable career path for staff in residential care facilities to include the following:
- o Authorize creation of gerontology career programs specific to residential care at the community college level;
 - o Mandate that the University of California and California State University and College systems require gerontology and social welfare students to include coursework in residential care as a degree requirement; and
 - o Authorize and fund internship programs to recruit individuals training for careers in medicine, nursing, dentistry, dental hygiene, social work, or psychology to apply their specialized training for the benefit of residents in long-term care settings.
2. Authorize and Fund Counties, at Their Option, to License Small Residential Care Facilities and Provide Placement Counseling and Assistance

The Commission recommends that counties be offered the option of licensing small residential care facilities. One of the services offered by many counties in their Adult Protective Services (APS) programs is "out-of-home care." This service has disappeared from some county welfare departments due to underfunding but, where it still exists, it frequently entails having APS social workers recruit local residential care facility administrators to provide temporary shelter for abused or neglected adults. Through this process, the APS social workers become familiar with the homes in their counties; this familiarity could be instrumental in helping prospective permanent residents and their families in selecting an appropriate facility.

The larger counties, through agreements with the Department of Social Services, already are in the business of licensing foster family homes for children. Licensing small residential care facilities for adults would constitute an extension in their scope. Exercise of this option would give counties better control over conditions in these facilities and would give the facilities access to a source of regular referrals.

3. Identify New Revenue Sources from Which to Increase Funding for Residential Care for the Elderly
- A. The Commission recommends that the Governor and the Legislature direct the Secretary of Health and Welfare and Director of Finance to identify potential new revenue sources from which funding for residential care for the elderly can be increased. State government

in California must confront the problem of who will pay for the care of the elderly when there are fewer younger taxpayers every year relative to the older population. The costs to society, families, and older Californians themselves will be catastrophic unless realistic financial planning and incentives for investment and savings are developed now. The Commission believes that the public sector alone cannot manage this burden. California needs a public-private partnership to ensure that elderly or dependent adults are cared for properly, now and in the future. The prospect of new costs in the millions of dollars caused the Administration to reject recent legislation that would have established supplemental SSI/SSP reimbursement for higher levels of care in RFEs. Yet, in its September 1988 report on long-term care, the Agency acknowledged that "additional resources and the expansion of program services to meet the needs of the State's growing frail elderly and disabled populations will be required." [HWA:1988]

- B. The Department of Personnel Administration should widely publicize and educate workers about its Dependent Care Assistance program, which allows State workers to pay for care for elderly dependents with tax-free portions of their salary. In addition, the Department should develop and propose other prototype eldercare benefit plan options for workers.
- C. The Department of Personnel Administration should develop and propose a benefits plan available to all State employees which includes the option to purchase long-term care insurance and a financial incentive to exercise that option before age 50.
- 4. Improve Effectiveness of Monitoring and Law Enforcement

The Commission found a number of flaws marring the effectiveness of State efforts to enforce licensing laws and health and safety regulations pertaining to residential facilities, which the following recommendations are designed to eliminate:

- A. The Department of Social Services should assemble a task force including representatives of the Long-Term Care Ombudsman Program, Adult Protective Services, and the California Association of District Attorneys to:
 - o Develop clear, concise definitions of elderly abuse and neglect;
 - o Establish clear procedures and role definitions for all affected agencies to enable timely response to and substantiation of cases of abuse and neglect;
 - o Train appropriate personnel from all affected agencies; and
 - o Standardize prosecution procedures throughout the State, including time frames for completion of each phase of investigation and prosecution.

- B. The Governor and the Legislature should enact legislation to make civil penalties for violation of licensing laws and regulations substantially more punitive. Department of Social Services should be required to evaluate the relative seriousness of various kinds and combinations of violations and recommend to the Legislature commensurate penalties.
- C. The Governor and the Legislature should amend Sections 1543 and 1569.43 of the Health and Safety Code to authorize all local prosecutors, rather than only district attorneys, to "independently" prosecute violations of law and regulations relative to residential facilities for the elderly. (Exhibit I provides additional code amendments needed to ensure that abuse and neglect of residents will be prosecuted more aggressively.)
- D. The Department of Social Services should work with the California District Attorneys' Association to develop a strategy to enforce current law which makes it a misdemeanor for discharge planners to place clients in unlicensed residential care facilities. This strategy should begin with the Department's publication of quarterly listings of the licensing status of all known facilities.
- E. The Medi-Cal Fraud Unit of the Attorney General's Office should be expanded to investigate abuse and neglect in RFE in addition to its current investigations of skilled nursing facilities.
- 5. Launch a Well-Coordinated Campaign to Detect and Eliminate Unlicensed Facilities

Distressingly little effort is currently made to deter operation of unlicensed facilities. The Commission believes that effective deterrence is possible only through a State-and-local partnership between licensing and law enforcement agencies that combines economic disincentives with stringent penalties for noncompliance with laws requiring licensure. To that end, the Commission offers the following recommendations:

- A. The Governor and the Legislature should enact legislation to substantially increase fines for operating residential care facilities without a license. Fines should be set on a per bed per day basis.
- B. The Governor and the Legislature should enact legislation to require the Department of Social Services to cooperate with local prosecutors to plan and publicize a six-month amnesty period for existing unlicensed facilities, during which time such facilities could apply for licensure without penalty.
- C. Post-amnesty, the Department and local prosecutors should pool resources to implement an aggressive and well-coordinated program to detect and eliminate unlicensed facilities. This program should include but not be limited to:
 - o Checking tapes for three or more recipients living at the same address and making follow-up investigations;

- o Checking yellow pages and other advertisements against records of licensed facilities;
- o Collecting maximum fines from administrators of confirmed unlicensed facilities; and
- o Creating a provisional license option for any unlicensed facility administrator whose application is not approved within 60 days, provided the applicant is making all reasonable efforts to satisfy requirements for licensure.

6. Strengthen Current Law and Regulations Pertaining to Resident Protections

Existing law and regulations are insufficient to protect the rights and safety of residential facility residents. The Commission believes the following changes are needed to correct these weaknesses:

- A. Amend regulations to require that someone who speaks and understands English is on the premises at all times in every residential facility, regardless of size, such capability is essential to being prepared for emergency situations.
- B. Implement current law requiring the Department of Social Services to develop and train administrators to use a resident assessment instrument.
- C. Enact legislation to require the Department of Social Services to analyze resident assessments and, on the basis of such analysis, to define all levels and classifications of administrative and caregiving staff required to meet the identified needs of residents and to establish in regulations appropriate staffing ratios for all personnel classifications in residential facilities.
- D. As an interim measure prior to implementation of administrator certification, enact legislation to require the Department of Social Services to develop a written exam designed to test licensure applicants' knowledge of regulations and ability to administer the Department's resident assessment instrument. Require the Department to determine an acceptable level of performance on this exam to serve as a condition for licensure (including renewals).
- E. Enact legislation to require the Department of Social Services to publish a quarterly listing of licensed residential care facilities, alphabetically by Licensing district, and to distribute this listing to all long-term care ombudsman programs in each district and all subscribing placement agencies. This listing should include a report of facility-by-facility citations issued for life-threatening conditions and other serious violations. It should report any failure to renew licensure and all revocation and suspension actions taken by the Department in each district during that quarter.

- F. Enact legislation to require all residential care facilities to include their license numbers in all advertising, including ads in the yellow pages of local telephone directories.
- G. Require the Department of Social Services to report to the Legislature during deliberations on the 1989 Budget Act on its progress in completing and distributing a consumer guidelines brochure for persons who are "shopping" for a residential facility.
- H. Enact legislation to require the Department to develop a written notice for the purpose of informing prospective residents that licensing analysts' inspection reports on all facilities are on file and available for public review in the nearest district office of Community Care Licensing. The Department should establish in regulations the requirement that all facility administrators provide this written notice and the address of the district office to all prospective residents.

7. Develop Protocols for Emergency Services Coordination

Closing a residential facility, although drastic, is occasionally necessary due to threatening conditions in the facility or refusal of the licensee to comply with law and regulations. In this event, the residents suffer the hardship of often unwanted relocation. The importance of achieving this transition as smoothly as possible cannot be overstated, given that many residents in these circumstances are already weakened and traumatized by the poor care they have been receiving. The Department of Social Services relies heavily in these situations on assistance from local emergency services, such as county adult protective services and law enforcement agencies, which is appropriate because local agencies are more familiar with alternative facilities in the community and the availability of support services. It is clear, however, that local agencies need guidelines for meeting the needs of facility residents in times of crisis.

The Commission recommends that the Governor and the Legislature enact legislation to require the Department of Social Services to develop written protocols for emergency services coordination specific to crises involving facility closure. These protocols should include:

- A. The Department's responsibilities to develop working relationships with local emergency service agencies;
- B. The roles of specific local emergency service agencies in the event a residential facility for the elderly must be closed and the residents transferred to other facilities in the community; and
- C. Step-by-step procedures that the Department and local emergency service agencies will follow in order to accomplish the transfer of residents with minimum confusion, including but not limited to assignment of responsibility for:
 - o The development of written relocation plans which include the address and contact information for individual residents' future homes; and

- o Contacting the residents' relatives or other persons to be notified of emergencies on the residents' behalf, as noted on admission agreements maintained by the facility administrator.

8. Develop a Waiver Application Procedure for Requesting Permission to Operate a Locked Facility

The promise of "least restrictive alternative" is explicit in current law regarding care for the "gravely disabled," but it is not met by forcing individuals who need protection from their own tendency to wander to be placed in nursing homes or other facilities offering higher levels of care than they need. The Commission believes the unmet need for locked facilities at levels of care lower than skilled nursing could be filled at least partially by granting to residential care facilities that meet specified conditions a waiver of Section 87144 of Title 22 of the California Administrative Code, which ensures all residents' right to leave a community care facility at any time. We recommend that the conditions such facilities should be required to meet include, but not be limited to, the following:

- A. Accept only residents who require the protection of living in a locked facility;
 - B. Develop each resident using a standardized assessment instrument to determine the resident's degree of functional impairment and, on the basis of the assessment, develop a written individualized care plan indicating the resident's need for placement in a locked facility;
 - C. Train staff to provide care to the target client population. Staff must be present on the premises at all times; and
 - D. Meet staffing ratios established by the Department of Social Services. These ratios should be appropriate for the particular client population.
9. Upgrade the Department of Social Services' Information Management Capabilities

The existing management information system used to monitor residential facilities for the elderly is inadequate to enable the Department effectively to monitor approximately 3,500 residential facilities serving nearly 80,000 residents. Therefore, the Commission recommends that the Governor and the Legislature authorize the Department to modernize its computer equipment and information processing capabilities. Specifically, the Department must be able to perform certain analyses, including but not limited to compiling aggregations of:

- Types of violations, by facility size (number of beds);
- Enforcement actions, by types of violations;
- Enforcement actions, by facility size;
- Turnaround time for licensure applications; and
- Turnaround time for complaint investigations, including reports of abuse and neglect, and investigations of unlicensed facilities.

