

KEEPING NURSING HOME RESIDENTS SAFE:

The State Must Hold Nursing Homes Accountable for Resident Deaths

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Disability Rights California is the independent protection and advocacy system for California. Established under federal law to protect the rights and interests of persons with disabilities, both Congress and the State of California have granted Disability Rights California the unique authority to investigate allegations of abuse and neglect involving Californians with disabilities. Disability Rights California investigations focus on systemic issues related to abuse and neglect, including those that indirectly support a culture of abuse or neglect and that challenge or diminish the effectiveness of the current system of response.

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Executive Summary

Greta Kim¹, a 56 year old nursing home resident, died from a brain hemorrhage after her nursing home repeatedly failed to perform routine blood testing that would have alerted them to her high risk of bleeding resulting from the blood thinners they were giving her. Alejandro Reynolds was a 30 year old man with paraplegia who died after poor care by his nursing home resulted in him bleeding uncontrollably from a massive pressure sore. Randall Gosling, an 82 year old nursing home resident, was found strangled in bed by a waist restraint which his nursing home had applied to stop this confused, elderly gentleman from getting out of bed unassisted. Staff then failed to closely monitor him despite the known risk of strangulation with such a dangerous device. These are just a few examples of poor care that directly contributed to patient deaths. Yet the California Department of Public Health, Licensing and Certification Division (Licensing) did not sanction the facilities with the penalty for care violations that are a direct proximate cause of a resident's death—a Class AA citation. Instead, Licensing issued a lesser citation—a Class A citation-- with a correspondingly lower fine level.

These cases are not isolated events. Disability Rights California analyzed hundreds of cases in which Licensing issued lower level citations for deaths where the conduct of nursing home staff directly contributed to the residents' deaths. Issuing a lower level of citation fails to accurately alert the public about the severity of resulting harm to residents in the long-term care facilities in which they entrust their loved ones and is a missed opportunity to levy fitting monetary penalties. Licensing fails to fulfill its

¹ Pseudonyms have been used for the names of individuals and facilities throughout this report.

responsibility as the oversight entity to protect the health, safety, and security of patients in long-term health care facilities.

Disability Rights California finds:

1. Licensing has failed to consistently apply the same citation level when staff misconduct is a direct proximate cause of a resident's death.
2. Licensing appears to lack consistent standards for issuing citations in the case of a resident's death.
3. Nursing facilities are not fined a higher penalty when Licensing concludes that staff conduct was not a direct cause of a resident's death.

These findings support the following recommendations

Disability Rights California recommends:

1. Licensing consistently issue a Class AA citation when staff conduct is a direct proximate cause of a resident's death.
2. Licensing apply consistent standards for issuing citations;
3. Licensing provide greater transparency regarding the facts supporting a finding of inadequate probable cause in the case of resident deaths; and
4. California increase the penalty amount for citations involving deaths of residents in long-term care facilities indirectly resulting from staff conduct.

During the final drafting of this report, Disability Rights California met with representatives from the California Department of Public Health Licensing and Certification Division and presented our preliminary findings and recommendations. Subsequently, Licensing has proactively

implemented several of the preliminary report's recommendations, most notably those pertaining to providing the public with greater on-line access to citation information. Specifically, Licensing committed to posting the full content of all Class A citations issued since January 2012 on their [Health Facilities Consumer Information System](#) (HFCIS) website. Licensing also previewed for Disability Rights California enhanced search capabilities which should provide the public with easier access to information about specific long term care facilities. We are encouraged by the responsiveness of Licensing to our recommendations and appreciate their readiness to augment the functionality of their consumer website to provide greater transparency about care issues that resulted in citations.

Oversight of California’s Nursing Homes

The California Department of Public Health Licensing and Certification Division (Licensing) is responsible for ensuring health care facilities comply with state laws and regulations. In addition to licensing and inspecting health care facilities, Licensing also investigates complaints of health and safety violations and non-compliance with regulatory requirements. This includes investigating reports of suspicious deaths of residents of long-term health care facilities. Long-term health care facilities include skilled nursing facilities (commonly known as nursing homes), intermediate care facilities for the developmentally disabled, and congregate living health facilities².

California law requires Licensing to establish a citation system for the imposition of prompt and effective civil sanctions against long-term health care facilities when they violate a state law or regulation. Licensing has established three classes of citation, based upon the nature of the violation and severity of the resulting harm to patients.

² “Long-term health care facility” means any facility licensed as a skilled nursing facility, intermediate care facility, (including those for developmentally disabled, habilitative, nursing and continuous nursing), congregate living health facility, nursing facility, and pediatric day health and respite care facility. Health and Safety Code §§1418(a) and 1760.

Classes of Citation:

Class AA citations are issued when the death of a patient or resident is **a direct proximate cause** of facility or staff misconduct that violates state regulations. The financial penalties for Class AA citations range from \$25,000 to \$100,000. If a long-term health care facility receives more than one Class AA citation within a 24 month period, Licensing must commence action to suspend or revoke the facility's license.

Class AA citations require approval by the District Office Manager, Licensing's Medical Consultant, the Office of Legal Services, and the Field Operations Branch Chief before they are issued.

Class A citations are issued when facility or staff conduct poses an **imminent danger** or a **substantial probability** that death or serious physical harm to patients or residents would result.

The financial penalties for Class A citations range from \$2,000 to \$20,000.

Class B citations are issued for all other regulatory violations that have a direct or immediate relationship to the health, safety, or security of long-term health care facility patients or residents but do not result in serious harm or death, with fines up to \$1,000.

California Health & Safety Code §1424 et seq.

It is important to emphasize that, when issuing a Class AA citation, the law does not require Licensing to conclude that staff conduct was the direct cause of the resident's death. There may be other contributing causes. The other factors may have equally or even more significantly contributed to a resident's death but the violation was also a factor. As the cases below clearly illustrate, lapses in care by staff were clearly a direct cause of the resident's death. They did not merely imminently endanger the resident or create a significant probability of harm – they were a direct proximate cause of the resident's death and warranted a Class AA citation. Holding the facility to a lower level of culpability diminishes the significant impact of the staff's misconduct in causing the death of a resident under their care. And it misrepresents to the public the substantial part staff conduct played in causing the death of a resident.