These types of analysis are necessary to enable the Department to target its enforcement resources to facilities that are statistically most likely either to pose dangers for the residents or to be operated by administrators who need prodding in order to comply with regulations. In addition, the Department should be using commercially available computer software to generate a schedule of Licensing analysts' periodic visits to facilities in a pattern that is more random than the current visitation pattern. Random visitation would be more likely to give Licensing analysts an opportunity to observe routine facility operations and conditions.

10. Develop Fire Safety Regulations Specific to Residential Care Facilities

Over the course of the Commission's study, providers and residents alike complained about inappropriate and inconsistent enforcement of the State fire code and regulations pertaining to residential facilities. Problems stem from the existing definition of "nonambulatory," classification of residential facilities as "institutional," and decentralized, idiosyncratic enforcement of State regulations by California's 1,200 local fire districts.

To bring fire code enforcement into better alignment with the nature and needs of residential facilities, the Commission offers the following recommendations:

- A. The Governor and the Legislature should enact legislation to amend Section 13129 of the Health and Safety Code to exclude individuals who use walkers and quad canes from the definition of "nonambulatory."
- B. The Governor and the Legislature should enact legislation to create an intermediate fire code designation between "R" (residence) and "I" (institution) to apply specifically to residential facilities meeting facility standards established in Community Care Licensing regulations.
- C. The Department should advise all residential care licensees of informal resources available from the State Fire Marshal's Office to help licensees resolve disputes with local fire jurisdictions.
- D. The Governor and the Legislature should order a transfer of responsibility for tracking residential facility fire clearances from the Department of Social Services back to the State Fire Marshal.
- E. The Governor and the Legislature should enact legislation to authorize the State Fire Marshal to make rulings and handle appeals regarding local interpretation of fire safety code and regulations related to residential facilities for the elderly.

E X H I B I T S

EXHIBIT A

WITNESSES WHO TESTIFIED AT COMMISSION PUBLIC HEARINGS

February 26, 1988 - Santa Ana

James Hahn
Los Angeles City Attorney

Roderick Leonard
Deputy District Attorney
Los Angeles County

James Biesner, Deputy Coroner
Orange County

Dr. Deborah Newquist
Gerontological Services of
Orange County

Pam McGovern
Orange County Long-Term
Ombudsman

Barbara Scott, Provider
Licensed Residential Care
Facility

Barbara Chilow, Administrative
Manager
Mental Health Department
Orange County

Pete Alexander, Vice President
American Retirement Villas

Lindajo Goldstein, Investigator
Audits & Investigations
Department of Social Services

Bill Thomas, Operator of RFE and
President of CARCH-Local Chapter

Henry Ford, Staff
Assemblyman Bill Bradley

Fran Christine Guest
Community Care Licensing
Department of Social Services

Fred Miller, Deputy Director
Department of Social Services

O. V. Smith, President
Society of California Care Providers

Charles W. Skoien, Jr.
California Associations of
Residential Care Homes

Linda Dean
Orange County Long-Term Ombudsman

David Valdez, Consultant
Department of Health Services
Medical Field Office, San Jose

Bob Ford, Administrator/Operator
Residential Care Homes for Children

Dennis McDaniel
Smith's Residential Care Homes and
Golden's Residential Retreat

Alan Pearson, Operator of RFE and
Vice President of CARCH-Santa Cruz

Patricia Copass, Administrator
Liberty Health Center-Irvine

Ellen Pratt, Owner/Operator
Residential Care Home in Hayward

Elizabeth Hallihan, Operator
Residential Care Home and
Vice President of CARCH-Orange Co.

April 29, 1988 - San Francisco

Pat McGinnis, Executive Director
Bay Area Advocates for Nursing
Home Reform

Michael Coonan, Long Term Care
Ombudsman-Sacramento Patients'
Rights Advocate

Derrell Kelch, Executive Director
California Association of Homes
for the Aging

Charles Monedero, Chairman
Residential Care Conference for
the Elderly, CAHF

Betty Dahlquist, Executive
Director
California Association of Social
Rehabilitation Agencies

Charles Skoien, Executive
Director
California Association of
Residential Care Homes

Elaine Harrison, Representative
McCormick Foundation Parents'
Guild

Alan Pearson, Operator
Residential Care Home-Santa Cruz

Saul Bernstein
Residential Care Owners Assoc.
Los Angeles

Bill Ott, Provider

Robert Surler, Chairman
Residential Care Task Force-
San Francisco

Paul Rempen, Operator
Residential Care Home-Santa
Clara County

Marvin Navarro
Family Members of Residents in
Convalescent Hospitals-San Francisco

Sterling Boyer, State Ombudsman
Department of Aging

Pat Nobis, Founder/President
San Francisco Association of
Residential Care Homes

Cathy Taylor, Representative
California Association of Health
Facilities

Hannah Hamovitch, Director
Jewish Family Services-Los Angeles

Kathy Badrak, President, LTC
Ombudsman Association-Santa Barbara

Kregg Miller, Administrator
Las Palmas Estates-Turlock

John Savoy, Operator
Care Home-Santa Maria

Kathleen Vogel, Administrator
Residential Care Home-Carmel

John Riggs, Coordinator
Case Management/After Care Service
Community Mental Health Services-
San Francisco

Benson Nadell, Coordinator
Long Term Care Ombudsman Program-
San Francisco

Gale Wright, Assistant to Director
Department of Social Services
Community Care Licensing

Terrie Kelly, Administrator
Residential Care Home-San Francisco

Dr. Eugene Gaenslen-San Francisco

EXHIBIT B

LITTLE HOOVER COMMISSION
COMMUNITY RESIDENTIAL CARE ADVISORY GROUP

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Mr. Gresham Roskamp
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EXHIBIT C

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

FACILITY EVALUATION REPORT
RESIDENTIAL FACILITIES — ELDERLY

DISTRIBUTION:
Original: Agency
Duplicate: Facility
Triplicate: Review

REFER TO:

This form is to provide a written report for site visits to residential facilities - Elderly.
See other side for further explanations.

FACILITY NAME		FACILITY NUMBER		CAPACITY / CENSUS	
ADDRESS (NUMBER, STREET,		CITY,		STATE, ZIP CODE)	
DATE		TIME VISIT BEGAN		TIME COMPLETED	
TYPE OF VISIT		<input type="checkbox"/> Prelicensing		<input type="checkbox"/> Evaluation	
		<input type="checkbox"/> Follow-up			
NAME OF PERSON CONTACTED		MET		*NOT MET	
				NOT RE-VIEWED	
1. 87206(a)(e) - Facility is clean, safe, sanitary and in good repair.					
2. 87206(b) - Proper heating and cooling temperatures maintained.					
3. 87602(a) - Living accommodations and physical plant meet requirements.					
4. 87134 - Telephone service maintained on premises.					
5. 87206(i) - Signal system meets specified criteria.					
6. 87406(a) - Appropriate fire clearance maintained.					
7. 87602(b)(c) - Sufficient toilets and bathing facilities.					
8. 87206(e), 87602(d)(e) - All persons are safe from hazards.					
9. 87604(a)(b) - The quality and quantity of food served is adequate.					
10. 87604(b)(26) - Adequate supply of staple and perishable foods on hand.					
11. 87604(b)(15)(23)(28) - Food is protected against contamination.					
12. 87604(b)(24)(25) - Soap and toxic substances are properly stored.					
13. 87604(b)(27)(29)(30)(31) - Kitchen, equip., & utensils clean & well maintained.					
14. 87604(b) - Food service staff sufficient in number, adequately trained.					
15. 87604(b) - Modified diets prepared for clients needing them.					
16. 87604(b) - Tray service and special equip. provided when needed.					
17. 87604(b) - Menus prepared, maintained and available for review.					
18. 87702(a)(b) - Persons accepted for care limited to specified criteria.					
19. 87606(a) - Prior approval obtained for the use of supportive restraints.					
20. 87600(f) - Minimum basic services are provided to clients.					
21. 87602(a) - Equip. and supplies for personal care/hygiene readily available.					
22. 87610(a) - Assistance in obtaining routine medical/dental care provided.					
23. 87610(a) - Assistance with self-administered medications as appropriate.					
24. 87610(a) - Assistance with prosthetic devices provided as appropriate.					
25. 87610(c) - Medications centrally stored and locked when appropriate.					
26. 87610(a) - Record of centrally stored medications is maintained.					
27. 87610(a)(8) - First aid supplies maintained if no medical unit on-site.					
28. 87610(b) - Emergency numbers posted in a visible location.					
29. 87610(b) - Emergency info. for physicians/dentists/ambulance readily available.					
30. 87144(a) thru (d) - Clients personal rights are not violated.					
31. 87144(a)(1) - Clients treated with dignity.					
32. 87144(a)(3) - No physical/mental abuse or interference with daily functions.					
33. 87612(a)(b)(c) - Services provided promote independent living.					
34. 87612(d) - Planned activities posted (capacity 7 or more).					
35. 87612(h)(i) - Sufficient space/equipment/supplies for activity programs.					
36. 87614 - Facility provides assistance and cooperation to client councils.					
37. 87520(a) thru (d) - Personnel records are complete and available for review.					
38. 87712(a) - Clients medical assessment (incl. amb. status) on file.					
39. 87716 - Documentation of pre-admission appraisals and reappraisals on file.					
40. 87718(a) thru (h) - Admission agreements complete and on file.					
41. 87522(a)(b)(d)(e) - Client records current, complete, available for review.					
42. 87522(c) - Confidentiality of client records is safeguarded.					
43. 87102, 87114 - Facility has valid license, appropriately posted.					
44. 87136(a)(b), 87137 - Persons received limited to those authorized by the terms of the license.					
45. 87138(a) thru (g) - Clients cash/personal property/valuables safeguarded.					
46. 87140(a) thru (e) - Facility is sufficiently bonded.					
47. 87142 - Clients money is not commingled with those of another facility.					
48. 87510(a)(f) - There is sufficient competent personnel to provide services.					
49. 87510(b) - Supervising personnel are at least 18 years of age.					
50. 87510(c)(d) - Orientation/training/continuing education for all personnel.					
51. 87514(a) - Night supervision in accordance with specified criteria.					
52. 87612(d) thru (g) - There is appropriate staffing for planned activities.					
53. 87516(a)(b)(c) - Administrator or designated qualified substitute on premises.					
54. 87518 (a) thru (f) - Administrator is qualified and fulfills responsibilities.					
55. 87404(a)(b)(c) - Criminal record clearance for staff/appropriate personnel/and other adults in facility.					
56. 87130(a)(b) - Facility has written disaster plan available for review.					
57. 87132 - Vehicles transporting clients maintained in safe operating condition.					
58. 87128(a)(b) - Persons received on non-discriminatory basis.					

COMMENTS:

*A Licensing Report (LIC 809) will accompany this form whenever violations are found in any of the areas noted on this report.

LICENSING EVALUATOR SIGNATURE	DATE	I UNDERSTAND MY LICENSING APPEAL RIGHTS.	
NAME OF SUPERVISOR	TELEPHONE NO.	FACILITY REPRESENTATIVE SIGNATURE	DATE



EXHIBIT D

Table 33
Programs Available to Older Californians
By Eligibility Type
1987-88 and 1988-89
(dollars in thousands)

Programs Available to	Services Provided	Requirement to Qualify	Estimated Number of Clients 1987-88	1987-88			1988-89		
				State	Federal	Total ^a	State	Federal	Total ^a
Low-Income Seniors Income Support Supplemental Security Income/State Supplementary Program (DSS)	Cash grants	Age 65 with (1) limited resources and (2) "countable" income that does not exceed the maximum grant	382,258 (average per month)	\$915,380	\$608,792	\$1,524,172	\$917,399	\$657,244	\$1,574,643
Senior Citizens Renters' Assistance Program (FTB)	Annual grant based on property tax equivalent	Renter age 62 or older and low-income (less than \$12,000) or disabled (all ages)	196,675	21,414	—	21,414	18,600	—	18,600
Senior Citizens Property Tax Assistance (FTB)	Direct reimbursements for portion of property taxes	Age 62 or older, or disabled; must own and occupy home; income less than \$12,000	54,625	4,836	—	4,836	4,800	—	4,800
Senior Citizens Property Tax Deferral (FTB)	Postponement of property tax payments	Age 62 or older; must own and occupy residence; income less than \$24,000	8,658	6,100	—	6,100	6,000	—	6,000
Foster Grandparents Program (CDA)	Stipends for seniors who provide supportive services to children with special needs	Age 60 or older and income less than the poverty level	112 (volunteers)	370	—	370	370	—	370
Senior Companion Program (CDA)	Stipends for seniors who provide supportive services to adults with special needs	Age 60 and older and income less than the poverty level	127 (volunteers)	321	—	321	321	—	321
<i>Health Services</i> Medi-Cal (DHS) ^b	Inpatient/outpatient acute medical services, long-term care, ancillary health services	Age 65 and older, and public assistance recipients or meet age, disability, and income requirements	306,540 (average per month)	664,114	664,114	1,328,228	722,721	722,721	1,445,442
Multipurpose Senior Services Program (CDA)	Case management to link clients to various health and social services	Age 65 or older, Medi-Cal eligible and certifiable for placement in nursing homes	8,800	10,322	— ^c	10,322	10,515	— ^c	10,515
<i>Supportive Social Services</i> Brown Bag (CDA)	Foodstuffs distributed to older persons	Age 60 or older and SSI/SSP eligible	42,200	780	—	780	780	—	780
In-Home Supportive Services (DSS)	Domestic and nonmedical services provided at home	SSI/SSP eligible	86,844 (average per month)	112,440	200,294	327,814	174,416	200,674	390,169
<i>Employment</i> Senior Community Employment Services (CDA)	Subsidized part-time jobs	Age 55 or older and income less than 125 percent of poverty level	1,048	—	4,995	4,995	—	4,995	4,995
<i>Discount Programs</i> Golden Bear Passes (DPR)	Reduced price on annual state park pass	Age 65 and older and below specified income level	3,000	150	—	150	150	—	150
Discount Fishing Licenses (DFC)	Reduced price on fishing license	Age 65 and older and receiving SSI/SSP or with specified income	15,307	252	—	252	267	—	267
Subtotals, Programs Available to Low-Income Seniors				(\$1,736,479)	(\$1,478,195)	(\$3,229,754)	(\$1,856,339)	(\$1,585,634)	(\$3,457,052)
Programs Available to All Seniors									
<i>Health Services</i> Preventive Health Care for Aging (DHS)	RNs provide health appraisals, counseling, referrals, education	Older adults (age 55 and older) in congregated settings who are well	1,647	\$1,303	—	\$2,606	\$1,303	—	\$2,606
<i>Supportive Social Services</i> Nutrition (CDA)	Meals provided at community centers or delivered at home	Age 60 or older (and spouses regardless of age)	263,900	11,970	\$47,773	99,891	11,970	48,815	100,833
Supportive Services and Centers (CDA)	Include in-home, transportation and case management services	Age 60 or older	834,817	2,904	25,864	54,051	2,904	23,881	52,068
<i>Employment</i> Job Training Partnership Act/Older Workers (EDD)	Employment and training services	Age 55 and older	Unknown	—	10,345 ^d	10,345 ^d	—	5,633	5,633
<i>Other Services</i> Senior Citizens' Shared Housing (HCD)	Grants to nonprofit entities to assist seniors in finding a roommate	Age 60 or older	4,500	500	—	500	500	—	500
Volunteer Service Credit Program (CDA) ^e	Service credits for seniors who provide supportive services to other seniors	Age 60 or older	—	—	—	—	65	—	65
Health Insurance Counseling and Advocacy Program (CDA)	Assistance in understanding coverage provided through Medicare and private insurance	Medicare beneficiaries	123,618	—	—	1,248	—	—	2,248

<i>Discount Programs^f</i>										
Golden State Senior Discount Program (DCA/CDA) ^g	Cards issued for purchase of discounted goods and services from volunteer merchants	Age 60 or older	Unknown	72	—	72	72	—	72	
California Exposition and State Fair (DFA)	Reduced State Fair admission	Seniors	22,800	23	—	23	33	—	33	
California State University (CSU)	Student fee waivers	Age 60 or older	Unknown	499 ^h	—	499 ^h	499 ^h	—	499 ^h	
Identification Cards (DMV)	Reduced price and extended period of validity on identification cards	Age 62 or older	85,100	333	—	333	355	—	355	
Subtotals, Programs Available to All Seniors										
				(\$17,604)	(\$83,982)	(\$169,568)	(\$17,701)	(\$78,329)	(\$165,012)	
<i>Programs Predominantly Serving Seniors</i>										
<i>Income Support</i>										
Low-Income Weatherization program (DEO) ⁱ	Low-cost home weatherization	Income less than 150 percent of poverty level	Unknown	—	\$5,071	\$5,071	—	\$3,563	\$3,563	
Low-Income Home Energy Assistance program (DEO) ⁱ	Heating assistance grants	Income less than 150 percent of poverty level	Unknown	—	16,798	16,798	—	11,963	11,963	
Emergency Crisis Intervention program (DEO) ⁱ	Emergency assistance to households unable to pay utility bills	Income less than 130 percent of poverty level	Unknown	—	2,069	2,069	—	2,069	2,069	
<i>Health Services</i>										
Alzheimer's Research, Diagnostic and Treatment Centers (DHS)	Research, diagnostic and treatment services provided to patients and families	Symptoms or indications of Alzheimer's Disease	Unknown	\$2,214	—	2,214	\$2,249	—	2,249	
Adult Day Health Care (CDA) ^j	Health and social services provided in nonresidential centers	Frail elderly and other adults	4,875	872	—	872	—	—	—	
<i>Supportive Social Services</i>										
Alzheimer's Day Care-Resource Centers (CDA)	Supportive services provided to patients and caregivers	Symptoms of Alzheimer's disease or related disorders	639	800	—	800	800	—	800	
Linkages (CDA)	Case management to link clients to various social services	Adults who are not certifiable for placement in nursing homes	4,037	3,900	—	3,900	3,900	—	3,900	
Respite Care program (CDA)	Referral of clients and families to respite care providers	Health of caregiver at risk; client at risk of institutionalization	970	61	—	61	60	—	60	
Senior Self-Reliance program (DOR)	Assistance in overcoming barriers to mobility	Age 55 or older, with limited visual acuity	Unknown	102	—	102	102	—	102	
Counselor/Teacher program (DOR)	Mobility orientation and other habilitation services	Client of DOR	Unknown	283	—	283	283	—	283	
<i>Other Services</i>										
Urban Mass Transportation Act 16b(2) program (Caltrans) ^k	Capital assistance to private nonprofit agencies to purchase specialized vehicles	Elderly and/or handicapped	Unknown	486	2,794	3,280	486	2,794	3,280	
Adult Protective Services (DSS)	Investigation and prevention of abuse/neglect of elders	Not applicable	Unknown	16,302	—	22,225	16,568	—	22,641	
Prevention of Crimes Against the Elderly (DOJ)	Information and technical assistance	Not applicable	Unknown	44	—	44	N/A ^l	N/A ^l	N/A ^l	
Adult Education Courses for the Elderly (SIDE)	Educational courses	Eligibility criteria established by local officials	216,000	32,000	—	32,000	33,573	—	33,573	
California Veterans' Home (DVA)	Residential nursing and medical services	Veteran and qualifying resident	1,300	22,445	12,059	34,514	24,855	10,071	34,926	
Subtotals, Programs Predominantly Serving Seniors										
				(\$79,509)	\$38,791	(\$124,233)	(\$82,876)	(\$30,460)	(\$119,409)	
Totals, All Programs										
				\$1,833,592	\$1,600,968	\$3,523,555	\$1,956,916	\$1,694,423	\$3,741,473	

^a Local expenditures not shown separately, but they are included in the totals.

^b Figures do not include amounts for recipients age 65 or older who receive aid to the blind or disabled.

^c Federal funds totaling \$10.3 million in both 1987-88 and 1988-89 are included in Medi-Cal figures.

^d Includes \$4.7 million in federal funds carried over from prior fiscal years.

^e Established January 1, 1988 by Ch 1199/87.

^f Estimated revenue loss, assuming older persons receiving discounts otherwise would have purchased full priced services (except for the Golden State program).

^g Transferred January 1, 1988 from the Department of Consumer Affairs to CDA. Expenditures are for program administration.

^h Assumes estimated revenue loss remains the same as in 1986-87.

ⁱ Expenditures for clients age 60 or older.

^j Except for \$872,000 in start-up grants, the amounts expended on this program (\$11.2 million in 1987-88 and \$12.3 million in 1988-89) are included in Medi-Cal figures.

^k Figures include amounts for handicapped as well as elderly.

^l Not available.