A Closer Look at Five Deaths: *Should Licensing Have Issued a Class AA Citation?*

Disability Rights California conducted in-depth investigations into the deaths of seven³ residents for which Licensing did not attribute staff conduct as a direct proximate cause of death but rather merely a possible cause. As a component of Disability Rights California's investigations, we consulted with the following medical, nursing, and respiratory care experts:⁴

1. Laura Mosqueda, M.D., Associate Dean of Primary Care and Chair and Professor of Family Medicine and Geriatrics at the University of Southern California, Keck School of Medicine. Dr. Mosqueda is a widely respected authority on geriatric medicine and elder abuse. As the co-director of the National Center on Elder Abuse, Dr. Mosqueda has pioneered systemic reform through research, training, and the development of best practices to reduce and eliminate elder abuse, neglect and exploitation.
2. Mary Cadogan, DrPH, RN, GNP-BC, FAAN, FGSA, Professor at the University of California, Los Angeles, School of Nursing, lead faculty member for the Adult/Gerontology Primary Care Nurse Practitioner Program and Co-Director of the Center for the Advancement of Gerontological Nursing Science. Professor

³ For confidentiality reasons, only five of the seven deaths will be described in this report. The other two deaths involve minor children whose family requested that Disability Rights California not include them in this report to ensure confidentiality.

⁴ Any views or opinions expressed by Laura Mosqueda, Mary Cadogan or Michael Lowder in this report constitute their personal opinion and do not represent the views or opinions of the agency or organization with which they are affiliated. Their opinions are based on the documents and evidence that they reviewed.

Cadogan's research and policy work has focused on improving the quality of care of nursing home residents.

3. Michael Lowder, Respiratory Therapist. Mr. Lowder is credentialed with the National Board of Respiratory Care. He is currently Charge Therapist at the California Pacific Medical Center and has expertise in all areas of adult and pediatric respiratory care, including ventilation and airway management.

These experts reviewed thousands of pages of records, including the clinical records of each deceased resident and Licensing's investigation records. As described below, the experts concluded that the deaths were a ***direct proximate result*** of staff misconduct and should have been issued as a Class AA citation. In each case, Licensing did not find the death directly attributable to negligent care by facility staff and issued the lower level Class A citation and at a lower monetary penalty.

1. Alejandro Reynolds:

At the time of his death, Alejandro Reynolds was a 30 year old man living at Verdant Vista Nursing Facility (Verdant Vista). Mr. Reynolds was paraplegic as the result of a gunshot wound sustained eleven years earlier. He used a wheelchair for mobility.

Mr. Reynolds had multiple, gaping pressure sores, or decubitus ulcers, at many of the bony prominences of his body, including at his hip bones and sacrum. Pressure sores develop when a body is left in the same position for too long and circulation to skin and tissue at pressure points, where the bone is close to the skin, is diminished. They can quickly advance and cause serious infections if left untreated for even a brief period of time. They are avoided by changing the body's position every two

hours, keeping the area of skin clean and dry, and using pillows and products that relieve pressure.⁵

Mr. Reynolds had numerous pressure sores on his back and legs. The largest, on his sacrum, measured 6 x 4 inches and extended down to his hip joint, sacrum and lower spine. He had a similar pressure sore on his right side, extending to the surface of his femur. Despite the presence of these severe pressure sores, for months Mr. Reynolds only received daily routine wound care by the facility's nursing staff. No special wound care was provided by nursing staff or a wound care expert.

Mr. Reynolds was also receiving two blood thinning medications. The facility failed to develop a care plan for monitoring his medications and failed to monitor his clotting times.

On July 20, 2010, at approximately 2:20 a.m., Mr. Reynolds began yelling and screaming for help. He was bleeding uncontrollably from his right groin or femoral artery. He shouted, "Help! Help! I do not want to die!" Nursing staff rushed in and applied direct pressure to stop the excessive and continuous bleeding from one of his more cavernous decubitus ulcers. The blood soaked his bed and was dripping onto the floor. Staff summoned paramedics who arrived shortly thereafter. Mr. Reynolds was transferred to Verdant Hills Hospital where he died a little more than one hour later, at 3:50 a.m.

The coroner's autopsy report documented the extreme advancement of the decubitus ulcers from the time of Mr. Reynolds's admission to Verdant Vista until his death. Many of the pressure ulcers were now gaping deep sores, festering down to the bone, including the hip, femur,

⁵ <https://www.nlm.nih.gov/medlineplus/pressuresores.html>

and lower spine. The coroner noted “Neglect by provider of care” on the autopsy report.

According to a wound care medical expert with whom Disability Rights California consulted, Mr. Reynolds should have been transferred to a facility for surgical intervention of his pressure ulcers. The failure to provide appropriate medical care or minimally treat his advancing wounds was a direct proximate cause of Mr. Reynolds’s death. The use of blood thinners undoubtedly contributed to the uncontrolled hemorrhaging when the pressure ulcers advanced down to his femoral artery.

This is not the first time Verdant Vista’s substandard care resulted in a patient’s death. A year earlier, Chester Maples, a 34 year old with developmental disabilities, committed suicide by inhaling the contents of a fire extinguisher and suffocating himself. In the preceding month, Mr. Maples had been caught attempting to kill himself on two separate occasions using the exact same method. Yet the facility failed to address his depression and suicidality or secure the fire extinguishers. Licensing issued a Class AA citation for his death and the Attorney General’s office filed a criminal complaint against the facility.

On August 30, 2014, Jerome Parks, a 58 year old resident, died from bronchopneumonia due to severe neglect by Verdant Vista’s staff—care that was so grossly negligent that the Attorney General filed voluntary manslaughter charges against the facility. A medical expert found that Parks “died prematurely and needlessly ... due to the woefully substandard monitoring, assessments, care, and treatment he received while a resident at Verdant Vista.” Licensing ultimately issued a Class AA citation for Mr. Parks’ death.

If Licensing had held Verdant Vista appropriately accountable for Alejandro Reynolds's death and issued a Class AA citation, they would have been legally obligated to take steps to revoke or suspend the facility's license, possibly preventing Mr. Parks' death. Any facility that receives two Class AA citations within a two year period is subject to license suspension or revocation. Verdant Vista received one Class AA citation for Mr. Maples's death but, because Licensing issued a Class A citation in the case of Mr. Reynolds's death, Verdant Vista was allowed to continue to operate following his death, leaving residents, including Mr. Parks, at grave risk.