THE LONG TERM CARE CONTINUUM

<u>Service Category</u>	<u>License/Funding Source(s)</u>	<u>Role in the Continuum</u>
<p><u>Service Coordination (Case Management)</u> An administrative service which acts as a link between the client and the providers of long term care. Often case management programs provide client assessment, service plan development and follow-up monitoring.</p> <p><u>Multipurpose Senior Services Program (MSSP):</u> Funded through Federal government waivers to use Medicaid funds, coordinated through case management, in non-traditional ways to reduce acute care and institutional placement.</p>	<p>Funded through Federal Medicaid waivers (Section 1115 of the Social Security Act) in the Multipurpose Senior Services Project (MSSP), and through state funds in the new "Linkages" program in the Dept. of Aging. Often a Central element of other services such as adult day health care. Local programs may receive Older Americans Act funds or private funding.</p>	<p>A critical service for all long term care users. Helps to assure the appropriate, timely, and cost effective delivery of long term care services and can assist in maintaining older people in the least restrictive setting.</p>
<p><u>Skilled Nursing Facility (SNF)</u> Continuous skilled nursing care or other skilled rehabilitative care provided in a residential facility on 24 hour a day basis.</p>	<p>License and Medi-Cal certification by the Department of Health Services. Funded primarily by Medi-Cal. Some funding through Medicare and private payments. Minimal Coverage through private health insurance.</p>	<p>Appropriate for people in need of continuous intense services, especially those in need of nursing care with rehabilitative therapy.</p>
<p><u>Intermediate Care Facility (ICF)</u> Health related services offered in an institutional setting which are below those offered in a hospital or SNF, but above that of residential care.</p>	<p>License and Medi-Cal certification by the Department of Health Services. Funded primarily by Medi-Cal. Some funding through Medicare and private payments. Minimal coverage through private health insurance.</p>	<p>Appropriate for those who are chronically ill and require intermittent nursing care.</p>

EXHIBIT E

Compliments of
 SENATOR HENRY J. MELLO
 Chairman, Senate Subcommittee on Aging

<u>Service Category</u>	<u>License/Funding Source (s)</u>	<u>Role in the Continuum</u>
<p><u>Residential Care Facility</u> A residential setting for people in need of personal assistance, such as bathing, grooming, dressing, eating, etc. and protective supervision.</p>	<p>Licensed by the Department of Social Services (DSS). Funded primarily through private payments of residents. 20-30% funded through SSI/SSP non-medical out-of-home care grants.</p>	<p>Appropriate for people who do not need intense medical care but are nevertheless unable to maintain independence and who require ongoing assistance with activities of daily living.</p>
<p><u>Congregate Housing</u> Housing developments with a common living area and the provision of support services relating to the dietary, social, recreational and housekeeping needs of the resident.</p>	<p>Grants provided through the Federal Government (Housing and Urban Development-HUD).</p>	<p>Intended as one option for providing support services to meet basic needs for the primary purpose of assisting older people to function independently.</p>
<p><u>Shared Housing</u> Assistance in matching seniors with individuals who wish to share existing housing units.</p>	<p>State funding through the Department of Housing and Community Development to local shared housing agencies.</p>	<p>Helps to keep seniors in the community, reduces housing costs, utilizes under-used housing stock, and increases security and companionship.</p>
<p><u>Respite Care</u> Short term inpatient or home care delivered to an elderly person as a substitute for their regular caregiver. The program is designed to provide relief to relatives and friends who care for a disabled or elderly person on a continuous basis.</p>	<p>No separate license required. No specific funding for respite care or special programs designed specifically to relieve caregivers. Could be provided by a variety of existing licensed providers (day care, home health, residential care, skilled nursing). Limited respite available through In-Home Supportive Services. An MSSP waived service.</p>	<p>A way to assist families who care for their elderly relatives by providing periodic relief from the demands of caring for an older person. Although it may be provided as a component of other services in the continuum, it differs in that the specific purpose is to meet the needs of the family/caregiver for relief.</p>

<u>Service Category</u>	<u>License/Funding Source (s)</u>	<u>Role in the Continuum</u>
<p><u>Hospice</u> Provided to terminally ill people and their families offering care and support to the family while also enhancing a terminally ill person's quality of life by enabling him/her to live as comfortably, alertly or independently as possible. May be provided inpatient or at home.</p>	<p>No separate license required. Medicare certification required for Medicare payments. Minimum coverage through private health insurance.</p>	<p>A critical component in the continuum designed to allow older people to die with dignity. Unlike many programs, hospice considers the <u>family</u> the unit of care.</p>
<p><u>Home Health Care</u> Medically oriented care for acute or chronic illness provided in the patient's home. Includes services like cleaning wounds, changing bandages, giving injections, inserting catheters.</p>	<p>Licensed by the Department of Health Services. Funded through Medicare, Medi-Cal and private payments. Minimum coverage through private health insurance.</p>	<p>A way to provide medical care to people outside of an acute care, skilled nursing or intermediate care facility, allowing them to remain at home.</p>
<p><u>Chore/Homemaker Services</u> Household services, such as shopping, cooking, and cleaning.</p>	<p>No License required. Some funding through In-Home Supportive Services for those eligible. Private payments. Waivered services in MSSP.</p>	<p>An essential aspect of any home care program. May be delivered in conjunction with home health care or as a separate service to those with functional limitations who are otherwise healthy. Helps to maintain older people in their homes.</p>
<p><u>Non-Medical Personal Care Services</u> Personal care includes such services as bathing, dressing, and grooming provided in the participant's home.</p>	<p>No License required. Some funding through In-Home Supportive Services for those eligible. Private payments. Waivered Services in MSSP. Helps to maintain older people in their homes.</p>	<p>Seen as an essential aspect of any home care program usually delivered in conjunction with home health care or chore/homemaker services.</p>

<u>Service Category</u>	<u>License/Funding Source(s)</u>	<u>Role in the Continuum</u>
<p><u>Preventive Health Care for the Aging</u> Health appraisals, referrals, counseling, follow-up and education provided to the well-ambulatory elderly 60 years and older by public health nurses in local sites where seniors congregate.</p>	<p>State funding through Department of Health Services. 50% local match required, cash or in-kind. Annual report presented by Department of Aging.</p>	<p>The goal of the program is to assist the well elderly in the community to maintain or improve their health so as to reduce the need for expensive acute care and institutional placement.</p>
<p><u>Home-Delivered Meals</u> The delivery of inexpensive, nutritionally sound meals in the participant's home. As well as providing meals to people who are unable or unlikely to cook for themselves, the program provides social contact to isolated people.</p>	<p>Monitored by Department of Aging. Funding through Older Americans Act, USDA meal reimbursement, state and local funds, and participant contributions.</p>	<p>Helps to maintain older people in their homes by providing a balanced meal each day. Contact with meals driver helps to reduce social isolation.</p>
<p><u>Congregate Nutrition Programs</u> Programs designed to provide inexpensive nutritionally sound meals to elderly people in congregate settings.</p>	<p>Monitored by Department of Aging Funding through Older Americans Act USDA meal reimbursement, state and local funds, and participant contributions.</p>	<p>Seen as a health promotion service which also encourages social interaction among elderly people.</p>
<p><u>Adult Day Care</u> A wide variety of day care programs exist. Two major models are:</p> <p><u>Adult Day Health Care:</u> An organized day program of therapeutic, social and health activities and services, provided to elderly persons or other persons with physical or mental impairments for the purpose of restoring or maintaining optimal capacity for self-care.</p>	<p>Licensed by Department of Health Services. Start-up grants, Medi-Cal certification and development through Dept. of Aging. Funding from Medi-Cal and private payments.</p>	<p>Adult Day Health Care programs serve a very frail client population in need of intensive therapy and rehabilitation. By providing these services, the programs can delay or prevent unnecessary placement in skilled nursing facilities and help older people to remain at home.</p>

<u>Service Category</u>	<u>License/Funding Source(s)</u>	<u>Role in the Continuum</u>
<p><u>Adult Social Day Care:</u> Programs which provide social interaction and support services to elderly persons and functionally impaired adults who can benefit from day care but do not require the full range of services available in ADHC.</p>	<p>Licensed by Department of Social Services. No specific category of state reimbursement. Funding occasionally available through Older Americans Act,* private payments, local contributions, foundations, etc. An MSSP waived service.</p>	<p>A needed service for many frail and vulnerable elderly in order to remain at home. Programs provide a wide ranging variety of services that can improve and maintain functional status and reduce social isolation.</p>
<p><u>Senior Centers and Recreation Services</u> Programs which increase social interactions for older people by providing formal social activities and a central meeting place. In addition, senior centers act as clearinghouses for elderly people in need of information or services.</p>	<p>Older Americans Act funding, state and local.</p>	<p>Seen as a way to improve the quality of life of its users through the promotion of social activity.</p>
<p><u>Transportation Services</u> Programs designed to increase an elderly person's mobility by improving his or her financial and/or physical access to transportation. These programs range from the provision of subsidies or public transit systems to the operation of special mini buses for the exclusive use of senior citizens.</p>	<p>Funding through Older Americans Act, Urban Mass Transit Act (UMTA), California Transportation Development Act Funds and Local Match. Non-medical transportation is an MSSP waived service.</p>	<p>Viewed as critical to insure adequate access to community services.</p>
<p><u>Telephone Reassurance</u> A program designed to decrease social isolation by providing regular telephone contact to elderly people living alone.</p>	<p>May receive Older Americans Act Funds, local contributions, private foundations.</p>	<p>Seen as a way to improve the quality of life of its users by increasing social interaction and making the users feel secure that help is available in times of emergency.</p>

<u>Service Category</u>	<u>License/Funding Source (s)</u>	<u>Role in the Continuum</u>
<u>Friendly Visiting/Companionship</u> A service designed to decrease the social isolation of the elderly through regular in-home visits by professionals or volunteers.	Some funding through Older Americans Act programs such as Senior Companions. Local funds, private foundations.	Seen as a way to improve the quality of life of its users by increasing social interaction and making the users feel secure that help is available in times of emergency.
<u>Legal Services</u> Free or partially subsidized assistance with legal matters, such as wills, tenant rights, and benefit programs.	Funds provided by Older Americans Act, Legal Services Corporation (Federal), State Bar Trust, and private contributions. An MSSP waived service.	Essential to assist older people to make critical legal decisions and to protect their rights. Can protect against abuse and unnecessary displacement due to rent disputes.

(1/86)

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* Older Americans Act funding for programs depends on local discretion and the actual availability of funds. References are to the potential for Older Americans Act funds to be used for these programs.