2. Barry Murphy:

Barry Murphy was an elderly gentleman who had lived in Green Gables Nursing Home for nearly three years. Mentally, he was sharp as a tack but, due a variety of medical issues, Mr. Murphy was at high risk for falling and injuring himself. Knowing this, Green Gables staff developed a plan of care for Mr. Murphy which included staff assisting him when getting in and out of bed and walking. Staff were specifically cautioned to make sure that he did not sit unsupervised on the edge of the bed.

In early March, in violation of the care plan, staff positioned Mr. Murphy sitting on the edge of the bed in reach of his breakfast tray and left the room. An aide heard a loud crash, came back into the room and found Mr. Murphy hemorrhaging on the floor from deep lacerations to his face and forearm. He had been badly wounded by the broken glass and dishes when he fell onto his shattered breakfast tray from his seat on the edge of his bed. He required emergency treatment at the local hospital, including receiving several units of blood and suturing.

Less than two weeks later, Mr. Murphy was again found lying on the floor next to his bed with a laceration to his scalp after apparently getting out of bed unsupervised. He was again rushed to the local hospital, this time with a life threatening acute subdural hematoma (a blood clot between the surface of the brain and the brain's outer covering) caused by his head hitting the hard floor. He was hurried into surgery but never recovered from his injuries. He died two weeks later from "head trauma with subdural hemorrhage suffered in a fall."

Professor Cadogan concluded that Mr. Murphy's death was a direct proximate cause of staff failing to properly supervise him and leaving him perched on the edge of his bed in direct violation of his plan of care. According to Professor Cadogan, the facility should have modified Mr. Murphy's plan after the first serious fall and ensured all precautions were taken to help him out of bed. "There was no evidence that they changed his care plan after his earlier bad fall at the facility... there is no documentation to say the plan that the facility had in place did not work. And so the facility needed to do something different. That didn't take place."

3. Greta Kim:

Greta Kim was an alert 56 year old who was admitted from a long term rehabilitation facility to be weaned off of her external mechanical breathing apparatus (i.e. a ventilator or vent). Ms. Kim regularly emailed family. She talked with staff by pressing a by-pass valve connected between her tracheostomy (curved tubes inserted through a hole in the neck and into the windpipe or trachea) and the ventilator.

Because of her medical conditions, Ms. Kim was on blood thinners which slow the time it takes for blood to clot. Patients on this medication

have their clotting times regularly checked to make sure they are not at risk of uncontrolled hemorrhaging. But staff at Brookside Skilled Nursing Facility did not check Ms. Kim's clotting times during her entire six week admission. Nursing staff just kept giving her the blood thinner. In addition, she was prescribed two antibiotics that were known to increase the risk of bleeding when taken in combination with the blood thinner that she was prescribed.

A little after noon on one autumn day, Ms. Kim was found unresponsive in bed and having seizures. Emergency bloodwork showed that her clotting times were six times slower than normal. A CT scan showed that she had sustained a large intracranial hemorrhage, massive bleeding between skull and the brain. Ms. Kim was brain dead.

By policy, the facility required staff to check the clotting times of patients on this medication at least once a month. The facility pharmacist claimed that they check the clotting times on patients every week but could not show any evidence that Ms. Kim's clotting times had been monitored at all. Ms. Kim's physician could not remember if he had ordered monitoring of her clotting times, claiming that he relied on the facility's policy. Staff admitted that getting an ongoing order to monitor clotting times "was overlooked for [Ms. Kim]."

One nurse subsequently reported that Ms. Kim had some minor bleeding the day before her death, which she reported to the physician. He told her to "watch Ms. Kim" but did not order any lab work. When interviewed, he said, "In retrospect, I wish I had done more."

Dr. Mosqueda concluded that staff and physician failure to check Ms. Kim's clotting times and to continue to give her the blood thinners was a

direct proximate cause of her death. According to Dr. Mosqueda, “She bled to death. She was overmedicated and they could have given her medication to reduce her risk of bleeding. They are supposed to check and monitor her blood levels. If they had done so, they would have seen immediately that she was at great risk for bleeding. They did not check her clotting times and she died. This was absolutely preventable.”

4. Randall Gosling:

Randall Gosling was an 82 year old man with a number of circulatory and other health problems. He was on hospice care at Mayweather Rehabilitation and Nursing Center (Mayweather). Since being admitted to Mayweather, Mr. Gosling had experienced a number of serious falls. Initially he was placed in a “low bed”, a bed approximately 12 inches from the ground, with a mattress on the floor next to the bed to cushion him should he fall out of bed. After falling four times, Mr. Gosling’s physician ordered that the low bed be replaced with a regular bed and that staff apply several restraint devices when Mr. Gosling was in bed, including side rails and a soft waist restraint. These restraining devices are well known to put patients at risk of strangulation, particularly individuals with a history of falling out of bed.

Several weeks later, nursing staff found Mr. Gosling entangled by the bed restraint. His limp body was hanging “half in the bed and half on the floor”, with the soft waist restraint around his neck and arm pit. His head was dangling at the level of the mattress and his legs and feet were pointed towards the elevated head of the bed. He was unresponsive, his eyes and mouth hanging open. Staff hurried to untie the restraint from the bedframe but it was taut. Eventually, staff released the restraint and lowered Mr.

Gosling to the floor. Resuscitation efforts failed and Mr. Gosling died shortly thereafter. The autopsy showed signs consistent with asphyxia.

Nursing staff later acknowledged that they had not monitored Mr. Gosling as required. According to the facility policy, patients in restraints are to be checked at least every two hours but there was no evidence that staff had been checking on Mr. Gosling. A video camera positioned in the hallway showed staff going into and out of Mr. Gosling's room that he shared with another resident. However, they could not verify that Mr. Gosling had actually been checked on. The privacy curtain surrounding each resident's bed may have precluded their ability to monitor Mr. Gosling when checking on his roommate.

According to Professor Mary Cadogan, "This should have been a AA citation. The evidence to support the AA is the language of the citation by Licensing, 'the facility failed to use the restraint in such a way not to cause injury, physical injury, to patient A; the failure led to his death.' His death fits the absolute definition of an AA because of the way they used the restraints."

5. Haddy Baskin:

Haddy Baskin, an elderly resident of Kind Care and Rehabilitation, had a tracheostomy through which she breathed. Ms. Baskin had short term memory problems and was moderately impaired in daily decision making. She could not speak because of the tracheostomy and vacillated in her ability to understand what others were saying to her.