SOURCES:

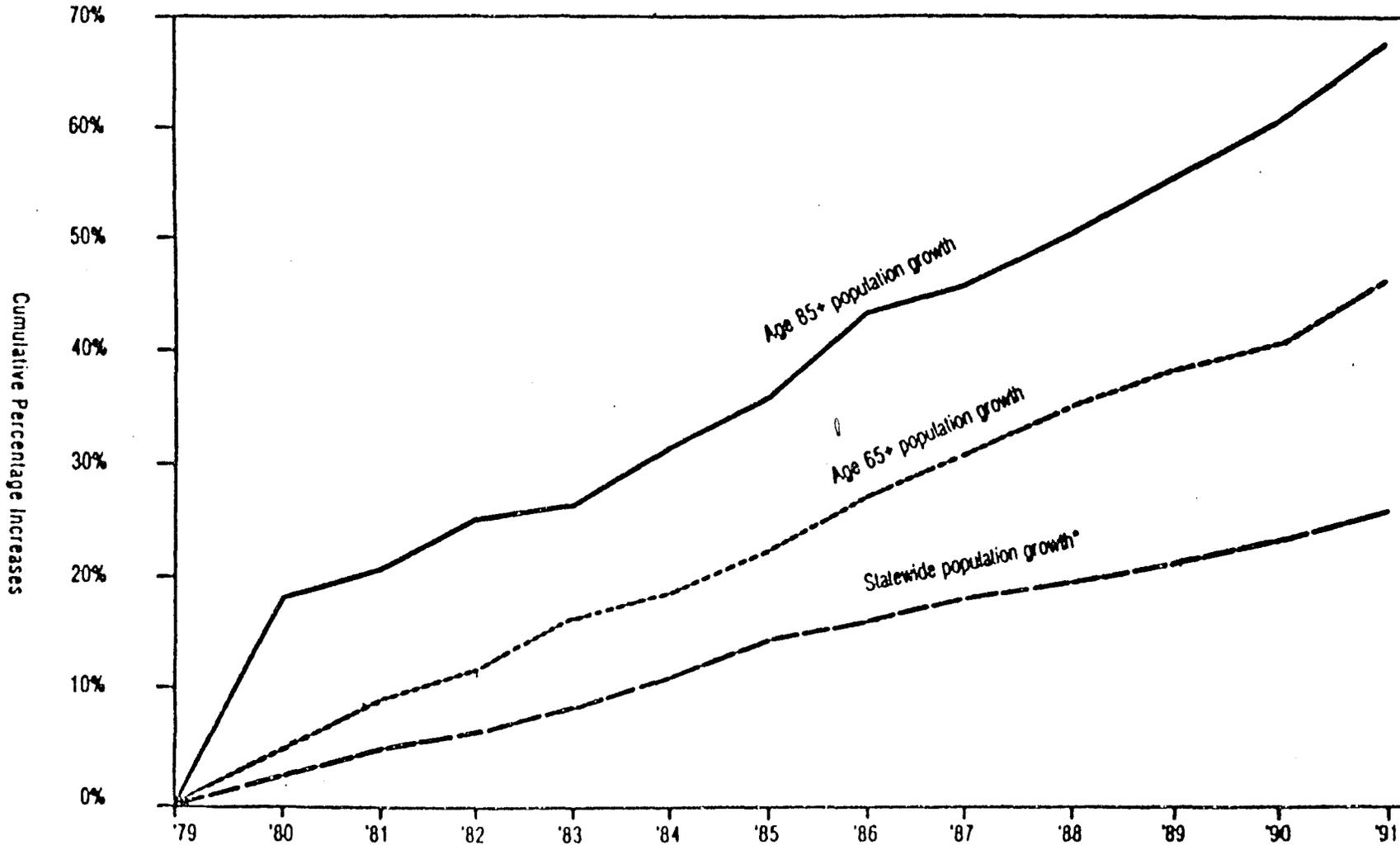
"Expanding Long Term Care Efforts: Options and Issues in State Program Design"
 National Center for Health Services Research - Paula Steiner and Jack Needleman
 U.S. Department of Health and Human Services - March 1981

"Bridging the Gaps: Non Traditional Services for the Elderly"
 California Association of Homes for the Aging - 1983

"Annual Report to the Legislature on the Preventive Health Care for the Aging Program"
 Fiscal Year 1983-84 - Department of Health Services

"Multipurpose Senior Services Project - Final Report"
 Health and Welfare Agency - July 1984

PROJECTED POPULATION GROWTH
General Population Growth* vs Senior Population Growth
Cumulative Percentage Increases



Source: Department of Finance

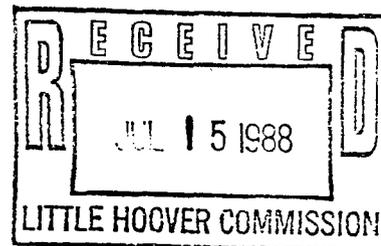
* on which the Gann Limit is based

Compliments of
 SENATOR HENRY J. MELLO
 Chairman
 Senate Subcommittee on Aging





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COUNTY OF LOS ANGELES
BUREAU OF SPECIAL OPERATIONS
CONSUMER PROTECTION DIVISION
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R. DAN MURPHY, DIRECTOR
SPECIAL OPERATIONS

July 12, 1988

Jeannine English
Assistant Executive Director
Commission on California State Government
Organization and Economy
1303 "J" Street
Sacramento, California 95814

Re: Residential Care Advisory Committee of the
Little Hoover Commission

Dear Jeannine:

The attached report of June 8, 1988 to the Little Hoover Commission discusses recommendations regarding legislation in the area of community care facilities and residential care facilities for the elderly. The report cites Health and Safety Code Section 1543 which authorizes the "District Attorney" of every county "upon application of the State Department or its authorized representative" to prosecute any violation concerning community care facilities. Likewise, Health and Safety Code Section 1569.43 authorizes the "District Attorney" upon the same application, to prosecute matters concerning residential care facilities for the elderly. Our report recommends that both Sections 1543 and 1569.43 be amended to permit all local prosecutor offices authority independently to prosecute violations under those two sections.

Recently, an incident was brought to my attention where a case was submitted by the State Department of Social Services to the prosecution office of a city attorney. This was not Los Angeles City nor Los Angeles County. Apparently, that city prosecutor declined to prosecute the matter because of language in the quoted sections 1543 and 1569.43, copies of which are also attached, which states that the "District Attorney" prosecute these matters and which does not mention local

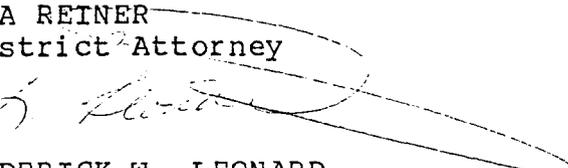
Ms. English
Page Two
July 12, 1988

prosecutors. The county district attorney's office also refused to prosecute the matter since it involved misdemeanors which are the jurisdiction of that city prosecutor's office. This specific example exemplifies the necessity that sections 1543 and 1569.43 be amended to provide independent authority of all prosecuting offices, including but not limited to district attorney's offices, to independently prosecute matters under the appropriate sections of Chapters 3 and 3.3 of the Health and Safety Code.

If you have any questions, please feel free to call.

Respectfully submitted,

IRA RETNER
District Attorney

By 

RODERICK W. LEONARD
Deputy District Attorney

bj

Attachment

c: Sue Frauens, Esq.



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SPECIAL OPERATIONS

LITTLE HOOVER COMMISSION
COMMUNITY RESIDENTIAL CARE ADVISORY COMMITTEE
LICENSING AND ENFORCEMENT WORKING GROUP

Set forth herein are present sanctions, generally excluding the California Administrative Code, and recommendations in regard to regulation of licensed and unlicensed residential care facilities.

A. INTRODUCTION

Regulation of community care facilities and residential care facilities for the elderly are found in the California Health and Safety Code. The California Community Care Facilities Act found in Health and Safety Code Sections¹ 1500 et seq. address community care facilities. Sections 1569 et seq. regulates residential care facilities for the elderly.

B. COMMUNITY CARE FACILITIES

(1) PERTINENT STATUTES

Section 1503.5 sets forth the circumstances under which a community care facility must be licensed.² Specifically, a facility must be licensed if it provides "care or supervision, as defined in this Chapter or rules and regulations adopted pursuant to this Chapter".³ (Id.) While "care and supervision" is defined in the California Administrative Code, Title 22 Section 80001 subdivision (a)(10), "care and supervision" is not defined in the Health and Safety Code Section 1502 which sets out the definitions for the California Community Care Facilities Act.

Section 1508 requires licensure of community care facilities.

1. Unless otherwise noted all section references, are to the California Health and Safety Code.
2. All cited Sections are attached to this report.
3. Chapter 3 of Division 2 of the California Health and Safety Code addresses the California Community Care Facilities Act. Chapter 3.3 of Division 2 of the California Health and Safety Code is directed to the California Residential Care Facilities for the Elderly Act.

Section 1540 makes it a misdemeanor for any person to violate any of the provisions of Chapter 3 (California Community Care Facilities Act) or to willfully or repeatedly violate any rule or regulation promulgated under the Chapter. Penalty is a \$1,000 fine, 180 days in the county jail, or both.

Section 1540.1 provides that a facility violating Sections 1503.5 or 1508 (pertaining to operation of a community care facility without a license) is guilty of an infraction punishable by a fine of \$200 for each day of violation.

Section 1547 provides in part that "notwithstanding any other provision of this Chapter, anyone who violates Section 1503.5 or 1508 or both" may be assessed by the Department of Social Services a civil penalty of \$200 per day of the violation.

Section 1548 provides for civil penalties of \$25 to \$50 or more a day for each violation of Chapter 3. In no instance may the penalty assessment exceed \$150 a day. A repeat violation of Chapter 3 within 12 months of the first violation is subject to a \$150 per day fine. The Department of Social Services shall assess fines and develop regulations implementing this section.

Section 1549 provides that civil, criminal and administrative remedies "available to the department pursuant to this article" (i.e. sections 1530-1549) are not exclusive.

Section 1543 authorizes the district attorney of every county "upon application by the state department or its authorized representative", to prosecute any violation within his/her county of any provision of Chapter 3.

(2). RECOMMENDATIONS

Section 1502 sets forth definitions for the Community Care Facilities Act. That section does not include a definition of "care and supervision" or "care or supervision". It is suggested that the definition Section 1502 include a definition of "care and supervision" or "care or supervision" since Section 1503.5 requires licensure where "care or supervision", as defined by this Chapter, is provided or required. If "care and supervision" is the definition to be used, then Section 1503.5 will have to be amended from "care or supervision" to "care and supervision". Note that "care and supervision" is defined in Health and Safety Code Section 1569.2 (California Residential Care Facilities for the Elderly Act) as well as Title 22 of the California Administrative Code Section 87100 subdivision (a)(8).

Violation of Sections 1508/1540, operation of an unlicensed community care facility, should be made a separate and distinct offense of those Sections in Chapter 3 which impose civil penalties (Sections 1540.1, 1547 and 1548). Sections 1508/1540

should also clearly state that misdemeanors may be prosecuted irrespective of concurrent enforcement of the civil penalty sections of Chapter 3.

Section 1540 should make clear that violation of that Section, including regulations promulgated thereunder, are independent and distinct crimes of those sections providing for civil penalties under Sections 1540.1, 1547, and 1548 irrespective of language of Section 1549. Additionally, punishment under Section 1540 should be increased from 180 days to one year in the county jail, in addition to the present \$1,000 fine.

Section 1543 provides that an action may be brought by the district attorney "upon application of the department". That section should be amended to specify that all local prosecutor's offices have authority, independently, to prosecute for violations under Chapter 3.

Present civil penalties which range from \$25 to \$150 (Section 1548) are inadequate. It is recommended that the penalty model utilized in the convalescent hospital context be utilized by increasing the amount of fines to be assessed and thereafter collected, in respect to violations of the chapter or regulations promulgated thereunder.

C. RESIDENTIAL CARE FACILITIES FOR THE ELDERLY

(1). PERTINENT STATUTES

Section 1569.10 provides that no residential care facility for the elderly shall be operated without a valid license.

Section 1569.312 sets out the basic services which the licensee shall provide including "care and supervision" as defined in Section 1569.2.

Section 1569.40 makes it a misdemeanor to violate Chapter 3.3 (Residential Care Facilities for the Elderly) or to willfully or repeatedly violate any rule or regulation adopted under that chapter. Penalty is a fine of \$1,000 and/or 180 days imprisonment.

Section 1569.405 makes it an infraction with a fine of \$200.00 a day to operate a residential care facility for the elderly without an license.

Section 1569.44 defines an unlicensed residential care facility for the elderly to be a facility which provides care and supervision or is held out as providing care and supervision as defined by Chapter 3.3 or the regulations promulgated thereunder. "Care and supervision" is defined in section 1569.2 and also in section 87100 (a)(8) of Title 22 of California Administrative Code.

Section 1569.45 requires that a residential facility for the elderly be licensed "if it offers care and supervision, as defined, to its residents".

Section 1569.485 provides that anyone who operates a residential facility for the elderly without a license (under Section 1569.10 or Section 1569.44) is subject to a civil penalty of \$200 per day of violation.

Section 1569.49 provides that daily fines from \$25 to a maximum of \$150 may be assessed for violations under the Chapter 3.3.

Section 1569.495 provides that criminal, civil and administrative remedies "available to the department" under this article (Sections 1569.10-1569.495) are not exclusive.

Section 1569.43 authorizes the district attorney, "upon application of the state department or its authorized representative", to prosecute violations in Chapter 3.3.

(2). RECOMMENDATIONS

Violation of Sections 1569.10/1569.40, operation of an unlicensed residential facility for the elderly, should be made a separate and distinct offense of those Sections in Chapter 3.3 which impose civil penalties (Sections 1569.485 and 1569.49). Section 1569.40 should clearly state that misdemeanors may be prosecuted irrespective of concurrent enforcement of the civil penalty sections of Chapter 3.3.

Section 1569.405 should make clear that violation of that Section, including regulations promulgated thereunder, are independent crimes of the sections providing for civil penalties under Sections 1569.49 and 1569.485. Additionally, punishment under Section 1569.40 should be increased from 180 days to one year in the county jail, in addition to the present \$1,000 fine.

Section 1569.43 provides that an action may be brought by the district attorney "upon application of the department". That section be amended to permit all local prosecutor's offices the authority, independently, to prosecute for violations under Chapter 3.3.

Present civil penalties which range from \$25 to \$150 (Section 1569.49) are inadequate. It is recommended that the penalty model utilized in the convalescent hospital context be utilized by increasing the amount of fines to be assessed and

thereafter collected, in respect to violations of the Chapter 3.3 and regulations promulgated thereunder.

June 8, 1988

IRA REINER
District Attorney

By

RODERICK W. LEONARD
Deputy-in-Charge
Nursing Home & Dependent Care



§ 80001
(p. 2316)

COMMUNITY CARE FACILITIES.

TITLE 22

(Register 83, No. 53—12-31-83)

(g) An existing facility licensed as a Social Rehabilitation Center shall by April 1, 1984, meet the requirements for Adult Day Facilities. Between January 1, 1984 and April 1, 1984 the facility shall comply with the requirements for Adult Day Facilities except for changes from the previous requirements regarding physical environment, staff training, staff ratios, and provision of care and supervision to minors who are not emancipated as specified in Section 86001(a)(1) and Civil Code Section 62.

NOTE: Authority cited: Sections 1530 and 1530.5, Health and Safety Code. Reference: Sections 1501, 1502, 1530 and 1531, Health and Safety Code.

HISTORY:

1. * Repealer of Chapter 1 (Articles 1-7, Sections 80001-80967, not consecutive) and new Chapter 1 (Articles 1-7, Sections 80000-80088, not consecutive) filed 10-7-83; designated effective 1-1-84 (Register 83, No. 42). For prior history, see Registers 81, Nos. 39 and 31; 80, Nos. 39, 24, 23, 11, 10, 9, 8 and 7; 79, Nos. 44, 15 and 5; 78, Nos. 51, 44 and 26; 77, No. 2; 76, Nos. 41, 21 and 4; and 75, No. 31.

* The reorganization of Chapter 1 is printed as a repealer and adoption for clarity.

2. Amendment filed 12-30-83; designated effective 1-1-84 pursuant to Government Code Section 11346.2(d) (Register 83, No. 53).

80001. Definitions.

(a) The following general definitions shall apply wherever the terms are used throughout Division 6, Chapters 1 through 7 and Chapter 9, except where specifically noted otherwise. Additional definitions found at the beginning of each chapter in this division shall apply only to such specific facility category.

(1) "Administrator" means the licensee, or the adult designated by the licensee to act in his/her behalf in the overall management of the facility.

(2) "Adult" means a person who is 18 years of age or older.

(3) "Adult Day Care Facility" means any facility of any capacity which provides nonmedical care and supervision to adults on less than a 24-hour per day basis.

(4) "Adult Residential Facility" means any facility of any capacity which provides 24-hour a day nonmedical care and supervision to adults except elderly persons.

(5) "Applicant" means any adult, firm, partnership, association, corporation, county, city, public agency or other governmental entity that has made application for an initial or renewal community care facility license.

(6) "Authorized Representative" means any person or entity authorized by law to act on behalf of any client. Such person or entity may include but not be limited to a minor's parent, a legal guardian, a conservator or a public placement agency.

(7) "Basic Rate" means the rate charged by a facility to provide basic services. For SSI/SSP recipients, the basic rate means the established nonmedical out-of-home care rate which includes any exempt income allowance but does not include that amount allocated for the recipient's personal and incidental needs.

(8) "Basic Services" means those services required by applicable law and regulation to be provided by the licensee in order to obtain and maintain a community care facility license.

(9) "Capacity" means the maximum number of persons authorized to be provided care and supervision at any one time in any licensed facility.

(10) "Care and Supervision" means any one or more of the following activities provided by a person or facility to meet the needs of the clients:

TITLE 22

COMMUNITY CARE FACILITIES

§ 80001

(Register 87, No. 25—6-20-87)

(p. 2317)

- (A) Assistance in dressing, grooming, bathing and other personal hygiene.
- (B) Assistance with taking medication, as specified in Section 80075.
- (C) Central storing and/or distribution of medications, as specified in Section 80075.
- (D) Arrangement of and assistance with medical and dental care.
- (E) Maintenance of house rules for the protection of clients.
- (F) Supervision of client schedules and activities.
- (G) Maintenance and/or supervision of client cash resources or property.
- (H) Monitoring food intake or special diets.
- (I) Providing basic services as defined in Section 80001(a) (8).
- (11) "Cash Resources" means:
 - (A) Monetary gifts.
 - (B) Tax credits and/or refunds.
 - (C) Earnings from employment or workshops.
 - (D) Personal and incidental need allowances from funding sources including but not limited to SSI/SSP.
 - (E) Allowances paid to children.
 - (F) Any other similar resources as determined by the licensing agency.
- (12) "Child" means a person who is under 18 years of age.
- (13) "Child Care Center" means any facility of any capacity other than a family day care home as defined in Section 88002(i) in which less than 24-hour per day nonmedical supervision is provided for children in a group setting.
- (14) "Client" means a child or adult who is receiving care and supervision in a community care facility. Client includes "resident" as used in the Community Care Facilities Act.
- (15) "Community Care Facility" means any facility, place or building where nonmedical care and supervision, as defined in Section 80001(a) (10) are provided.
- (16) "Completed Application" means:
 - (A) The applicant has submitted and the licensing agency has received all required materials including: an approved fire clearance, if appropriate, from the State Fire Marshal; a criminal record clearance on the applicant and any other individuals specified in Section 80019.
 - (B) The licensing agency has completed a site visit to the facility.
- (17) "Conservator" means a person appointed by the Superior Court pursuant to the provisions of Section 1800 et seq. of the Probate Code or Section 5350 of the Welfare and Institutions Code, to care for the person, or estate, or person and estate, of another.
- (18) "Consultant" means a person professionally qualified by training or experience to provide expert information on a particular subject.
- (19) "Deficiency" means any failure to comply with any provision of the Community Care Facilities Act (Health and Safety Code, Section 1500 et seq.) and/or regulations adopted by the Department pursuant to the Act.
- (20) "Department" is defined in Health and Safety Code Section 1502(b).
- (21) "Developmental Disability" means a disability as defined in Welfare and Institutions Code Section 4512(a).
- (22) "Dietitian" means a person who is a member of or registered by the American Dietetics Association.
- (23) "Director" is defined in Health and Safety Code Section 1502(c).
- (24) "Elderly Person" means any person who is 62 years of age or older.

CALIFORNIA COMMUNITY CARE FACILITIES ACT

§ 1502. Definitions

As used in this chapter:

(a) "Community care facility" means any facility, place, or building which is maintained and operated to provide nonmedical residential care, day treatment, adult day care, or foster family agency services for children, adults, or children and adults, including, but not limited to, the physically handicapped, mentally impaired, incompetent persons, and abused or neglected children, and includes the following:

(1) "Residential facility" means any family home, group care facility, or similar facility determined by the director, for 24-hour nonmedical care of persons in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual.

(2) "Adult day care facility" means any facility which provides nonmedical care to persons 18 years of age or older in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis.

(3) "Day treatment facility" means any facility which provides nonmedical care, counseling, educational, or vocational support, or social rehabilitation services on less than a 24-hour basis to persons under 18 years of age who would otherwise be placed in foster care or who are returning to families from foster care. Program standards for these facilities shall be developed by the department, pursuant to Section 1530, in consultation with day treatment and foster care providers.

(4) "Foster family agency" means any individual or organization engaged in the recruiting, certifying, and training of, and providing professional support to, foster parents, or in finding homes or other places for placement of children for temporary or permanent care. Private foster family agencies shall be organized and operated on a nonprofit basis.

(5) "Foster family home" means any residential facility providing 24-hour care for six or fewer foster children which is owned, leased, or rented and is the residence of the foster parent or parents, including their family, in whose care the foster children have been placed. Such placement may be by a public or private child placement agency or by a court order, or by voluntary placement by a parent, parents, or guardian.

(6) "Small family home" means any residential facility providing 24-hour care for six or fewer foster children who have mental disorders or developmental or physical disabilities and who require special care and supervision as a result of their disabilities.

(7) "Social rehabilitation facility" means any residential facility which provides social rehabilitation services for no longer than 18 months in a group setting to adults recovering from mental illness who temporarily need assistance, guidance, or counseling. Program components shall be subject to program standards pursuant to Section 5458.1.

(8) "Community treatment facility" means any residential facility which provides mental health treatment services to children in a group setting. Program components shall be subject to program standards developed by the State Department of Mental Health pursuant to Section 5405 of the Welfare and Institutions Code.

Nothing in this section shall be construed to prohibit or discourage placement of persons who have mental or physical disabilities into any category of community care facility that meets the needs of the individual placed, if the placement is consistent with the licensing regulations of the department.

(9) "Adoption agency" means any individual, other than a parent, or entity engaged in the business of providing adoption services, who does any one or more of the following:

(A) Assumes care, custody, and control of a child through relinquishment of the child to the agency or involuntary termination of parental rights to the child.