The facility had tried to transition Ms. Baskin to a valve (known as a Passy-Muir valve, or PMV) that would allow her to speak by redirecting air

flow through her vocal cords. However, Ms. Baskin had not tolerated attempts at breathing with the valve. When breathing with the valve, her heart rate would accelerate and her breath sounds indicated a blockage of her airway. Her physician ordered a consultation by an ear, nose, and throat expert but did not order that trials on the valve breathing stop.

On the day of her death, the respiratory therapist again placed Ms. Baskin on the valve and left the room, in violation of facility policy. The respiratory therapist later reported that he had left Ms. Baskin to check on other residents. He claimed to have “peeked in on” her at some point during the hour and that she “looked good.”

Nearly an hour later, two nursing assistants came to check on Ms. Baskin and found that she was unresponsive, without a pulse and not breathing. CPR was attempted but was unsuccessful.

After her death, facility staff acknowledged that the respiratory therapist should have remained with Ms. Baskin during the trial on the valve, especially in light of her not tolerating the valve in previous attempts, including the day before. Another physician familiar with Ms. Baskin’s history expressed that he thought the valve trials should have been discontinued after learning that Ms. Baskin was not tolerating them.

Michael Lowder, Disability Rights California’s respiratory therapy expert, found the failure of staff to monitor Ms. Baskin while on the valve a direct cause of her death. According to Mr. Lowder, “I looked through her records and read the Licensing report and, frankly, this should never have happened. With Passy-Muir valves, you don’t leave a patient unsupervised if they can’t understand what’s happening or remove the valve themselves. What they did was very unsafe.” Mr. Lowder faulted the facility for

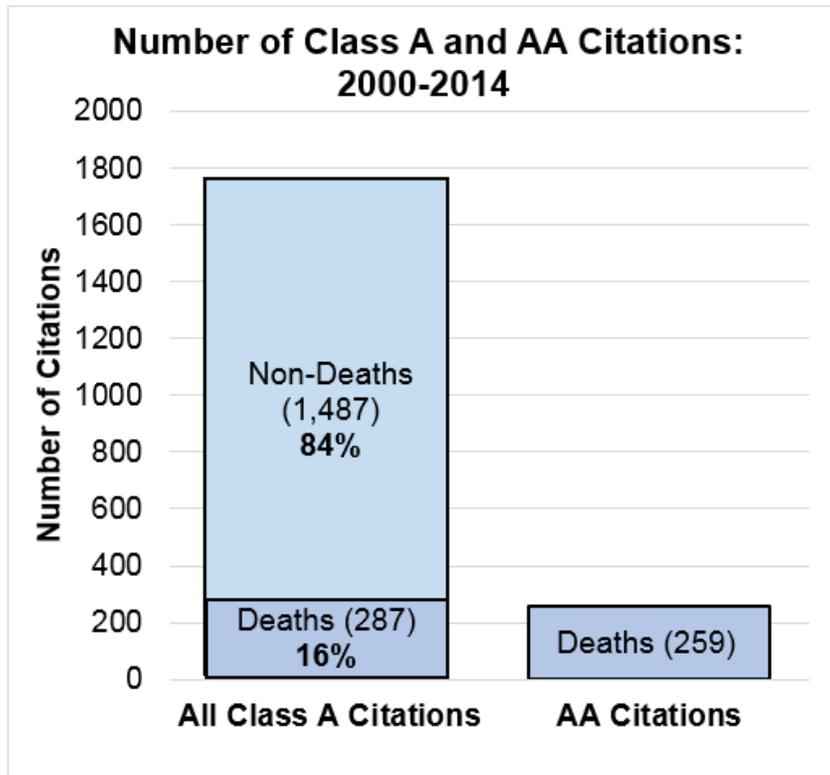
continuing the Passy-Muir valve trials when it was known that she was not tolerating being put on the valve and faulted the respiratory therapist for leaving Ms. Baskin unattended. “This death could have been prevented.”

This was not the first serious incident at this facility due to staff negligence; Kind Care has also received seven Class A or AA citations, including five for incidents involving resident deaths.

Indistinguishable Facts, Uneven Accountability

Disability Rights California reviewed all of the Class A and AA citations issued to long term health care facilities between 2000 and 2014, a total of 2033 citations: 1,774 Class A citations and 259 AA citations. Of the 1,774 Class A citations, 287, or 16%, involved resident deaths. In other words, nearly 1/5 of all Class A citations involved a resident death that was the result of staff conduct but, according to Licensing, was not a direct proximate cause. In over half of the resident deaths, Licensing concluded that staff misconduct posed an imminent danger or substantial probability of death but was not a proximate cause. More deaths were given a Class A citation than a Class AA death citation. As described further below, Disability Rights California compared these 287 Class A deaths with the 259 Class AA deaths, and could not discern a factual basis for why some deaths warranted a Class A (the lower level penalty) rather than a Class AA citation.

Table 1: Number of Citations: Deaths vs. Non-deaths



Disability Rights California compared the facts in the deaths resulting in a Class AA citation with those deaths resulting in a Class A citation and found, in many cases, nearly exact circumstances and care deficiencies. It was not possible to discern why Licensing found staff misconduct a direct proximate cause of some deaths and others merely a contributing cause. In fact, the circumstances of many of the Class A deaths were even more egregious than those that received the more serious penalty of a Class AA citation. In other words, in cases of strikingly similar facts, there was no apparent difference why some deaths were assigned a Class AA citation and others a Class A citation.

The table below compares summaries of nearly identical Class AA and Class A citations which resulted in a patient's death.