(B) Assesses the birth parents, prospective adoptive parents, or child.

(C) Places children for adoption.

(D) Supervises adoptive placements.

Private adoption agencies shall be organized and operated on a nonprofit basis.

(b) "Department" or "state department" means the State Department of Social Services.

(c) "Director" means the Director of Social Services.

(Amended by Stats 1982, c. 1124, p. 4051, § 1; Stats 1983, c. 1015, § 2; Stats 1984, c. 1305, § 1; Stats 1984, c. 1615, § 1.5; Stats 1985, c. 1127, p. —, § 1; Stats 1985, c. 1473, p. —, § 2; Stats 1986, c. 248, § 116; Stats 1986, c. 1120, § 2, urgency, eff. Sept. 24, 1986; Stats 1987, c. 1022, § 2.5.)

§ 1503.5. Unlicensed community care facility; definition; operation prohibited; procedure upon discovery

(a) A facility shall be deemed to be an "unlicensed community care facility" and "maintained and operated to provide nonmedical care" if it is unlicensed and not exempt from licensure and any one of the following conditions is satisfied:

(1) The facility is providing care or supervision, as defined by this chapter or the rules and regulations adopted pursuant to this chapter.

(2) The facility is held out as or represented as providing care or supervision, as defined by this chapter or the rules and regulations adopted pursuant to this chapter.

(3) The facility accepts or retains residents who demonstrate the need for care or supervision, as defined by this chapter or the rules and regulations adopted pursuant to this chapter.

(4) The facility represents itself as a licensed community care facility.

(5) The facility is performing any of the functions of a foster family agency or holding itself out as a foster family agency.

(6) The facility is performing any of the functions of an adoption agency or holding itself out as performing any of the functions of an adoption agency as specified in paragraph (9) of subdivision (a) of Section 1502.

(b) No unlicensed community care facility, as defined in subdivision (a), shall operate in this state.

(c) Upon discovery of an unlicensed community care facility, the department shall refer residents to the appropriate local or state ombudsman, or placement, adult protective services, or child protective services agency if either of the following conditions exist:

(1) There is an immediate threat to the clients' health and safety.

(2) The facility will not cooperate with the licensing agency to apply for a license, meet licensing standards, and obtain a valid license.

(Added by Stats.1985, c. 728, p.—, § 1, urgency, eff. Sept. 18, 1985. Amended by Stats.1986, c. 1016, § 1; Stats.1987, c. 1022, § 3.)

§ 1508. Necessity of license; special permit; community care facility; local public agency defined

No person, firm, partnership, association, or corporation within the state and no state or local public agency shall operate, establish, manage, conduct, or maintain a community care facility in this state, without . . . a current valid license therefor as provided in this chapter.

No person, firm, partnership, association, or corporation within the state and no state or local public agency shall provide specialized services within a community care facility in this state, without . . . a current valid special permit therefor as provided in this chapter.

Except for a juvenile hall operated by a county, or a public recreation program, this section applies to community care facilities directly operated by a state or local public agency. Each community care facility operated by a state or local public agency shall comply with the standards established by the director for community care facilities.

As used in this chapter, "local public agency" means a city, county, special district, school district, community college district, chartered city, or chartered city and county.

(Amended by Stats.1984, c. 1486, § 2; Stats.1985, c. 728, p.—, § 2, urgency, eff. Sept. 18, 1985; Stats.1986, c. 1016, § 2.)

§ 1540. Violation of chapter or regulations; misdemeanor; punishment; operation of community care facility without license; summons

(a) Any person who violates * * * this chapter, or who willfully or repeatedly violates any rule or regulation promulgated under this chapter, is guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not to exceed one thousand dollars (\$1,000) or by imprisonment in the county jail for a period not to exceed 180 days, or by both such fine and imprisonment.

(b) Operation of a community care facility without a license shall be subject to a summons to appear in court.

(Amended by Stats.1983, c. 1092, § 146, urgency, eff. Sept. 27, 1983, operative Jan. 1, 1984; Stats.1985, c. 1415, p. —, § 2.)

§ 1540.1. Community care facilities; violations; penalties; notice

Upon a finding by the licensing authority that a facility is in operation without a license, a peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code, may enforce Section 1503.5, or Section 1508, or both sections by utilizing the procedures set forth in Chapter 5 (commencing with Section 853.5) of Title 3 of Part 2 of the Penal Code. A facility violating Section 1503.5 or 1508, or both, is guilty of an infraction punishable by a fine of two hundred dollars (\$200) for each day of violation. Upon a determination that a community care facility is in violation of Section 1503.5 or 1508, or both, and after a citation has been issued, the peace officer shall immediately notify the licensing authority in the department.

(Added by Stats.1985, c. 1415, p. —, § 3. Amended by Stats.1987, c. 856, § 1.)

§ 1543. District attorney; institution and prosecution of actions

The district attorney of every county shall, upon application by the state department or its authorized representative, institute and conduct the prosecution of any action for violation within his county of any provisions of this chapter.

(Added by Stats.1973, c. 1203, p. 2590, § 4.)

§ 1547. Violation of §§ 1503.5, or 1508; civil penalty; appeal

(a) Notwithstanding any other provision of this chapter, any person who violates Section 1503.5 or 1508, or both, may be assessed by the department an immediate civil penalty in the amount of two hundred dollars (\$200) per day of the violation.

(b) The civil penalty authorized in subdivision (a) shall be imposed if an unlicensed facility is operated and the operator refuses to seek licensure or the operator seeks licensure and the licensure application is denied and the operator continues to operate the unlicensed facility.

(c) An operator may appeal the assessment to the director. The department shall adopt regulations setting forth the appeal procedure.

(Added by Stats.1985, c. 1415, p. —, § 5, operative Jan. 1, 1986.)

§ 1548. Civil penalties

(a) In addition to suspension or revocation of a license issued under this chapter, the department may levy a civil penalty in addition to the penalties of suspension or revocation.

(b) The amount of the civil penalty shall not be less than twenty-five dollars (\$25) or more than fifty dollars (\$50) per day for each violation of this chapter except where the nature or seriousness of the violation or the frequency of the violation warrants a higher penalty or an immediate civil penalty assessment, or both, as determined by the department. In no event shall a civil penalty assessment exceed one hundred fifty dollars (\$150) per day.

(c) Notwithstanding Section 1534, any facility that is cited for repeating the same violation of this chapter within 12 months of the first violation is subject to an immediate civil penalty of one hundred fifty dollars (\$150) and fifty dollars (\$50) for each day the violation continues until the deficiency is corrected.

(d) Any facility that is assessed a civil penalty pursuant to subdivision (c) which repeats the same violation of this chapter within 12 months of the violation subject to subdivision (c) is subject to an immediate civil penalty of one hundred fifty dollars (\$150) for each day the violation continues until the deficiency is corrected.

The department shall adopt regulations implementing this section.

(Added by Stats.1985, c. 1372, p.—, § 3.)

§ 1549. Remedies not exclusive

The civil, criminal, and administrative remedies available to the department pursuant to this article are not exclusive, and may be sought and employed in any combination deemed advisable by the department to enforce this chapter.

(Added by Stats 1985, c. 1415, p.—, § 6.)

TITLE 22

COMMUNITY CARE FACILITIES

§ 87100

(Register 22, No. 42-16-83)

(p. 2451)

CHAPTER 8. RESIDENTIAL FACILITIES FOR THE ELDERLY

Article 1. Definitions

87100. Definitions.

(a) For purposes of this chapter the following definitions shall apply:

(1) Administrator. "Administrator" means the individual designated by the licensee to act in behalf of the licensee in the overall management of the facility. The licensee, if an individual, and the administrator may be one and the same person.

(2) Adult. "Adult" means a person who is eighteen (18) years of age or older.

(3) Ambulatory Person. "Ambulatory Person" means a person who is capable of demonstrating the mental competence and physical ability to leave a building without assistance of any other person or without the use of any mechanical aid in case of an emergency.

(4) Applicant. "Applicant" means any individual, firm, partnership, association, corporation or county who has made application for a license.

(5) Basic Rate. "Basic Rate" means the SSI/SSP established rate, which does not include that amount allocated for the recipient's personal and incidental needs.

(6) Basic Services. "Basic Services" means those services required to be provided by the facility in order to obtain and maintain a license and include, in such combinations as may meet the needs of the residents and be applicable to the type of facility to be operated, the following: safe and healthful living accommodations; personal assistance and care; observation and supervision; planned activities; food service; and arrangements for obtaining incidental medical and dental care.

(7) Capacity. "Capacity" means that maximum number of persons authorized to be provided services at any one time in any licensed facility.

(8) Care and Supervision. "Care and Supervision" means those activities which if provided shall require the facility to be licensed. It involves assistance as needed with activities of daily living and the assumption of varying degrees of responsibility for the safety and well-being of residents. "Care and Supervision" shall include, but not be limited to, any one or more of the following activities provided by a person or facility to meet the needs of the residents:

(A) Assistance in dressing, grooming, bathing and other personal hygiene;

(B) Assistance with taking medication, as specified in Section 87610;

(C) Central storing and distribution of medications, as specified in Section 87610;

(D) Arrangement of and assistance with medical and dental care. This may include transportation, as specified in Section 87610;

(E) Maintenance of house rules for the protection of residents;

(F) Supervision of resident schedules and activities;

(G) Maintenance and supervision of resident monies or property;

(H) Monitoring food intake or special diets.

(9) Community Care Facility. "Community Care Facility" means any facility, place or building providing nonmedical care and supervision, as defined in Section 87000(a)(8).

(10) Conservator. "Conservator" means a person appointed by the Superior Court pursuant to the provisions of Section 1800 *et seq.* of the Probate Code to care for the person, or person and estate, of another.

CALIFORNIA RESIDENTIAL CARE FACILITIES FOR THE ELDERLY ACT

§ 1569.2. Definitions

As used in this chapter:

(a) "Care and supervision" means the facility assumes responsibility for, or provides or promises to provide " " in the future, ongoing assistance with " " activities of daily living without which resident's physical health, mental health, safety or welfare would be endangered. Assistance includes assistance with taking medications, money management, or personal care.

(b) "Department" means the State Department of Social Services.

(c) "Director" means the Director of Social Services.

(d) "Health related services" means services which shall be directly provided by an appropriate skilled professional including a registered nurse, licensed vocational nurse, physical therapist, or occupational therapist.

(e) "Instrumental activities of daily living" means any of the following: housework, meals, laundry, taking of medication, money management, appropriate transportation, correspondence, telephoning, and related tasks.

(f) "License" means a basic permit to operate a residential care facility for the elderly.

(g) "Personal activities of daily living" means any of the following: dressing, feeding, toileting, bathing, grooming, and mobility and associated tasks.

(h) "Personal care" means assistance with personal activities of daily living, to help provide for and maintain physical and psychosocial comfort.

(i) "Protective supervision" means observing and assisting confused residents, including persons with dementia, to safeguard them against injury.

(j) "Residential care facility for the elderly" means a group housing arrangement chosen voluntarily by residents over 60, but also including persons under 60 with compatible needs, who are provided varying levels and intensities of care and supervision, protective supervision, or personal care, based upon their varying needs, as determined in order to be admitted and to remain in the facility. This subdivision shall be operative only until the enactment of legislation implementing the three levels of care in residential care facilities for the elderly pursuant to Section 1569.70.

(k) "Residential care facility for the elderly" means a group housing arrangement chosen voluntarily by residents over 60, but also including persons under 60 with compatible needs, who are provided varying levels and intensities of care and supervision, protective supervision, personal care, or health related services, based upon their varying needs, as determined in order to be admitted and to remain in the facility.

This subdivision shall become operative upon the enactment of legislation implementing the three levels of care in residential care facilities for the elderly pursuant to Section 1569.70.

(l) "Supportive services" means resources available to the resident in the community which help to maintain their functional ability and meet their needs as identified in the individual resident assessment. Supportive services may include any of the following: medical, dental, and other health care services, transportation, recreational and leisure activities, social services, " " and counseling services.

(Added by Stats 1985, c. 1127, § 3. Amended by Stats 1986, c. 844, § 1.)

§ 1569.10. Residential facility for the elderly; license or permit; necessity

No person, firm, partnership, association, or corporation within the state and no state or local public agency shall operate, establish, manage, conduct, or maintain a residential facility for the elderly in this state without * * * a current valid license or current valid special permit therefor, as provided in this chapter.

(Added by Stats.1985, c. 1127, § 3; Stats.1985, c. 728, § 4, urgency, eff. Sept. 18, 1985 Amended by Stats.1987, c. 1069, § 4.)

§ 1569.312. Basic service requirements

Every facility required to be licensed under this chapter shall provide at least the following basic services:

(a) Care and supervision as defined in Section 1569.2

(b) Assistance with instrumental activities of daily living in the combinations which meet the needs of residents.

(c) Helping residents gain access to appropriate supportive services, as defined, in the community.

(d) Being aware of the resident's general whereabouts, although the resident may travel independently in the community.

(e) Monitoring the activities of the residents while they are under the supervision of the facility to ensure their general health, safety, and well-being.

(f) Encouraging the residents to maintain and develop their maximum functional ability through participation in planned activities.

(Added by Stats.1985, c. 1127, § 3. Amended by Stats.1986, c. 844, § 4.)

§ 1569.40. Misdemeanor; punishment; summons to appear in court

(a) Any person who violates this chapter, or who willfully or repeatedly violates any rule or regulation adopted under this chapter, is guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not to exceed one thousand dollars (\$1,000) or by imprisonment in the county jail for a period not to exceed 180 days, or by both such fine and imprisonment.

(b) Operation of a residential care facility for the elderly without a license shall be subject to a summons to appear in court.

(Added by Stats.1985, c. 1127, § 3; Stats.1985, c. 1415, § 6.5.)

1985 Legislation

Section 8.5 of Stats.1985, c. 1415, provides

"Section 6.5 of this act shall not become operative unless SB 185 of the 1985-86 Regular Session [Stats.1985, c. 1127] becomes effective and operative and in that case Section 6.5

of this act shall become operative at the same time as SB 185 or this bill, whichever is later."

Addition of § 1569.40 by Stats.1985, c. 1127, § 3, by its own terms, was subordinated to the addition of § 1569.40, by Stats.1985, c. 1415, § 6.5

§ 1569.405. Violations; penalties; notice

Upon a finding by the licensing authority that a facility is in operation without a license, a peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code, may enforce Section 1569.10 by utilizing the procedures set forth in Chapter 5 (commencing with Section 853.5) of Title 3 of Part 2 of the Penal Code. A facility violating Section 1569.10 is guilty of an infraction punishable by a fine of two hundred dollars (\$200) for each day of violation. Upon a determination that a residential care facility for the elderly is in violation of Section 1569.10, and after a citation has been issued, the peace officer shall immediately notify the licensing authority in the department.

(Added by Stats.1987, c. 856, § 2.)

§ 1569.44. Unlicensed residential facility for elderly; definition; operation without license prohibited; procedure upon discovery

(a) A facility shall be deemed to be an "unlicensed residential facility for the elderly" and "maintained and operated to provide residential care" if it is unlicensed and not exempt from licensure, and any one of the following conditions is satisfied:

- (1) The facility is providing care and supervision services, as defined by this chapter or the rules and regulations adopted pursuant to this chapter.
- (2) The facility is held out as, or represented as, providing care and supervision and services, as defined by this chapter or the rules and regulations adopted pursuant to this chapter.
- (3) The facility accepts or retains residents who demonstrate the need for care and supervision and services, as defined by this chapter or the rules and regulations adopted pursuant to this chapter.
- (4) The facility represents itself as a licensed residential facility for the elderly.

(b) No unlicensed residential facility for the elderly, as defined in subdivision (a), shall operate in this state

(c) Upon discovery of an unlicensed residential care facility for the elderly, the department shall refer residents to the appropriate placement or adult protective services agency or the appropriate local or state long-term care ombudsman, if either of the following conditions exist:

- (1) There is an immediate threat to the clients' health and safety.
- (2) The facility will not cooperate with the licensing agency to apply for a license, meet licensing standards, and obtain a valid license.

(Added by Stats.1985, c. 1127, § 3; Stats.1985, c. 728, § 5, urgency, eff. Sept. 18, 1985. Amended by Stats.1986, c. 844, § 7.)

§ 1569.45. Mandatory licensing of facilities offering care and supervision to the elderly

A facility shall be licensed as a residential care facility for the elderly if it offers care and supervision, as defined, to its residents. Every residential care facility for the elderly in this state shall be licensed under this chapter.

(Added by Stats.1985, c. 1127, § 3.)

§ 1569.485. Civil penalty: appeal

(a) Notwithstanding any other provision of this chapter, any person who violates Section 1569.10 or 1569.44, or both, may be assessed by the department an immediate civil penalty in the amount of two hundred dollars (\$200) per day of the violation.

(b) The civil penalty authorized in subdivision (a) shall be imposed if an unlicensed facility is operated and the operator refuses to seek licensure or the operator seeks licensure and the licensure application is denied and the operator continues to operate the unlicensed facility.

(c) An operator may appeal the assessment to the director. The department shall adopt regulations setting forth the appeal procedure.

(Added by Stats.1985, c. 1415, § 6.7.)

§ 1569.49. Civil penalties

(a) In addition to suspension or revocation of a license issued under this chapter, the department may levy a civil penalty in addition to the penalties of suspension or revocation.

(b) The amount of the civil penalty shall not be less than twenty-five dollars (\$25) or more than fifty dollars (\$50) per day for each violation of this chapter except where the nature or seriousness of the violation or the frequency of the violation warrants a higher penalty or an immediate civil penalty assessment, or both, as determined by the department. In no event, shall a civil penalty assessment exceed one hundred fifty dollars (\$150) per day.

(c) Notwithstanding Section 1569.33, any residential care facility for the elderly that is cited for repeating the same violation of this chapter within 12 months of the first violation is subject to an immediate civil penalty of one hundred fifty dollars (\$150) and fifty dollars (\$50) for each day the violation continues until the deficiency is corrected.

(d) Any residential care facility for the elderly that is assessed a civil penalty pursuant to subdivision (c) which repeats the same violation of this chapter within 12 months of the violation subject to subdivision (c) is subject to an immediate civil penalty of one hundred fifty dollars (\$150) for each day the violation continues until the deficiency is corrected.

The department shall adopt regulations implementing this section.

(Added by Stats.1985, c. 1372, § 6.)

§ 1569.495. Nonexclusive remedies

The civil, criminal, and administrative remedies available to the department pursuant to this article are not exclusive, and may be sought and employed in any combination deemed advisable by the state department to enforce this chapter.

(Added by Stats 1985, c. 1127, § 3.)

§ 1569.43. Prosecution of actions for violation upon application of the department

The district attorney of every county shall, upon application by the state department or its authorized representative, institute and conduct the prosecution of any action for violation of this chapter within his or her county.

(Added by Stats.1985, c. 1127, § 3.)

Home Health Services (Cont'd)

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 MEDICARE/MEDI-CAL
 Fair Oaks Bl 486 8484

AN JUAN HOSPITAL
 537 5248

MEDICARE-MAPS
 MAPS Pharmacy
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482-HOME
 1209 El Toro Wy 482 4663

Action Home & Yard Repair 991 2682
 Bear Tavern Construction 972 1210

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EXHIBIT I

PROPOSED STATUTORY LANGUAGE TO DEFINE
UNIFORM CORE OF KNOWLEDGE

The uniform core of knowledge 20 clock hour training requirement for administrators shall focus on the following areas:

1. LAWS, REGULATIONS, POLICIES AND PROCEDURAL STANDARDS THAT IMPACT THE OPERATIONS OF RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE).

Such information shall include but not be limited to:

- a. RCFE laws, regulations, policy and procedures
- b. Local ordinances
- c. Fire Marshall standards
- d. Role and Authority of Long Term Care Ombudsman Program
- e. Social Security Administration's standards that impact SSI/SSP recipients
- f. Guardian/Conservatorship

2. BUSINESS OPERATION

- a. Developing and operating a facility budget
- b. Review and approve contracts for services and personnel
- c. Keeping appropriate business and financial records
- d. Payroll information
- e. Professional Development

3. MANAGEMENT/SUPERVISION OF STAFF

Such information shall include but not be limited to:

- a. Hiring/firing of staff
- b. Staff training and development
- c. Scheduling of employees to ensure sufficient coverage
- d. Addressing staff complaints
- e. Responding to staff suggested changes for improved facility operation
- f. Labor laws

4. PSYCHOSOCIAL NEEDS OF ELDERLY RESIDENTS

Such information shall include but not be limited to:

- a. Protective supervision of residents with dementia
- b. Utilization of community resources
- c. Activities to maximize resident independence
- d. Maximizing resident's communication with family, friends and significant others.
- e. Recreational activities
- f. Resident's need for community involvement
- g. Advocacy for the elderly population
- h. Resident's Personal Rights (87144)

5. PHYSICAL NEEDS FOR ELDERLY RESIDENTS

Such information shall include but not be limited to:

- a. Recognition of health-related needs of the elderly in RFE's
- b. Nutrition
- c. Personal care services
- d. Promoting exercise and physical therapy programs
- e. Transportation (arranging and providing)
- f. Maintaining records of resident's monies and personal property
- g. Specialized equipment
- h. Assessment/reassessment of the elderly persons
- i. Medication (use and abuse)

6. COMMUNITY SERVICES

Such information shall include but not be limited to:

- a. Adult Day Health Care
- b. Home Health Agency
- c. Linkages Program
- d. Transportation
- e. Adult Protective Services
- f. Foster Grandparent Program
- g. Adult Educational Program
- h. Multipurpose Senior Services Program (MSSP)
- i. Senior Centers
- j. AAA's

EXHIBIT J

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