Table 2: Comparison of Inconsistent Citation Levels for Similar Incidents

| AA Citations | Class A Citations |
|---|--|
| <p>Fall (AA) Penalty Amount: \$60,000</p> <p>Citation #030002079 95 year old at high risk for falls fell out of bed and died two days later. He had a care plan for a soft waist restraint which was not implemented.</p> | <p>Fall (A) Penalty Amount: \$20,000</p> <p>Citation #220010147 An elderly resident fell out of bed 15 days before his death, sustaining multiple lacerations. He fell out of bed again and sustained subdural hematoma, died within hours. There was no care plan to address his falls.</p> |
| <p>Too Much Blood thinner (AA) Penalty Amount: \$60,000</p> <p>Citation #030006469 A 78-year-old client on Coumadin died from an intracerebral hemorrhage. The facility initially checked blood clotting times, but failed to transfer her to the hospital when she became unresponsive.</p> | <p>Too Much Blood thinner (A) Penalty Amount: \$16,000</p> <p>Citation #0200010227 A 56-year-old resident on Coumadin died after the facility failed to check blood clotting times or monitor her medications that increased her risk for bleeding. She died from a massive brain hemorrhage.</p> |
| <p>Strangled in Bed restraint (AA) Penalty Amount: \$90,000</p> <p>Citation #030002098 A resident's head got stuck in her bed side rail; she had been placed in a roll waist restraint and died from neck compression.</p> | <p>Strangled in Bed restraint (A) Penalty Amount: \$10,000</p> <p>Citation #250010605 A resident was strangled to death in bed with a soft roll waist restraint.</p> |
| <p>Respiratory Device Malfunction (AA) Penalty Amount: \$60,000</p> <p>Citation #060001186 A respiratory therapist changed the resident's trach tube alone; it was not functioning properly but he left</p> | <p>Respiratory Device Malfunction (A) Penalty Amount: \$20,000</p> <p>Citation #020010043 A resident died after being left alone by a respiratory therapist who had used a breathing device which she</p> |

| AA Citations | Class A Citations |
|---|--|
| the room without monitoring her and she died. | was known not to tolerate (a Passy Muir Valve). |
| <p data-bbox="191 363 630 443">Blood loss (AA) Penalty Amount: \$100,000</p> <p data-bbox="191 489 743 611">Citation #120004404 A resident on blood thinners bled out from her gastrointestinal tract.</p> | <p data-bbox="800 363 1219 443">Blood loss (A) Penalty Amount: \$20,000</p> <p data-bbox="800 489 1409 611">Citation #920009239 A resident on blood thinners bled out from a pressure ulcer.</p> |
| <p data-bbox="191 663 610 743">Choked on Food (AA) Penalty Amount: \$32,500</p> <p data-bbox="191 789 678 953">Citation #910007605 A resident choked on food provided by staff that was not consistent with his soft diet.</p> | <p data-bbox="800 663 1219 743">Choked on Food (A) Penalty Amount: \$20,000</p> <p data-bbox="800 789 1430 995">Citation #070004062 Facility staff gave a resident regular food instead of pureed food as ordered by her doctor and she choked to death</p> |
| <p data-bbox="191 1104 773 1226">Burned to death from unsupervised smoking (AA) Penalty Amount: \$60,000</p> <p data-bbox="191 1272 760 1520">Citation #010002068 A resident with limited mobility caught on fire after smoking a cigarette unattended on the facility patio. She sustained fatal burns and died shortly thereafter.</p> | <p data-bbox="800 1104 1382 1226">Burned to death from unsupervised smoking (A) Penalty Amount: \$20,000</p> <p data-bbox="800 1272 1430 1604">Citation #220008683 A resident who had previously sustained a stroke caught on fire while smoking unsupervised, sitting in his wheelchair. Another resident found the man on fire and called for help, but staff did not respond for over two minutes.</p> |

| AA Citations | Class A Citations |
|--|---|
| <p data-bbox="191 254 695 380">Severe Untreated Dehydration (AA) Penalty Amount: \$100,000</p> <p data-bbox="191 426 760 674">Citation #070003427 A resident developed severe dehydration and died. Facility had not adequately assessed and monitored her for signs of dehydration.</p> | <p data-bbox="800 254 1365 338">Severe Untreated Dehydration (A) Penalty Amount: \$16,000</p> <p data-bbox="800 426 1414 758">Citation #030002307 A resident became severely dehydrated and was admitted to a hospital. Her family was told that there was little hope for recovery due to renal failure and associated dehydration. She died ten days after her admission.</p> |
| <p data-bbox="191 768 610 852">Patient Elopement (AA) Penalty Amount: \$50,000</p> <p data-bbox="191 898 764 1375">Citation #050001539 A resident eloped from the building. Her Wanderguard alarm did not alert staff when she exited the facility. She was found on the ground outside of the front door in her overturned wheelchair, bleeding from laceration on side of head. According to staff, the resident was conscious, but disoriented. She died a week after her fall.</p> | <p data-bbox="800 768 1219 852">Patient Elopement (A) Penalty Amount: \$10,000</p> <p data-bbox="800 898 1414 1375">Citation #940009065 A 61-year-old resident who had a known risk of elopement left the facility at night in his wheelchair. The alarm did not sound. He was found unresponsive hours later outside of a convenience store with blood on his head. Surveillance footage showed he had fallen from his wheelchair and hit his head on the ground. He was pronounced dead at the scene.</p> |
| <p data-bbox="191 1388 626 1472">Fatal Medication Error (AA) Penalty Amount: \$83,000</p> <p data-bbox="191 1518 773 1837">Citation #030003486 A resident was prescribed Morphine at a rate of 10 mg an hour, but the medication was instead given at a rate of 120-150 mgs over a two hour period. The resident died shortly thereafter of a morphine overdose.</p> | <p data-bbox="800 1388 1268 1472">Fatal Medication Error (A) Penalty Amount: \$17,000.00</p> <p data-bbox="800 1518 1414 1753">Citation #040009912 LVN gave a resident 100 mg of Morphine Sulfate instead of 5 mg. The resident died from a morphine overdose (morphine toxicity).</p> |

| AA Citations | Class A Citations |
|---|---|
| <p data-bbox="191 254 716 331">Botched medical procedure (AA) Penalty Amount: \$75,000</p> <p data-bbox="191 373 537 411">Citation #940009762</p> <p data-bbox="191 449 724 611">Staff accidentally inserted a resident's gastrostomy tube or G-tube into her peritoneal cavity, causing septic shock.</p> | <p data-bbox="802 254 1433 331">Botched medical procedure (A) Penalty Amount: \$18,000.00</p> <p data-bbox="802 365 1141 403">Citation #090002851</p> <p data-bbox="802 441 1429 602">Staff punctured a resident's colon when inserting a G-tube and then administered formula through it. The client went into septic shock and died.</p> |

Licensing has told Disability Rights California that it issues the maximum level of citation supportable by the evidence. For case involving resident deaths, Licensing maintains, if a Class A citation is issued, there was insufficient evidence to support a finding that the resident died as a direct proximate result of staff misconduct. Licensing has refused to produce any explanation or findings supporting these legal conclusions, including the findings of their medical experts on causation, claiming they are protected by attorney client privilege.

Ramifications for Failing to Issue a Higher Level of Citation:

1. Public may be misled by the inaccurate portrayal of severity of harm.

Licensing is responsible for ensuring that nursing facilities are held accountable when they provide poor and substandard care in violation of a state regulation and accurately reporting these lapses in care to the public. When Licensing fails to hold nursing facilities fully accountable for patient deaths, the public is misled about how potentially unsafe these facilities might be or the actual level of resulting harm to a resident.

We are pleased that Licensing has committed to posting the full content of all Class A citations issued since January 2012 on their [Health Facilities Consumer Information Systems](#) (HFCIS) website. Having the full content of citations available to the public will better inform the public about the egregiousness of the harm involved for those who read the entire citation.

2. Licensing allows substandard facilities to continue to operate.

If a facility receives more than one Class AA citation within a two year period, Licensing must take steps to either revoke or suspend the facility's license. In contrast, if a nursing home receives more than one Class A citation within a 24 month period, Licensing is not required to take similar action.⁶ Multiple Class A citations within a short time period results in trebling of fine amounts but does not necessarily provoke license suspension or revocation. Thus, the decision by Licensing to issue a Class

⁶ See Health and Safety Code §1424.5(a)(1).

A citation in the case of a resident death rather than a Class AA citation is critical to the action Licensing must take in addressing imminently dangerous care issues recurring at problematic facilities.

For example, as described earlier in this report, Licensing did not issue a Class AA citation following the death of Alejandro Reynolds in 2010. The facility had received a Class AA citation the year before for the death of Mr. Maples due to staff neglect. Had Licensing issued Verdant Vista a Class AA citation for Alejandro Reynolds's death, Licensing would have been legally required to take steps to suspend or revoke Verdant Vista's license. Instead, by issuing a Class A citation, Verdant Vista continued to operate. In 2014, Jerome Parks, another Verdant Vista resident, died from poor care by the facility.

In our review of citations from 2000 through 2014, we found 24 facilities that had received more than one Class A citation within a two year period which resulted in a resident death due to staff conduct which created imminent danger or substantial probability of death. Current law does not require Licensing to take action to suspend or revoke the license when deaths are directly caused by poor care and these problematic facilities continue to operate.

3. By issuing Class A citations for deaths, Licensing is limited in the amount of fines it can levy.

Statutorily, Class AA citations penalties range from \$20,000 to \$100,000; Class A citations penalties range from \$2,000 to \$20,000. By issuing a Class A citation in deaths resulting from staff misconduct, Licensing is limited to a lower financial penalty than if it had issued a Class AA citation. The chart below illustrates this difference in the 11 cases listed above. We estimated the Class AA penalty level based on the comparable

citations issued in other deaths in which a Class AA citation was issued. Cumulatively, the imposition of a Class A instead of a Class AA citation resulted in a loss of nearly \$600,000, just for 11 cases.

Table 3: Disparity between Average Penalty Amounts From Table 2

| Category | Class A Citations | AA Citations |
|---------------------------------|-------------------|------------------|
| Bed restraint | \$10,000 | \$90,000 |
| Blood loss | \$20,000 | \$100,000 |
| Blood thinner | \$16,000 | \$60,000 |
| Botched medical procedure | \$18,000 | \$75,000 |
| Burns | \$20,000 | \$60,000 |
| Choking | \$20,000 | \$32,500 |
| Dehydration | \$16,000 | \$100,000 |
| Elopement | \$10,000 | \$50,000 |
| Fall | \$20,000 | \$60,000 |
| Medication | \$17,000 | \$83,000 |
| Resp. Device Malfunction | \$20,000 | \$60,000 |
| Total Penalties Assessed | \$187,000 | \$770,500 |

\$583,500 in lost revenue just for 11 cases

Table 4: Total Lost Revenue

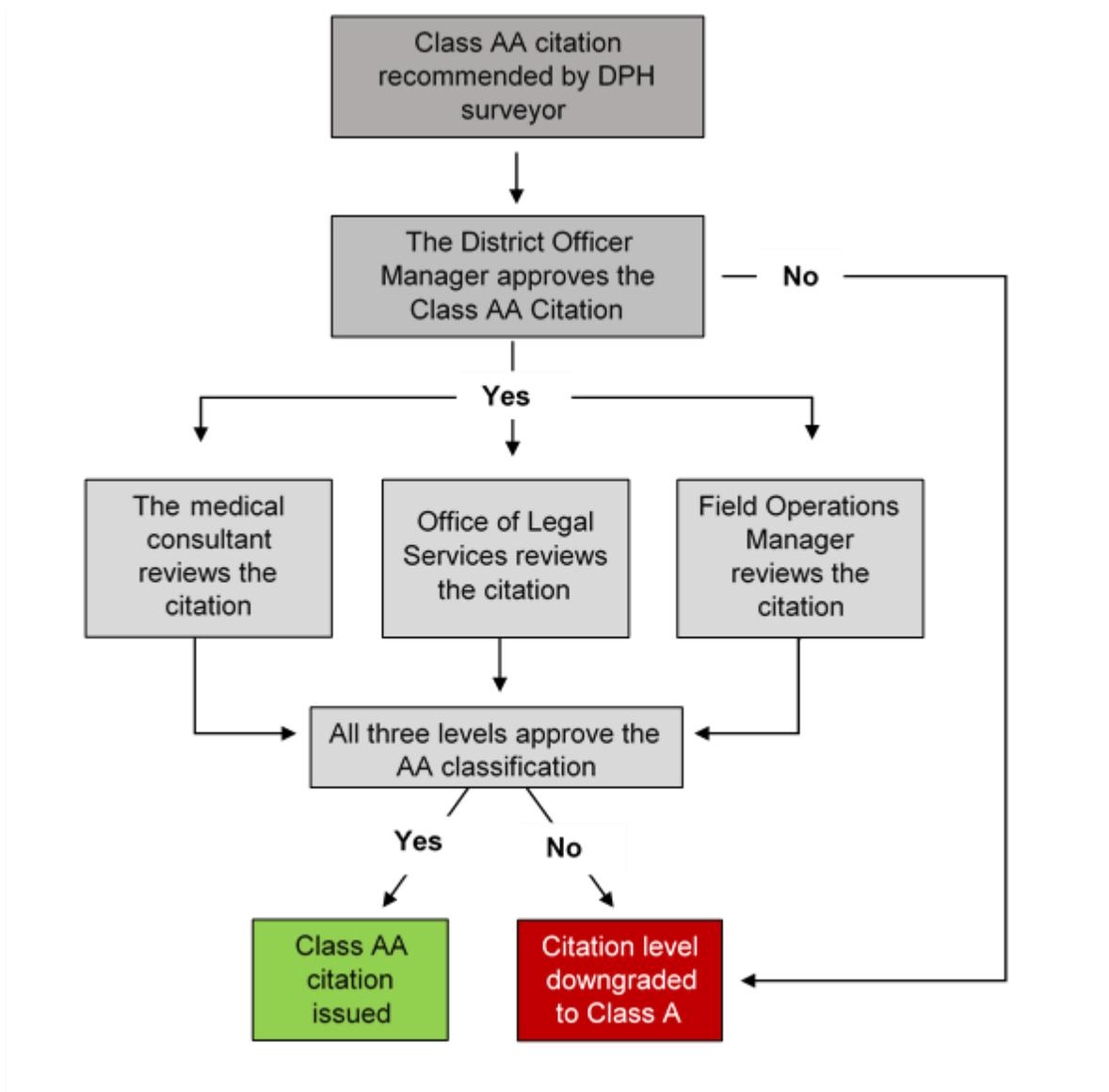
| | Class A Citations | AA Citations |
|-------------------------------|-------------------|------------------|
| Maximum Penalty | \$20,000 | \$100,000 |
| Minimum Penalty | \$10,000 | \$32,500 |
| Average Penalty Amount | \$17,000 | \$70,045 |

Licensing Provides Insufficient Information to the Public of Lack of Direct Proximate Cause in Resident Deaths Related to Poor Care

Citations, particularly those involving resident deaths, undergo multiple levels of review and approval within the Licensing hierarchy before they are issued⁷. This is a general depiction of the review and approval process of death investigations (see Figure 1).

⁷ <http://www.cdph.ca.gov/certlic/facilities/Documents/NurseHomeAaFAQ.pdf>

Figure 1: Class AA Citation Review Process



1. District Office Level: Individual surveyor finds that staff conduct directly caused a patient’s death and recommends that death be given a Class AA citation. District Officer Manager must approve of this recommendation or can downgrade the citation to a Class A.
2. Field Operations Manager Level: The District Office Manager agrees that a citation be given a Class AA. However, Licensing’s medical consultant, Office of Legal Services, and

the Field Operations Manager must also approve the District Office's recommendation of a Class AA citation.

3. Medical Consultant: A Medical Consultant must review and approve Class AA citations. Not all medical consultants have expertise in the particular medical conditions or treatment involved in a death.
4. Office of Legal Services: The Office of Legal Services (i.e. the Department's legal staff) review and approve of a Class AA Citation, determining whether there is sufficient evidence that staff conduct was a direct proximate cause of the resident's death.
5. Headquarters: Citation AA is issued or downgraded to Class A or B citation

According to Licensing, complaint investigations may be referred back to the individual nurse surveyor for further investigation or collection of additional evidence to support the citation level.

In the deaths that we investigated, Disability Rights California requested the internal Licensing documentation of each level of review to establish the reason Licensing found insufficient evidence of direct proximate cause. We were denied access to any evidence of these reviews and are unable to conclude why these deaths were awarded a lower level of citation.

After Licensing has issued a Class AA citation, a long-term care health facility can either accept or contest the citation. To contest a citation, the facility files an appeal in Superior Court. Licensing can settle with the nursing home, usually for a lower penalty fine, instead of litigating the

appeal in court. If appealed, the court, after hearing the facts of the case, can reduce the citation to a Class A or substantiate the issuing of the Class AA citation. This provides a level of independent oversight, ensuring that nursing facilities have a means of petitioning what they believe to be excessive enforcement action. There is no similar means of judicial appeal for family members who feel that Licensing inappropriately issued too low a level of citation in the case of their loved ones' death. Family members can instead request that Licensing reconsider the citation level it issued, but cannot contest Licensing's final determination to a court.

Licensing explained that some of the Class A citations we reviewed were initially issued as a Class AA citation, and that the citation might have been reduced by a court to a Class A citation. However, we did not receive any further details or confirming information about which citations were reduced because of judicial involvement. Licensing plans to include whether a citation has been appealed and the course of the citation level assigned on their HCFIS website. Disability Rights California supports this decision.

In August 2014, the Los Angeles County Auditor-Controller concluded that Licensing was "downgrading" citations. In an analysis of thirty cases, the Los Angeles County Auditor found that "for 12 (40%) of the 30 closed case files reviewed, the surveyors' recommended deficiencies and citations were deleted or downgraded. Five (42%) of the 12 cases involved the deaths of residents as young as three years old." In 42% of the

downgraded cases, “the district manager, who deleted or downgraded the citations/deficiencies, could not provide justification for the change.”⁸

⁸ County of Los Angeles Department of Auditor-Controller, August 27, 2014, [Department of Public Health-Nursing Home Investigation Follow-Up Review](#) (Board Agenda Item 49-A, March 4, 2014).

Findings and Recommendations

Finding 1: Licensing has failed to consistently apply the same citation level when staff misconduct is a direct proximate cause of a resident's death.

By law, a Class AA citation must be issued when facility staff conduct is a “direct proximate cause” of death of a resident of a long-term health care facility. By contrast, a Class A citation is issued when staff conduct poses an “imminent danger to patients” or there is a “substantial probability of death or serious physical harm” but there is insufficient evidence that the conduct was a direct cause. Staff conduct need not be the *only* cause of an individual's death, but if it is a direct proximate cause, Licensing is obligated to issue a Class AA citation.

In the cases that our experts reviewed, they found that the deaths were directly and proximately caused by staff conduct; that the deaths were preventable, not inevitable. Our review of thousands of other Class A and AA citations, issued between 2000 and 2014 uncovered hundreds of other deaths where Licensing decided to issue the lower level Class A citation, inexplicitly not finding sufficient evidence of direct cause. Licensing fails in its duty when it does not issue the appropriate level of citation for residents' deaths that are directly due to staff misconduct or negligent care. Furthermore, the public may be misled about how potentially unsafe these facilities might be or the actual level of resulting harm to a resident.

Recommendation 1: Licensing must consistently issue a Class AA citation when staff conduct is a direct proximate cause of a resident's death.

Licensing must fulfill its obligation to issue prompt and effective civil sanctions against long-term health care facilities for violation of the laws and regulations related to patient care. When staff conduct is a direct cause of a resident's death, Licensing must issue a Class AA citation and hold the facility fully accountable. This means imposing the appropriate level of citation, especially when conduct of facility staff leads to patient deaths.

Finding 2: Licensing Appears to Lack Consistent Standards for Issuing Citations in the Case of Residents Deaths

Licensing appears to lack consistent standards for determining whether to issue a Class AA citations in the case of a patient death. Disability Rights California compared the facts in over 500 citations involving a resident death – approximately half were issued a Class AA citation and the other half were issued a Class A citation. In many cases, the deaths involved a seemingly identical fact pattern. DRC was unable to discern why some deaths were awarded a Class AA citation and others were given a Class A; in other words, why staff misconduct was found to be a direct proximate cause in some deaths and not in others. In many cases, the facts involved in a Class A death were even more egregious than the facts in deaths that received the more serious penalty of a Class AA citation.

There is no information in the citation explaining why Licensing found insufficient evidence of direct proximate cause and decided to issue a Class A instead of a Class AA citation. In the cases that Disability Rights

California investigated, Licensing refused to provide information or explain what evidence they relied upon in supporting why these deaths were awarded a lower level of citation. Licensing did not provide any standard criteria they use other than a general statement that the evidence failed to support a legal finding of direct proximate cause.

Recommendation 2a: Licensing must apply consistent standards for issuing citations.

Licensing must apply consistent standards for issuing citations, and uniformly hold facilities accountable where staff conduct was a direct proximate cause of residents' deaths. These standards should be publicly available and reference to the standards should be articulated in each citation, particularly those citations involving resident deaths. Licensing should periodically audit citations issued in the case of residents deaths, as Disability Rights California did - comparing the facts in similar deaths to ensure consistency in the level of citation issued.

Recommendation 2b: Licensing must provide greater transparency regarding the facts supporting a finding of inadequate probable cause in the case of resident deaths.

There must be greater transparency and public accountability about why a death involving staff misconduct resulted in the lower level Class A. Licensing should make available to the public a statement of reasons that supports its decision not to assess a Class AA citation for a death that directly involved staff conduct. The information provided should be factual and not merely a recitation that there was insufficient evidence of direct proximate cause. For example, Licensing could list other intervening factors that were more directly contributing to the individual's death. This

will better inform the public about the facts involved in a resident's death and provide greater transparency regarding actual care concerns.

Disability Rights California hopes that Licensing's new consumer website will allow the public to have easier access to information, including at which point in the citation review process it was decided a resident death should receive a Class A versus a AA citation; for example at the time of its initial issuance by Licensing, or after an appeal by the facility. This will enable the public to more easily monitor at what stage in the citation process the citation pertaining to a resident's death is downgraded and why.

Finding 3: Nursing facilities are not fined a higher penalty when Licensing concludes that staff conduct is not a direct cause of a resident's death.

For citations involving skilled nursing facilities and ICF/DDs⁹, the financial penalties for Class AA citations range from \$25,000 to \$100,000; by contrast, the financial penalties for Class A penalties range from \$2000 to \$20,000, regardless of whether a resident's death resulted. These amounts are reduced even further—up to 65%--if the facility pays the fine within 30 days of receiving the citation.¹⁰

In the deaths Disability Rights California investigated, facilities paid, on average, \$17,000 despite providing poor care that resulted in resident deaths. In the hundreds of other Class A deaths Disability Rights California reviewed, many were issued fines as low as \$10,000 – at a 65% discount for early payment, a facility could pay as little as \$3,500 for negligent care that resulted in a resident death. Low penalties do not serve as deterrent

⁹ Intermediate Care Facility/Developmentally Disabled

¹⁰ Health and Safety Code §1424.5(b).

for negligent care and undervalues the cost of human life. This contradicts the original intent of the legislation in authorizing Licensing to assess penalties. Furthermore, they represent a significant loss in revenue to the State.

Recommendation 3: California should increase the penalty amount for citations involving deaths of residents in long-term health facilities indirectly resulting from staff misconduct.

Disability Rights California recommends that an additional citation level be added for those incidents when staff misconduct resulted in a resident death but there is insufficient evidence that it was a direct proximate cause. Assigning a higher penalty amount for incidents resulting in resident deaths more appropriately recognizes the magnitude of the resulting harm and loss and is a more accurate measure of magnitude of the misconduct. Assessing financial penalties commensurate with the resulting harm due to negligence and poor care will likely serve as a greater deterrent to addressing imminently dangerous substandard care and ultimately improve the quality of care in long-term health care facilities.

California law should define “a direct proximate cause of death” and clarify that a Class AA citation does not require evidence that the staff conduct is the proximate cause of death. Staff failing to monitor the level of Mr. Reynolds’s clotting times and to aggressively treat his advancing Stage 4 pressure sores was a direct cause of his death when the cavernous decubitus ulcers opened to his femoral artery. Staff leaving Ms. Baskin unattended for nearly an hour on a breathing device she had not tolerated in the past was a direct cause of her death. Failing to monitor Ms. Kim’s blood clotting times during her six week hospital stay not only violated

policy and failed to detect that her clotting times were six times slower than normal but was a direct cause of her sustaining a fatal, massive intracranial hemorrhage. In each case, staff misconduct was a direct proximate cause of the resident's death. California law should be amended to ensure that these are included within the definition of a direct proximate cause and are sufficient evidence to support a Class AA citation.

Disability Rights California further recommends that license suspension or revocation result when a long-term care facilities receives three or more Class A citations within two years. Currently, multiple Class A citations within a short time period results in trebling of fine amounts but does not necessarily provoke license suspension or revocation, even when the incident(s) resulted in a resident death. In contrast, if a facility receives more than one Class AA citation within a two year period, Licensing must take steps to either revoke or suspend the facility's license. Licensing must be required to take action similar action against the facility's license with multiple Class A citations within a limited time period. Merely trebling the penalties for multiple Class A citations, particularly those resulting in a resident's death, is insufficient to address the pattern of imminent danger to residents due to recurring staff misconduct.